TE TOKA TUMAI
Auckland DHB

AUCKLAND DISTRICT HEALTH BOARD

Annual Report 2020 | 2021

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

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

Contents

Who we are and what we do

Auckland DHB | Te Toka Tumai is the Government's funder and provider of health and disability services, mai te whenua ki te whenua/mō te katoa. We serve an estimated 507,000 residents who live in the Auckland isthmus, Waiheke Island and Great Barrier Island, and provide specialist healthcare services to patients and whānau from the Northern Region, and across Aotearoa New Zealand.

Our population is increasingly diverse and rapidly growing. Just over 8% of Auckland residents are Māori, 11% are Pacific, and 34% are Asian. Around 45% of our population were born overseas, with over 200 languages spoken. Our population is projected to increase by 8% (40,000 people) by 2030.

Our DHB's population is generally healthier than that of New Zealand as a whole. We have the second highest life expectancy in New Zealand at 83.4 years, with an increase of 3.1 years since 2001.

Auckland DHB operates Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital, the largest teaching hospital and research centre in New Zealand. We provide many highly specialised services to the entire motu.

Services are also delivered from 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.

Around 12,000 people are employed by Auckland DHB. In 2020/21, we had a budget of $2.6 billion.

As Auckland's largest business, we endeavour to positively impact the local economy, improve our environmental footprint, and support our people to achieve the health outcomes they want.

Our population in 2020/21

507 thousand Te Toka Tumai residents

40,000 more people by 2030

83.4 years life expectancy at birth

8% Māori

11% Pacific

34% Asian

47% Other

Working together to achieve Māori health gain

Message from Gwen Tepania-Palmer, Chair of Kōtui Hauora

E ngā iwi, e ngā karangatanga maha, tēnā koutou

E ngā mate kua mene ki te pō, haere, haere, haere

Ka huri mātou ki te hunga ora, tēnā koutou katoa

Ngā mihi maha hoki ki a koutou, mānawatia a Matariki

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Matariki 2021 brings us into the second year of Kōtui Hauora, a Tiriti-based partnership of mutual benefit between iwi across Te Tai Tokerau and the three northern most DHBs. Although we have a long journey ahead, I look back on the year that was with admiration for all involved and the work achieved for whānau and communities. It was truly inspiring to see how we, as a team, are responding to the COVID-19 pandemic.

The impact of COVID-19 has tested our partnership and I am proud to say that we are responding brilliantly. With the support of Kōtui Hauora, our iwi partners throughout the north provided necessities and home-based care to over 23,000 households, set up a COVID-19 coordination hub, and employed 90 Kaimanaaki as their frontline workforce to engage with whānau in the community. Ngā Kaimanaaki based with iwi conducted over 5,000 whānau wellbeing assessments and assisted them to access healthcare and social support. This massive effort was funded by a number of agencies, with Northland, Waitematā and Auckland DHBs providing a large part of this investment. The success was so great from these efforts that further support and investment will be made into Ngā Kaimanaaki services.

The wider sector response is also important to acknowledge. It was great to see Māori-led pop-up clinics in communities, outreach support services and testing sites across Te Tai Tokerau.

In Auckland and Waitematā, Māori-led outreach services, supported by Kōtui Hauora, provided healthcare in vulnerable communities. A big part of this included influenza vaccinations for Māori. In 2020, the coverage for influenza vaccination for Māori aged 65 years and over increased by 7.7% in Auckland DHB and by 13.1% in Waitematā DHB compared with 2019 coverage. This is a good outcome, and shows that we need to continue to work together to engage and care for our communities.

In 2020/21 and beyond, vaccination against COVID-19 is a priority. We know that Māori are at a greater risk of severe illness from COVID-19 and we are working together with our partners to deliver vaccinations to our communities.

Kōtui Hauora is about action in the face of need, and we firmly believe that this requires our collective resource, knowledge and influence to achieve. On behalf of Kōtui Hauora, I am heartened to see the progress we made in 2020/21 and look forward to challenging ourselves to do more to improve the wellbeing of Māori in the future.

Kia pūmau tā tātou hononga, kia haere tonu ā tātou mahi

(Our partnership will endure and our work will continue)

Equity and quality in a challenging year

This year we have made good progress against our strategic priorities in partnership with Iwi and relationships with stakeholders.

We have had a strong focus on enacting our Te Tiriti responsibilities to protect the rights that Māori hold as tangata whenua and to ensure we achieve equitable health outcomes for Māori.

This has meant considerable transformation as we interrogate our services and practices to make equity synonymous with quality.

The last 12 months has been one of uncertainty and change globally, nationally, for the people we serve and for our staff at Auckland DHB as we respond to the COVID-19 pandemic. We've had to work at pace to adapt and evolve to meet the needs of a rapidly changing situation. Our people embraced those changes and went above and beyond every single day for our patients and communities. A clear illustration of our values in action.

We did this together, as a whole health system. Jointly with our Māori partners and our Pacific partners we have dealt with outbreaks, lockdowns and a massive push to get Aucklanders vaccinated.

Along with our regional DHB partners we set up the Northern Regional Health Coordination Centre when the COVID outbreak first began. The team have led the COVID-19 outbreak control, including vaccination, testing and managing the health component of managed isolation and quarantine working. Like with all our work, the focus of the COVID response within the DHB and regionally has been to ensure we uphold Te Tiriti and equity of outcomes for Māori and for Pacific people.

Our Māori providers and our Pacific providers have responded to the challenges faced by the communities they serve. Their leadership and knowledge has demonstrated why community leaders are the right people to find the solutions. Our job is to support them and back them up.

Our nurses deserve a special mention this year, we recognise that this dedicated group of professionals is under a great deal of pressure. They have borne the brunt of the demands of the COVID response at the same time that we are experiencing a nationwide shortage of nurses.

We have continued to look at different ways to attract more nurses and midwives as part of our recruitment strategy. We've also continued to look at creative ways to increase our nursing, midwifery and healthcare assistant workforce. One of these is to set up a training programme for healthcare assistants so they can be part of our paid workforce while training on site. We saw more than 30 people join us in the first cohort of this group.

It's been a very busy year for the health system. On top of responding to COVID and dealing with increasing demand the whole New Zealand health and disability system is going through a significant period of change, with the Health reforms.

Our response to COVID has further highlighted that the health sector is under stress and the value of integration across the regional health system. The health reforms are intended to relieve that pressure and drive us towards greater regional collaboration. Most importantly they put in place the structures and leadership to ensure we are upholding Te Tiriti o Waitangi and achieving health gain for Māori.

The reforms are ambitious but I believe they are the right ones to ensure we create an even better health system for all New Zealanders. There is no doubt it is going to be a challenge and it will mean some changes in how we work but you can be assured we will continue to put the best interest of our patients, our community and our staff at the centre.

What a year. We can all be justly proud of what we've achieved. Again our people have stepped up and shown what a truly amazing team they are.

Pat Snedden

Chair
Auckland DHB

Ailsa Claire OBE

Chief Executive
Auckland DHB

Te Toka Tumai 2020-2023 – our strategy

A new strategic plan took effect in 2020/21, guiding the way we work and setting out the operating model we need to deliver results for iwi, Māori and Pacific communities, and patients and whānau until 2023.

We have five strategic priorities over the coming three years. They are:

Under each domain, we align our mahi in our provider and community-based services. These work plans operate at different levels to cover the spectrum of large strategic programmes, portfolios, and/or operational business. With shifts in the volume of work in response to COVID-19, the majority of the transformation work is targeted at the first two priority areas.

There are four organisational pillars that enable us to target our priorities:

- Pūmanawa Tāngata – people, culture and values
- Quality, safety and risk
- Commissioning services to meet our people's needs
- Financial sustainability.

To deliver our priorities, we work in partnership with our MOU partner, Te Rūnanga o Ngāti Whātua. We also work in co-governance with the regional leadership of Kōtui Hauora, as we build our capability to implement substantive change under our first priority and improve Māori health outcomes.

Equity

Auckland DHB | Te Toka Tumai is committed to achieving health equity for all those in our community, in particular for Māori.

We know that Māori and Pacific people in our district have poorer health status than pākehā. We know that inequity is not only avoidable, but unfair and unjust. Māori are guaranteed rights under Te Tiriti o Waitangi, which means attention to our Tiriti obligations as a Crown entity is paramount to securing Māori health gain. We prioritise health gain for Māori, based on the rights that Māori hold as tangata whenua.

We are developing strong relationships across the sector, focused on health equity. Collaboration with our iwi and stakeholders allows us to offer whānau-centric, comprehensive and holistic models of care. Our provider reinforces our equity agenda to improve support for our lower income employees, increase our employment of Māori and Pacific, and mandate specific services to accelerate health gains for our community.

The Māori Health Pipeline is a dedicated group of projects, which focuses on identified areas to accelerate Māori health gain. The pipeline provides an opportunity to develop a more streamlined process for proposals, project implementation and robust evaluation. The pipeline work programme includes: lung cancer screening, alternative community cardiac and pulmonary rehabilitation prototypes, breast screening augmented data match, targeted cervical cancer projects, abdominal aortic aneurysm (AAA) screening, and the Hepatitis C Lookback and Reoffer programme.

We are committed to eliminating inequity for Pacific peoples. We are reviewing our systems to find barriers that deny our Pacific people equitable access. We progressed work in Did Not Attracts (DNAs), cancer, mental health, child health and women's health. Service changes in bariatrics showed real benefits for Pacific patients and fanau. We will continue to enable other directorates to re-organise service delivery to achieve equity.

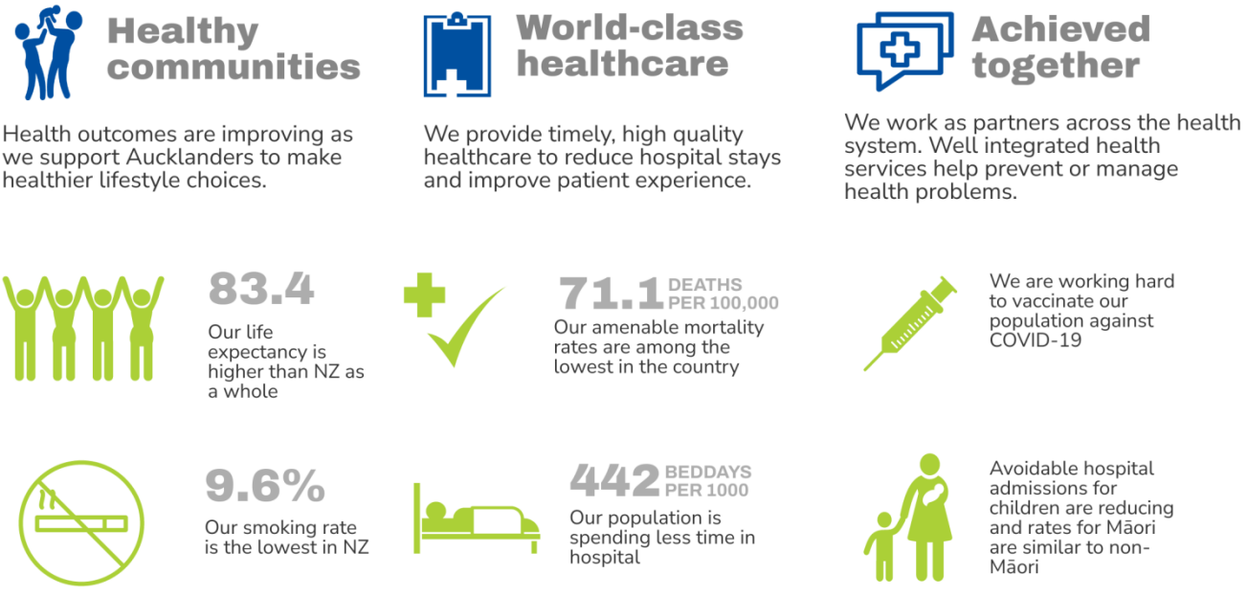
We also focus on improving equity for disabled and older people. We are committed to the New Zealand Disability Strategy and the principles of the United Nations Convention on the Rights of Persons with Disabilities, and the Healthy Ageing Strategy.

Some of our key achievements

Auckland DHB | Te Toka Tumai is one of the healthiest communities in Aotearoa New Zealand, and we performed well against our key indicators in 2020/21.

Our achievements in 2020/21 include:

- Life expectancy continues to improve, reaching 83.4 years (2018-20), one of the highest in the motu and an increase of 3.1 years since 2001
- Our smoking rates are the lowest in New Zealand, at 9.6% (Census 2018 usually resident population) and we continue to help more smokers to quit. 98% of pregnant women and 82% of PHO-registered smokers received advice and help to quit smoking. 67% of all six-week old babies live in smokefree homes
- Amenable mortality has steadily declined over the past decade, and our rates are among the lowest in New Zealand, at 71.1 per 100,000 population
- Our acute bed day rate is declining and is currently 442 per 1,000 population (standardised for age) compared with 402 per 1,000 population nationally as at March 2021
- Auckland DHB has the highest 5-year cancer survival rate in New Zealand and we achieved the Faster Cancer Treatment 90% target
- Our childhood immunisation rates are among the highest in New Zealand, and almost all preschool children are enrolled with oral health services
- We delivered 23,642 elective surgical procedures
- We are working hard to manage COVID-19. By the end of June 2021, our residents had been tested for COVID-19 355 thousand times and 84 thousand people had received at least one vaccine dose.



Our COVID-19 response

A region-wide effort

COVID-19 has a material impact on the way we plan and deliver healthcare services. Our challenges in the year to June 2021 were to recover and grow from the initial outbreaks in early 2020, respond to resurgences (most significantly in August/September 2020), and deliver a comprehensive vaccination programme.

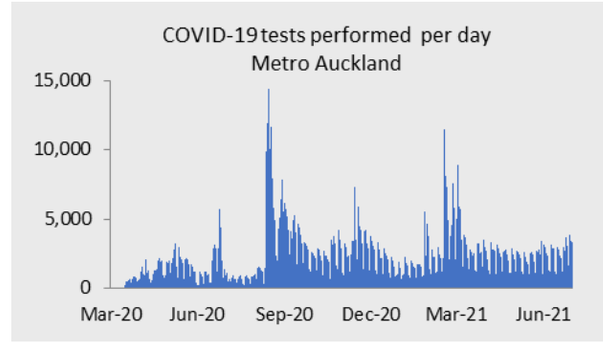
Working together with Counties Manukau, Waitematā and Northland DHBs, the region is delivering a whole-of-health-system response to COVID-19 through the Northern Regional Health Coordination Centre (NRHCC). The NRHCC is responsible for community COVID-19 testing and outbreak control, surveillance testing of border workers, the entire health component of the managed isolation and quarantine (MIQ) system in the Northern Region, and the vaccination programme.

A flexible testing model is in place that can adapt rapidly to changing circumstances. These include community testing centres, mobile testing units, and general practice and urgent care clinics. Most of our community testing centres and pop-up clinics are run by Māori and Pacific health providers, including Whānau Ora Community Clinic and marae-based providers.

A COVID-19 community testing centre in Ōtara.

In August/September 2020, and again in February/March 2021, new outbreaks saw the Auckland region sent back into lockdown. The NRHCC immediately increased testing capability. Within 24 hours of the first positive case in the August 2020 outbreak, 16 new testing centres were opened across the Auckland region, with over 500 healthcare workers redeployed to support testing.

Testing volumes peaked at around 16,000 swabs per day, and there were more than 30 testing centres, pop-up sites and mobile units operating across Auckland.



Testing capacity across Metro Auckland rapidly increased to meet demand.

Additional contact tracing teams were put in place at the Auckland Regional Public Health Service, and laboratories vastly increased their processing capacity.

The August 2020 outbreak predominantly affected our Pacific (61% of cases) and Māori (22% of cases) communities living in less affluent areas of south and west Auckland. Housing and other adverse socioeconomic problems, along with a high prevalence of chronic health issues (e.g. diabetes and heart disease), combine to increase the risk of infection and death in these communities.

Our Māori and Pacific health teams played a significant role in limiting the outbreak by working with community leaders and healthcare and social service providers to provide equitable access to testing and wider support.

Working with our Māori and Pacific partners, flexible services are provided to support vulnerable populations. During periods where there is no additional need for increased COVID-19 testing, mobile units support whānau to access primary care, welfare and other social services support. Ngāti Whātua Ōrākei have delivered this service in the Auckland DHB area since January 2021, working with over 200 households in the first six months.

Up to 120 new community health workers supported whānau wellbeing as part of a partnership between iwi, Māori health providers and the Northern Region DHBs. Lead Māori health providers employed community leaders and volunteers to carry out basic welfare checks, help whānau navigate the care they need, and support with the collection and distribution of essential items.

The Prepare Pacific website was launched to help keep our Pacific communities up to date with the latest COVID-19 information. As well as being an excellent resource for the public, the site is used by our Pacific team as a support tool while providing cultural and pastoral support to our patients and their families.

The lockdowns in 2020 caused high levels of anxiety in Pacific families, resulting in an increase in requests for food and whānau support and the impact of the pandemic on families is on going. The Aiga Fono Care (AFC) team works with other agencies to help with housing, navigating health services, immigration issues and family and social problems.

Our COVID-19 vaccination roll-out

Providing a safe and effective vaccine for COVID-19 is essential to protect our communities. The delivery of a swift and comprehensive vaccination roll-out programme is a key piece of work for DHBs.

The NRHCC oversees the set up and operation of community vaccination centres all over Auckland, and Auckland DHB staff help to man both the community and staff vaccination clinics. As part of the regional work programme, Auckland DHB is committed to completing the roll out of the COVID-19 vaccination programme and ensuring its success.

Border and MIQ workers are the most at risk of contracting COVID-19, and were the first group to be vaccinated, beginning in February 2021.

Our first large-scale COVID-19 vaccination clinic opened in south Auckland on 9 March 2021 to vaccinate household contacts of border staff and MIQ workers. Several more large scale centres, capable of vaccinating up to 1,000 people a day, were opened across greater Auckland.

We are working in partnership with Māori and Pacific NGOs to set up more small, community-based vaccination centres. There are several Māori-led vaccination centres in Auckland, run by providers who operate a Te Ao Māori model of care, including the Henderson vaccination centre, led by our partner Te Whānau o Waipareira. There are Pacific-led vaccination centres in Ōtara, led by South Seas Healthcare Trust, and in west Auckland led by The Fono.

Vaccination of those living in aged residential care began in late April 2021, starting with those living in the south Auckland communities highlighted as a priority within the national vaccination programme.

Staff and residents at Kenerdine Park Rest Home in Papatoetoe were the first to be vaccinated as part of the region's aged residential care outreach programme.

Many general practices, urgent care facilities and pharmacies are now delivering vaccines. The Waiheke Island Medical Centre was the first GP clinic to begin vaccinating its patients against COVID-19 in May 2021, with large numbers of additional clinics planned. Delivery of vaccines by community pharmacies is also ramping up in 2021.

The Auckland DHB onsite vaccination clinic opened in March 2021 and by 30 June 85% of staff have been fully vaccinated. At its peak, the clinic delivered over 700 vaccinations per day.

By the end of June 2021, Ministry of Health data shows 12.7% of those aged 12 years and over and living in our catchment area were fully vaccinated. Rates were slightly lower for Māori and Pacific (11%) and we are hard at work to address this inequity.[1]

Vaccine delivery has ramped up quickly in the second half of 2021, with a huge amount of effort going towards reaching all members of the community.

By 7th December 2021, 97% of eligible people (now including 12-15 year olds) had received at least one dose and 94% are fully vaccinated.[1]

[1] The data presented here has been provided by Ministry of Health and is based on the Health Service User eligible population

Recovery and risk management

2020/21 saw a transition to a new phase in our COVID-19 response to progress from outbreak control in August 2020 to recovery planning and risk management.

The initial focus for regional management of the initial COVID-19 outbreak in 2020 was to provide an immediate response and develop regional plans and actions to support MIQ, contact tracing and testing, hospital and public health infrastructure and workforce.

In 2020/21, our people engaged in significant work programmes to clear the backlog of activity that was deferred during the 2020 lockdowns, and return access and participation rates to levels seen prior to the pandemic. For much of the year, Auckland DHB was also in a phase of sustaining and adjusting our response to the risk of COVID-19. There was a continued focus on both the ongoing management of COVID-19 risks and managing our usual operations, which required an understanding of the impacts of each on the other.

All new patient contacts (inpatient and outpatient) are screened for COVID-19 risk. The screening tool has evolved in response to changes in community prevalence, scientific understanding around infectivity risk and procedures, disease definitions and travel restrictions. Different versions of the screening tool were developed and are available for different disease risk scenarios.

A number of controls in the COVID-19 escalation tool were reviewed and updated. The escalation tool (with associated actions) is reviewed routinely, focusing on COVID-19 risk and other system-wide pressures and potential impacts.

One of our key concerns is the safety of our workforce. The in-house staff vaccination programme was implemented, and over 85% of staff on the payroll received 2 doses of the COVID-19 vaccine. Other staff access vaccination via community vaccination providers.

We continue to encourage unvaccinated staff to be vaccinated, with communication and individual occupational health assessment. National guidance around vaccination of healthcare workers is adhered to and protocols are in place to manage the risk to our vulnerable workers.

PPE is sourced by the Ministry of Health and distributed to Auckland DHB. The PPE supplied is appropriately tested, validated, verified and approved for national use. We have a supply of masks for staff and public use, available if community prevalence necessitates their use. In 2020/21, we made good progress towards a robust respiratory protection programme. We completed a significant N95 fit testing programme and have an up-to-date database that is linked to our HR database to monitor this.

An on-going facilities improvement programme focuses on increasing the number of airborne infection isolation rooms across the organisation. Some improvements have already occurred in our adult ED and Critical Care Medicine department, with detailed design occurring on further developments planned for the these areas as well as our children's ED, cardiovascular ICU, critical care unit and paediatric ICU.

We know we will need to manage COVID-19 patients with other health conditions across all of our patient pathways, and we are developing and refining plans to safely enable this. This ensures that patients with possible COVID-19 are streamed to certain restricted areas in the hospital, while we optimise their care. MIQ patients are similarly streamed to specific areas of the organisation to reduce risk.

The on going activities and enhancements to routine care that were put in place in 2020/21 are flexible and adaptable and, in conjunction with an escalation planning approach, will ensure that we are able to maintain the delivery of timely, safe and high quality care to our population.

Delivering on our plans

Our strategic priorities guide the way we work and help us realise our vision of *Healthy communities, World-class healthcare, Achieved together* Kia kotahi te oranga mo te itime te rahi o te hāpori. 2020/21 saw some great examples of how we deliver on our priorities.

Creating change for Māori and Pacific patients

Te Tiriti o Waitangi in action

Our Māori and Pacific patients will now be better supported on their surgical journeys thanks to two new teams.

Inequities exist for our Māori and Pacific patients. Both groups wait longer for surgery and are more likely to have their surgery cancelled. The Kaiārahi Nāhi and Pacific Planned Care Navigation teams are Clinical Nurse Specialists who assist our Māori and Pacific patients on their journey to surgery. This can involve helping patients to understand the hospital system or their treatment plan and working with services to book suitable surgery dates. By working with patients, we can identify changes we need to make as an organisation to achieve equitable care for all.

The Kaiārahi Nāhi team, led by Clinical Nurse Specialist Dawson Ward (front)

Kia Ū Ora (breast wellness)

Eliminate inequity

Wāhine living in Auckland now have easier access to breast screening services, due to the launch of a new clinic and a mobile screening unit.

The new Breastscreen Auckland clinic, located in Greenlane, is a collaborative approach between Auckland and Waitematā DHBs. The service, which Ngāti Whātua gifted the name of Kia Ū Ora, has a focus on equity. Māori and Pacific wāhine have a significantly higher breast cancer registration rate than non-Māori and non-Pacific women. For this reason, the clinic will prioritise Māori and Pacific wāhine, especially those who are overdue for screening. A diverse workforce was recruited into the clinic, which is reflective of the community it serves; translators will be available for the women attending if they feel this assistance is needed.

To encourage breast screening among Māori wāhine, BreastScreen Auckland Central held a Wāhine Day. Twenty four wāhine and their whānau were welcomed into the centre, where everyone sat together sharing their kōrero over kai.

"The wāhine were supported through the breast screening process and seven wāhine had a smear," says Susie Kite, Health Promotion Retention and Recruitment Advisor. "But the best part of the day was whakawhanaungatanga, where we were able to establish relationships with our community."

A new mobile breast screening unit plans to see 200 women per week. The unit's beautiful design represents Papatūānuku (earth mother) who will encourage women to be strong and make a screening appointment.

Room for whānau in our hospitals

People, patients and whānau at the centre

Many of the whānau rooms across Auckland City Hospital have been refurbished to be more welcoming, comfortable and practical, and give loved ones the space they need in often challenging circumstances.

As the first hospital in the world to have dedicated Te Ao Māori whānau spaces, we are proud to be able to bring them back to a condition that honours their heritage. Our design lab, Ara Manawa, undertook an in-depth co-design process with whānau, patients, staff, community members, designers and architects. This made sure the new designs cater to the needs of our community when they are in our hospitals.

Our Whānau Rooms are an expression of manaakitanga | respect. They value and support the contribution that whānau make to the hauora | health of our patients, while acknowledging the spirit of generosity with which the land was gifted by Ngāti Whātua. These are spaces that honour Te Ao Māori and are intended for all patients and whānau, regardless of ethnicity or cultural identity.

Paul Faalogo and partner Tanya spent 13 weeks in hospital following a lung transplant, and the Whānau Room at Auckland City Hospital's Intensive Care Unit became a home away from home for his family.

"Having our family around was so important to Paul's recovery. It was great everyone felt welcome to visit him, and great they could regroup in the waiting room, when they couldn't all be at Paul's bedside, which was difficult when he was so sick. The more welcoming and comforting these spaces can be, the better for everyone," says Paul's partner Tanya (pictured right, with Paul).

Thank you to the generous supporters of the Auckland Health Foundation for funding this special programme.

Keeping our communities connected

Digital transformation

COVID-19 has changed the way we work. Telehealth (telephone or video conference) appointments have become a great way to meet with patients and keep our communities connected with health services.

Telehealth offers many benefits over the traditional model of bringing all patients into our facilities, helping us to reach patients who experience barriers to care, as well as saving patient and staff time.

We are working to further embed and expand the gains made from the rapid roll-out of telehealth during lockdowns. Several improvements have been made to encourage the use of telehealth by improving support and access for all our communities.

Patients are now able to include whānau or caregivers in their phone or video appointments. The language used in appointment letters is more culturally appropriate and we trialled the option of having a clinician-led karakia at the start of the consultation.

Mt Eden Corrections Facility is now set up for phone and video appointments. This means that inmates can have appointments with our specialists without an escorted trip to our hospital sites. Telehealth appointments are now hosted by the City Mission and community providers on Waiheke Island, making it easier for patients without access to digital technology to benefit from the convenience of video appointments.

The road to recovery

Resilient services

COVID-19 highlighted the need to change our approach to delivering outpatient care. Due to the Alert Level 4 lockdown in early 2020, many outpatient appointments were delayed, leading to large increases in waiting times.

In late 2020, our biggest and most challenged services used Auckland DHB's Outpatients Toolkit to address waiting times. The Outpatients Toolkit is a menu of initiatives developed at Auckland DHB for services to better manage demand.

The SOS patient-directed follow-up programme allows patients to be discharged with access to clinical advice and an appointment quickly, if required. Care is being provided closer to home with additional off-site clinics in vascular and ophthalmology. Better models of care were developed that more effectively utilise allied health and nursing clinicians and avoid unnecessary follow-ups, including nurse-led pathways in urology and improved triage and embedded physiotherapy clinics, along with standard joint replacement pathways in orthopaedics.

Toolkit initiatives release capacity for services to better manage outpatient demand. We anticipate releasing the equivalent of 6,000 extra appointments from the first 12 services to use the programme in our first year.

Supported services saw a dramatic improvement across key metrics. In June 2020, more than 2,000 patients (15%) waited longer than 120 days for their first appointment, but this was reduced to fewer than 500 patients waiting this long (3%) at the end of June 2021. There is no inequity in outpatient waiting times; our

Māori and Pacific patients do not wait longer than any other ethnic group.

Sustainability

At Auckland DHB, we continue to drive our sustainability programme and are committed to reducing our carbon footprint. Clinical leadership is leading initiatives in recycling, procurement and reduction in the use of some medical gases, transport, and is helping to advance a collective culture for change.

In 2020, COVID-19 had a positive impact on Auckland DHB's emissions, with a 19% reduction on 2019 and 37% against the baseline year of 2015. The decrease was mainly attributed to air travel restrictions, which saw emissions in this category fall by 47%. This decrease is equivalent to driving from Auckland to Wellington nearly 100,000 times.

Natural gas consumption continues to decrease, a result of the growing number of energy efficient projects to deliver against the Energy 50/50 strategy, which aims to cut energy use in half and produce 50% on-site renewable energy requirements by 2030. Our collaboration with the Energy Efficiency and Conservation Authority (EECA) is progressing well, with many innovation and technology upgrades to existing facilities. The project to build a new central plant building is a major infrastructure upgrade programme, and will mean a switch from gas boilers to renewable energy. Other initiatives to reduce our carbon emissions include electrification of the Board fleet, changing practice in medical gases, patient and staff commuting, and air travel offsetting. This work was well timed and will help us to achieve the Carbon Neutral Government Programme (CNGP) requirements to accelerate the reduction of emissions in the public sector.

Waste management continues to be a major issue with limited options for plastics recycling. COVID-19 has caused a dramatic increase in waste to landfill emissions. 770 additional tonnes of waste was sent to landfill in 2020, a 24% increase. This was largely due to the high levels of PPE use in the hospital environment and recycled waste streams sent to landfill during the 2020 lockdowns.

The DHB is leading an investigation into the types of plastic waste generated in the hospital, with a view to seek Government support to find new solutions and improve recycling plastic waste for the health sector.

Water refill stations reduce the number of plastic bottles that end up as waste

Members of the Women's Health operating room team with the new biodegradable drug trays made from potato starch

In partnership with some of our main suppliers, several waste reduction pilots are underway. Single-use surgical instruments are being recycled and empty syringes are being turned into fence posts. Paper towels and patient plates are being composted and more environmentally-friendly consumables are being sourced.

The DHB has received recognition for its sustainability programme, and in 2020 received the following awards:

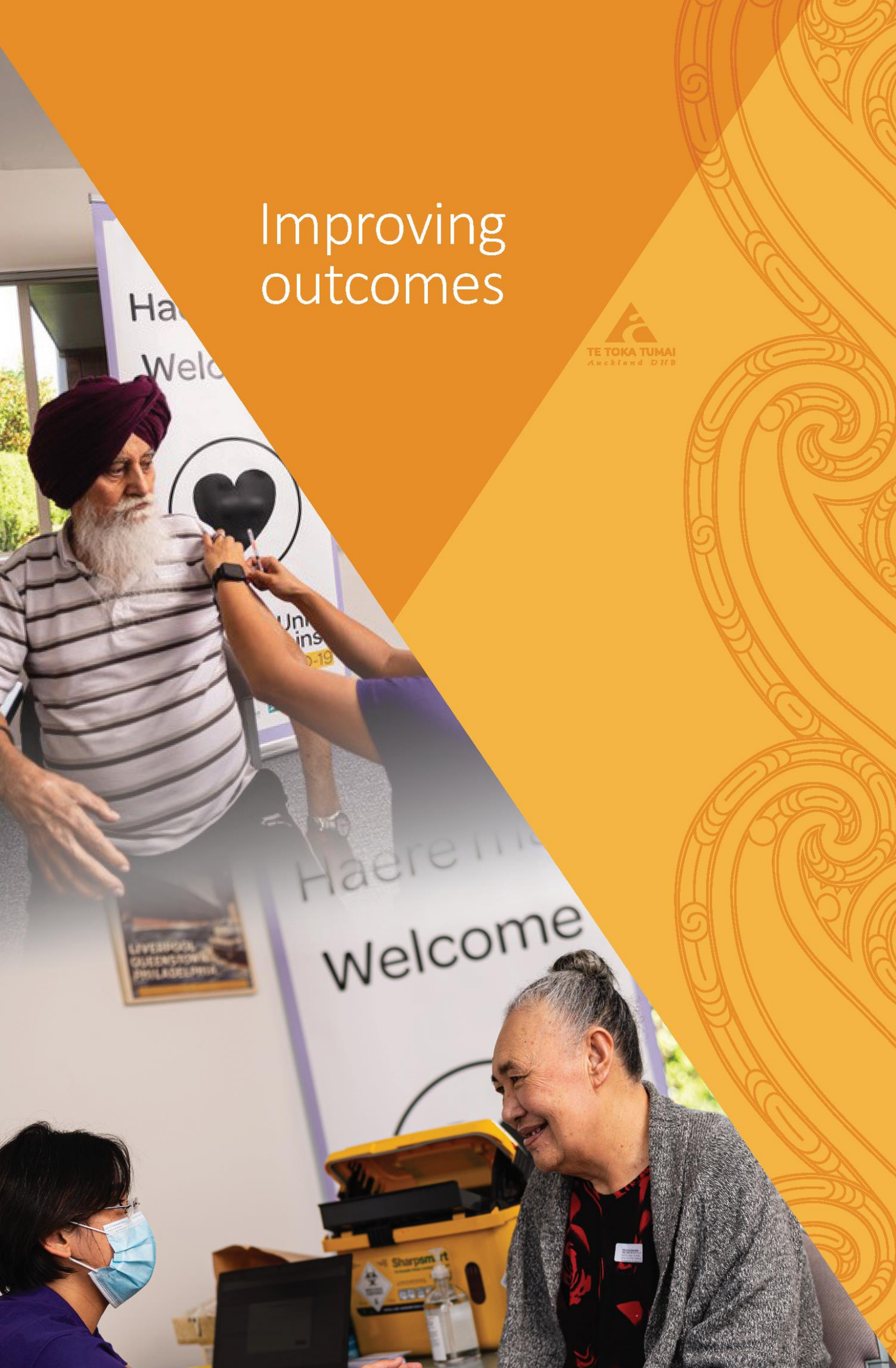
- Top 10 carbon reducers by Toitū Envirocare
- Two gold awards in GHG Energy Reduction, Climate Leadership and a silver award for Climate Resilience by Green Global Healthy Hospitals network.

In 2021, we continue to strengthen our sustainability programme with the following activities:

- Participating in Auckland Council Climate Action – impact on health working group
- Auckland DHB is the lead in the Northern Region DHB climate change risk assessment project
- Commencing planning for CNGP requirements with data collection and emissions reduction target setting projects
- Conducting a plastic waste audit at the Grafton site
- Re-setting our sustainability strategy in line with Government legislation.

Improving outcomes

TE TOKA TUMAI
Auckland DHB



Making a difference to the health of our population

Auckland DHB's performance framework demonstrates how the services we fund or provide contribute to the health of our population and to achieving our longer-term outcomes and the expectations of the Government. Overall, our progress against these indicators suggests we are delivering on our vision and we are a high performing DHB that is making a difference to the health of our population.

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

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

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

Our medium-term outcome goals and short-term priorities support these overall objectives. Equity is an over-arching priority in our performance framework, and our goals focus on three priority areas: child wellbeing, prevention and early intervention, and mental health. For each measure, annual improvement milestones were set, and local progress will be tracked.

Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. To help identify equity gaps and measure progress, we monitor all medium-term outcomes by ethnicity.

For those indicators where a comparison against the national results is provided, please note that the national data has not been subject to audit.

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

AUCKLAND DHB RESIDENTS HAVE ONE OF THE HIGHEST LIFE EXPECTANCIES IN THE MOTU, AT 83.4 YEARS

Our life expectancy continues to improve, reaching 83.4 years (2018-20), which is the second highest in the motu and an increase of 2.0 years over the past decade. Although life expectancy for our Māori and Pacific populations increased by a similar amount, this remains around 7 years lower than that for the rest of the population.

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

Amenable mortality (deaths potentially avoidable through healthcare intervention) is reducing, and in 2018 (the latest available data), 71 deaths out of every 100,000 were considered to be amenable, which is lower than the national rate of 89 per 100,000. An estimated 418 deaths (47% of all deaths in those aged under 75 years) in Auckland DHB were potentially avoidable in 2018.

FEWER CHILDREN ARE ADMITTED TO HOSPITAL WITH DECREASING ASH RATES FOR THOSE AGED 0-4 YEARS

Our children receive a great start to life. The number of preschool children admitted to hospital for conditions that are considered ambulatory sensitive (i.e. potentially avoidable though primary healthcare) has decreased by 7% since 2018 and our ASH rate for Māori children has decreased by nearly 20%. Rates for our Pacific children are also decreasing but remain twice as high as those for other ethnicities in Auckland DHB.

Understanding our performance

Performance against our framework measures are reported in the following section. For our medium-term outcomes, movement over three years is shown in the highlight boxes. For our short-term priorities, movement from the previous year is reported. The arrows indicate the direction of the movement, and the colour indicates whether performance has improved or worsened:

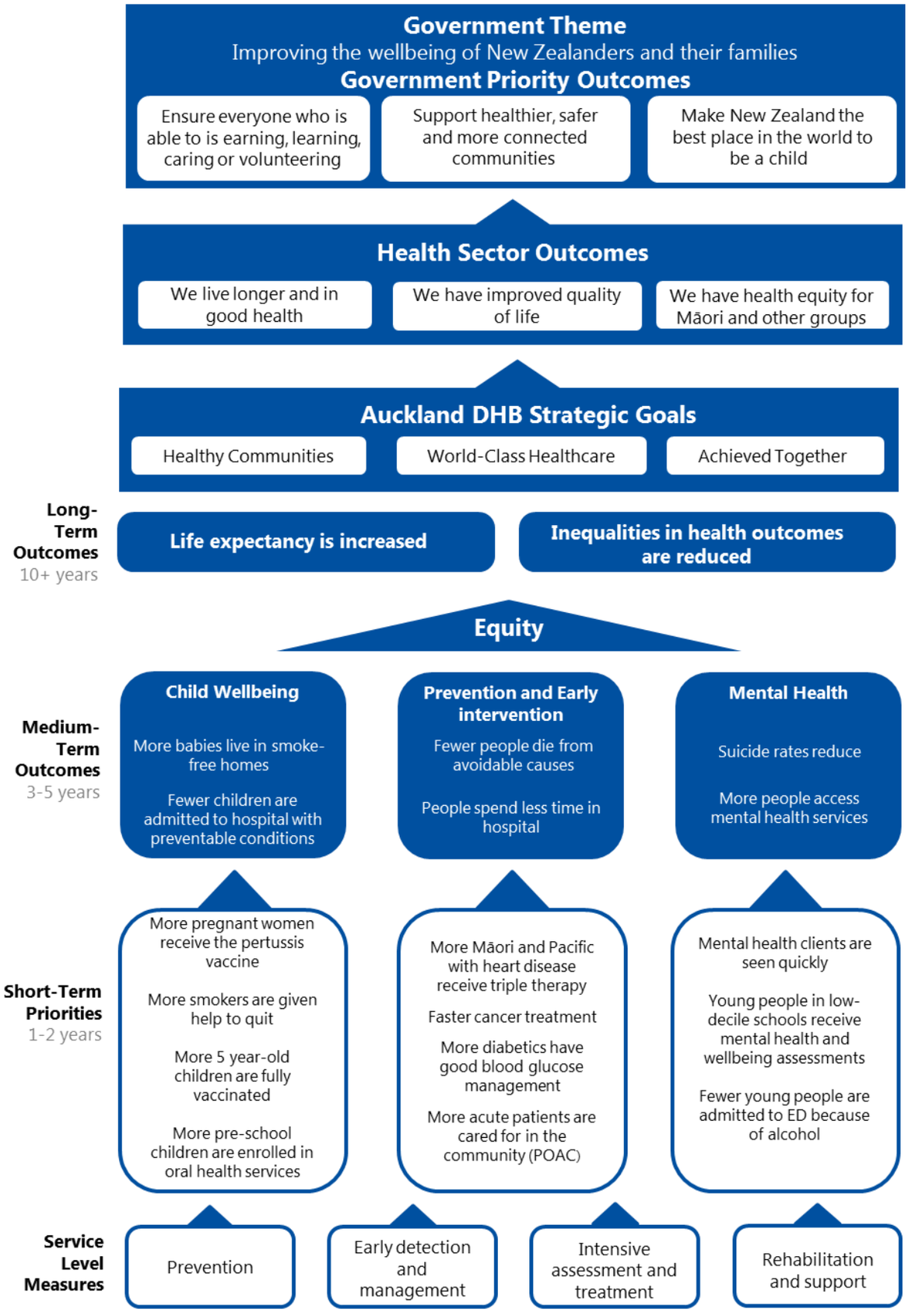

performance has improved


performance has worsened


no change in performance.

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

Performance and intervention framework



Improving life expectancy for everyone

Increasing life expectancy (measured by life expectancy at birth) and reducing inequalities between different ethnic groups (measured by the ethnic gap in life expectancy) are our two overall long-term objectives for our population.

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

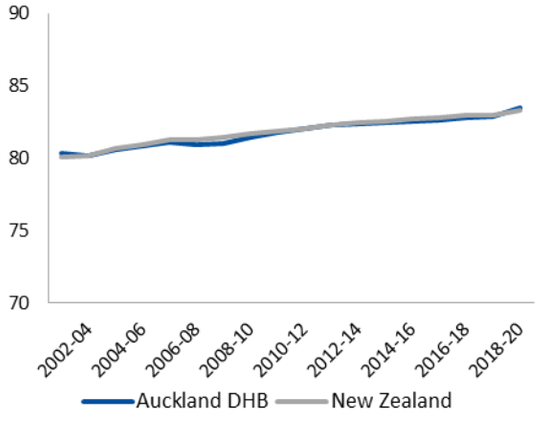
PEOPLE IN AUCKLAND DHB LIVE 1.3 YEARS LONGER THAN NEW ZEALAND OVERALL

We have the second highest life expectancy of any DHB in New Zealand, at 83.4 years (2018-20[2]), which is 1.3 years higher than New Zealand as a whole.

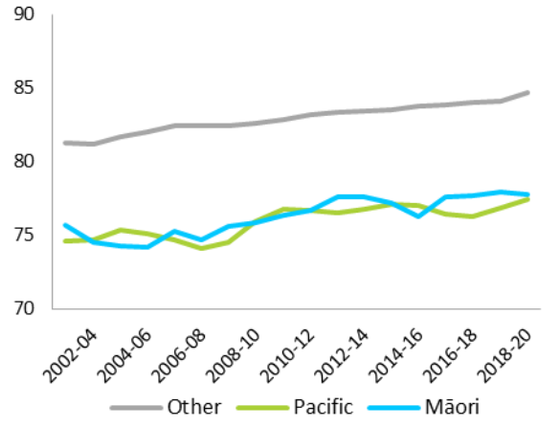
LIFE EXPECTANCY INCREASED BY 2 YEARS OVER THE LAST DECADE

In Auckland DHB, life expectancy increased by 2.0 years over the last decade. Around half of this increase can be attributed to the reduction in amenable mortality.

LIFE EXPECTANCY AT BIRTH: 3-YEAR COMBINED ESTIMATE



LIFE EXPECTANCY AT BIRTH, BY ETHNICITY: 3-YEAR COMBINED ESTIMATE



Life expectancy differs significantly between ethnic groups in our district. Māori and Pacific people have a significantly lower life expectancy than other ethnic groups, with a gap of 6.9 years for Māori and 7.2 years for Pacific.

Māori have a life expectancy of 77.8 years, and Pacific 77.5 years, significantly shorter than the 84.7 years experienced by other ethnicities.

INEQUALITIES EXIST: LIFE EXPECTANCY FOR OUR MĀORI AND PACIFIC POPULATIONS IS AROUND 7 YEARS SHORTER THAN OTHER ETHNIC GROUPS

Life expectancy for our Māori and Pacific populations has increased at a similar rate to all other ethnicities over the past decade, but this means the life expectancy gap is closing very slowly.

Deaths from avoidable conditions account for around two-thirds of life expectancy gap between Māori and other populations and around half of the gap between Pacific and other populations.

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

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

[2] The most recent life expectancy data available is for deaths occurring in the 2020 calendar year. Three-year combined estimates were produced to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

Child Wellbeing

The foundations of a healthy adult life are laid in early childhood. Promoting healthy behaviours and environments, along with ensuring access to well integrated primary and community services, can prevent health problems and improve health outcomes. We aim to increase the proportion of babies living in smoke-free homes and reduce the number of children admitted to hospital due to preventable health conditions.

Children grow up smoke free

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

New Zealand has comprehensive tobacco control policies in place, yet smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the death of approximately 300 of our residents every year.

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

Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities. The rate of smoking in pregnancy and likelihood of worse pregnancy outcome for mothers and babies is higher among Māori women and those living in areas of high deprivation.

Research shows that Māori women aged between 18 and 24 years are a group of particular concern, with 43% of this group reporting regular (daily) smoking, compared with 9% of non-Māori women of the same age. In 2020/21, 219 women in our community smoked when first pregnant, and 53% of these women were Māori. Young Māori women who are regular smokers are three times more likely to live in a household where there are other smokers compared with those who do not smoke.

Our focus is on reducing equity gaps for Māori.

More babies living in smokefree homes

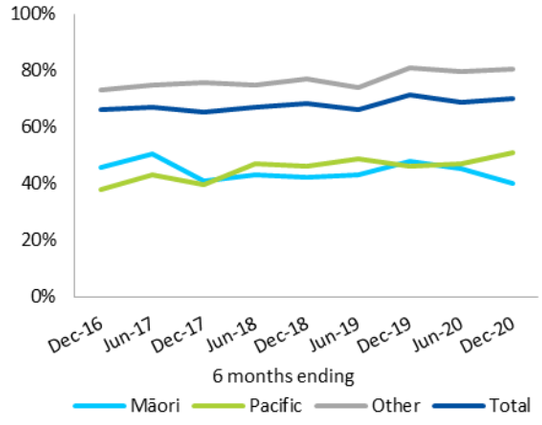
67% of babies live in smokefree homes ↑ 1%

Well Child Tamariki Ora (WCTO) service providers ask about smoking status at babies' 6-week postnatal check. A home is considered to be smokefree if no person living there is a current tobacco smoker.

In the 12 months to December 2020 (the latest available data), 67% of 6-week-old babies in our district lived in smokefree homes. This is a slight increase from the December 2017 result.

Note: only babies registered with WCTO will be counted towards this measure. Any baby not registered with WCTO will effectively be considered not smokefree, regardless of the household's smoking status.

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



More Māori and Pacific babies are exposed to smoking in their homes, with only 43% of Māori and 49% of Pacific babies living in smokefree homes. The percentage of babies living in smokefree homes is gradually improving for Pacific and other ethnicities; however, there was little improvement for Māori.

Child Wellbeing

Keeping children out of hospital

Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Well integrated, high quality primary and community services can prevent health problems and improve health outcomes.

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

ASH rates are much higher for Māori and Pacific children. Access to primary and community health care programmes can help reduce ASH rates, but underlying determinants of health (e.g. housing, exposure to smoking and poverty) also influence the incidence of ASH.

Fewer young children are admitted to hospital with preventable conditions

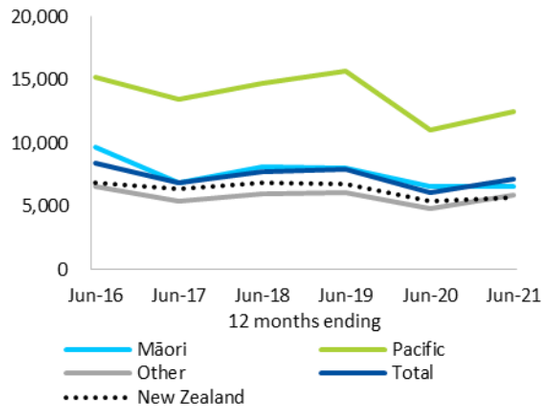
7,128 PER 100,000 ambulatory sensitive admissions ⇩ 7%

In the 12 months to June 2021, there were 7,128 admissions per 100,000 children in our 0-4 year-old population (1,802 events) that were considered to be ambulatory sensitive.

Ambulatory sensitive hospitalisation events, children aged 0-4 years old, year ending 30 June 2021

	Māori	Pacific	Other	Total
Asthma and respiratory infections	121	325	612	1,058
Gastroenteritis	42	74	59	340
Skin conditions	27	70	54	180
Dental conditions	27	54	24	144
Other	8	13	292	80

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



The COVID-19 lockdown period in March-April 2020 saw a significant decrease in acute hospital admissions, as many people avoided seeking treatment at healthcare facilities, including hospitals. This included admissions for ambulatory sensitive conditions, resulting in a drop in ASH rates for the 2019/20 year.

While ASH rates for the 2020/21 year have increased slightly since 2019/20, it is pleasing to note that they have not returned to pre-COVID-19 levels, and for our total population are now 7% lower (i.e. better) than in June 2018. Rates have reduced even further for our Māori (15%) and Pacific (19%) children. Even with this significant reduction, Pacific ASH rates are twice as high as those for other ethnicities.

Many Pacific whānau experience varied and complex housing needs, which contribute to conditions like respiratory illness and skin infections. The Noho Āhuru - Healthy Homes programme provides housing supports across Auckland and Waitematā DHBs, and 46% of referrals are for Pacific whānau. This service is delivered by social workers who complete housing assessment and provide broader bio-psychosocial supports to whānau.The programme should help to reduce ASH rates in 0-4 year olds, including those who are Pacific.

The incidence of some ASH conditions may have improved through the efforts to reduce the spread of COVID-19. For example, seasonal influenza and other respiratory infection rates have decreased due to border restrictions, social distancing and good hygiene practices. Higher vaccination rates may have also helped to improve influenza rates.

29% of smokers were helped to quit

8%

64% of pregnant women were vaccinated against pertussis

51% of pregnant women were vaccinated against influenza

88% of five year olds were fully vaccinated

1%

100% of pre-schoolers were enrolled with oral health services

3%

Delivering on our priorities

To reduce the number of infants exposed to cigarette smoke, we are focusing on the wider family/whānau environment and encouraging an integrated approach between maternity, community and primary care.

Support to quit offered by primary care includes referral to a smoking cessation programme and prescribing nicotine replacement therapy, other medicines or behavioural support. In the 15 months to June 2021, 29% of smokers received cessation support in primary care, which is an 8% reduction from the 31% recorded in 2019/20.

More than half (59%) of all avoidable hospital admissions for Auckland DHB children in 2020/21 were for respiratory conditions. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine-preventable conditions and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Vaccination rates are increasing. For babies born in 2021, 64% of mothers received a pertussis vaccination during pregnancy and 51% received an influenza vaccination; however, the rates are much lower for Māori and Pacific.

Immunisation is one of the most effective and cost-effective medical interventions to prevent diseases. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and death. Immunisation protects not only the child, but others that are unable to be vaccinated, via herd immunity.

In the year ending June 2021, 88% of all five-year-old children were fully vaccinated. This is higher than the national rate, albeit a decrease on the previous year. COVID-19 meant some families were reluctant to attend GPs or receive home visits for vaccinations. Immunisation rates are also significantly lower for Māori children. We are implementing a targeted action plan to improve immunisation in Māori and Pacific children.

Dental conditions account for nearly 10% of preventable hospital admissions in pre-school children. Engagement with oral health services facilitates prevention and early treatment of dental problems. Our data reports high levels of enrolment overall*, but Māori children in particular miss out on dental care, with only 82% estimated to be enrolled.

* The numerator is the actual number of children enrolled with oral health services and the denominator is an estimated population (from Stats NZ). The estimated population is likely to be understated, giving a result of 100% enrolment.

Knowing every child – Uri Ririki Child Health Connection Centre

Opened in 2020, Uri Ririki - Child Health Connection Centre is a coordination hub focused on ensuring that babies and children receive their free health checks and immunisations on time.

This information is stored on the National Child Health Information Platform (NCHIP) for the Northern Region. NCHIP gives health providers a shared view of a child's care, including newborn checks, immunisations, Well Child Tamariki Ora (WCTO) checks, hearing and vision checks, and B4 school checks. The Uri Ririki team also help to maintain the accuracy of the National Immunisation Register (NIR).

The Uri Ririki team works with teams in GP clinics, out-reach immunisations, WCTO services, social workers, Ministry for Social Development (MSD), and lead maternity carers (LMCs) to help keep children well.

Our Midwife Newborn Enrolment Coordinator and the team work with whānau, LMCs and all WCTO providers (including Plunket and Māori health providers) to strengthen connections. Starting with 7-week-old babies, our aim is to confirm a WCTO provider for every tamariki who is Māori, Pacific or lives in lower income areas of Auckland or Waitematā DHB.

Uri Ririki helps ensure all children receive the Well Child Tamariki Ora health visits and support they are entitled to

Since the start of September 2020, we linked WCTO providers with 321 (94%) priority babies who were overdue their 4-6 week check. This is a fantastic outcome, and we will continue to connect with our partners and these whānau

Healthier homes for healthier children

The Noho Āhuru - Healthy Homes service sits within Uri Ririki and provides housing support to low-income whānau across Auckland and Waitematā DHBs. This service is part of the national Healthy Homes Initiative, established by the Ministry of Health in 2013 as a support for whānau who have children that are considered to be at high risk for rheumatic fever. Since then, the service has grown to offer support for a wider range of eligible whānau, including pregnant women, to take a preventative approach to health care, rather than a reactive one.

Cold, damp, and crowded homes contribute to recurrent and chronic respiratory illnesses, as well as preventable conditions, such as rheumatic fever and skin infections. The programme aims to increase the number of children living in warm, dry, and healthy homes to reduce avoidable hospitalisations due to housing-related conditions.

This service is delivered by social workers who complete housing assessments and provide broader bio-psychosocial supports to whānau. Many Māori and Pacific whānau experience varied and complex housing needs. Pacific whānau make up 46% of the referrals received by Noho Āhuru - Healthy Home service to date. The use of social workers allows for individualised support plans to be developed with whānau to address their housing, health and social barriers.

Help is provided through a mixture of social work and interagency collaboration. The team reviews the whole family situation, not just the physical house. Home improvements, such as insulation, ventilation, heating, curtains, carpets, bedding and minor repairs, can be provided. Significant complexity may impact the logistics of the family's day-to-day life. The support team can assist with budgeting or information on WINZ entitlements; the family may need help to navigate the process of applying for social housing or support with referrals for mental health issues.

Between 1 January and 1 December 2020, 595 families were referred to the service and 2,113 family members benefited from healthier home interventions. The service assisted 112 families to get onto the social housing waiting list, and re-housed 28 families. Winter Warmer Packs were provided (heater, blankets, and anti-mould kits) to 132 families.

Preventing and managing disease early

Chronic diseases are the leading cause of death and disability in our region, with increasing prevalence linked to increasing health costs. Preventative care is centred on individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. When people become unwell, prompt diagnosis and early intervention in the initial stages can significantly improve the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for our population to require fewer and shorter stays in hospital.

People live longer, healthier lives

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

Fewer people die from avoidable causes

71 amenable mortality rate

DEATHS PER 100,000

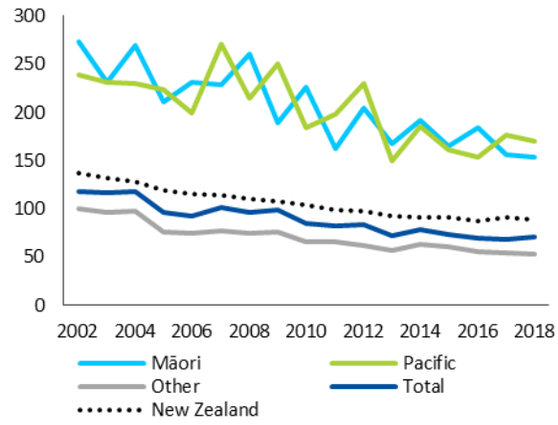
Amenable mortality is death in people aged under 75 years that were potentially avoidable through healthcare intervention.

Auckland DHB's rate of amenable mortality is declining and is one of the lowest in New Zealand, although annual fluctuations are seen, especially when viewing the smaller numbers of deaths at ethnicity group level.

In 2018* (the latest available data), an estimated 418 deaths (44% of all deaths in those aged under 75 years) in Auckland DHB were amenable; this is a rate of 71 deaths per 100,000 population and reflects 4% fewer deaths than in 2015.

The biggest contributors to amenable mortality are heart diseases (32% of all amenable deaths) and those cancers considered to be amenable (20%). Cerebrovascular disease (e.g. stroke), diabetes and respiratory conditions are also significant contributors.

MORTALITY RATE FROM CONDITIONS CONSIDERED TO BE AMENABLE, PER 100,000 POPULATION (AGED UNDER 75 YEARS)



Since 2010, the rate of decline has slowed. This is largely due to an increasing number of deaths related to coronary disease, mainly in those aged over 65 years.

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

*It can take several years for some coronial cases to return verdicts; therefore, data for this indicator is delayed by up to three years.

Preventing and managing disease early

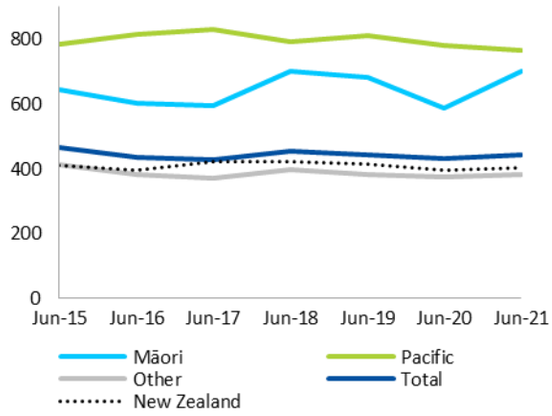
Reducing the demand for acute care

Acute admissions account for approximately half of all hospital admissions in New Zealand. The demands on New Zealand's acute care services are increasing due to our growing and ageing population, and long-term conditions, such as cardiovascular disease and diabetes.

Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities.

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.

STANDARDISED ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



People spend less time in hospital

442 acute hospital bed days

[PER 1,000 POPULATION]

3%

Acute hospital bed days per capita is a measure of the demand for unplanned care in hospitals.

In the 12 months to June 2021, Auckland residents spent more than 200,000 days in hospital receiving acute care, with a total of 62,863 acute admissions. This equates to 442 days in hospital for every 1,000 people in our population (standardised for age), and this is a reduction of 3% on the June 2018 result.

Although our overall standardised rate of acute bed days is slowly declining (i.e. improving), it remains higher than the national rate (402 per 1,000 population). The rate of acute bed day use is significantly higher for Māori (701 per 1,000) and Pacific people (768 per 1,000).

A reduction in acute bed days, in particular for Māori, was observed in the 12-month period ending June 2020. This is largely because some people avoided seeking treatment at healthcare facilities, including hospitals, during alert level 4 in March-April 2020. Acute care utilisation appears to have returned to pre-COVID-19 levels for Māori in 2020/21.

Given the inequity in acute bed day utilisation, we implemented targeted initiatives to improve the health status of Māori and Pacific peoples in particular.

Our focus is on the populations most likely to be admitted or readmitted to hospital, and targeted prevention and treatment of conditions that contribute the most to acute hospital bed days.

Priority areas in 2020/21 included alcohol harm reduction, cardiovascular disease (CVD) management and influenza vaccination for high risk groups. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

62%(M)
71%(P)
of Māori and Pacific people with CVD received triple therapy

94%
of cancer patients were treated quickly

60%
of people with diabetes have good blood sugar management

5,401
acute patients were cared for in the community

Delivering on our priorities

In 2018, 172 people in the Auckland DHB region aged under 75 died from cardiovascular disease (CVD), i.e. disorders of the heart and blood vessels, including heart attack and stroke; CVD contributed to one in ten of every acute day in hospital.

New Zealand guidelines recommend that people who have experienced a heart attack or stroke should be treated with medication known as triple therapy: a combination of blood pressure, cholesterol and anti-clotting medications.

As at June 2021, 62% of all patients who had a previous CVD event were dispensed triple therapy medication. Dispensing rates were higher for Pacific than the total population, but Māori were slightly lower. Compared with the previous year, 11% more Māori and 3% more Pacific people were provided triple therapy.

Diabetes is also a major cause of disability and premature death. Poorly controlled diabetes can lead to serious damage to the heart, kidneys, eyes and nerves. The management of diabetes includes patient education, lifestyle intervention and medication. Managing blood sugar (HbA1c levels) can reduce a patient's risk of complications. In 2020/21, 60% of patients with diabetes had an HbA1c level of less than 64mmol/mol, indicating their diabetes is well managed. Diabetes is less well managed in our Māori and Pacific communities, with only 47% of both Māori and Pacific people with diabetes recording ideal blood sugar levels.

In 2020/21, Auckland DHB appointed a full-time care coordinator to work with patients not readily engaging with the diabetes service, with a focus on Māori and Pacific patients. Pacific-focussed diabetes self-management programmes are held with church, community and family groups where whānau can talk to a registered nurse about their condition and receive general health information, including about COVID-19 vaccination.

Prompt investigation, diagnosis and treatment of cancer increases the likelihood of better outcome for patients. Care of cancer patients continued as usual throughout Alert Level 3. In 2020/21, 94% of cancer patients received their first treatment within 62 days of referral, exceeding the 90% target but a slight reduction on the previous year's result.

Primary Options for Acute Care (POAC) provides access to care in the community so that patients can be safely managed by primary care at home, avoiding or shortening hospital stays. Service provision was restricted in 2019/20 due to COVID-19, but has since returned to normal levels.

Te Oranga Pūkahukahu – Māori-led lung cancer screening

The first trial of lung cancer screening in New Zealand is about to commence in Auckland and Waitematā DHBs.

University of Otago senior Māori health researcher Professor Sue Crengle (Kāi Tahu, Kāti Māmoe, Waitaha), a GP and public health medicine specialist, will lead the trial that focuses on developing a lung cancer screening process to reduce the stark inequities in lung cancer incidence and survival rates between Māori and non-Māori.

The trial will focus on Māori, whose mortality rates from the disease are up to four times higher than rates in other ethnic groups, and who develop lung cancer about 8 years earlier. Around 450 Māori are diagnosed with lung cancer each year and approximately 300 die from it.

Lung cancer is the single biggest contributor to the difference in life expectancy between Māori and non-Māori, and is the leading cause of death for Māori women and the second leading cause of death for Māori men, after CVD. Compared with rates in non-Māori, rates in Māori women are more than four times higher and rates in Māori men are nearly three times higher.

Early detection is vital to increasing the odds of survival. Professor Crengle says that international lung cancer screening trials showed that early detection of lung cancer through screening can reduce mortality by 20-24%.

The Māori-led trial will investigate how Māori would most like to engage with a screening programme for lung cancer, through a GP clinic or a nurse-led central hub. Survey work by the collaborative research team indicates a relatively even split in how people want to be invited.

The initial work involved a series of focus groups with Māori. The groups explored beliefs and attitudes relating to the lung cancer screening pathway, including questions around information required to make an informed choice on participation and other key issues, such as blood sampling, the provision of smoking cessation advice and how to avoid the risk of stigmatisation of participants.

Following the focus groups, a survey was conducted of more than 300 Māori smokers or ex-smokers, to investigate attitudes, beliefs and intention to participate. Whānau members were also surveyed.

Involving whānau from the beginning of the journey is a foundational approach for the research programme. As a result of the consultation process, a Consumer Advisory Group was developed. Participants include potentially eligible people and their whānau. The group meets regularly, supported by DHB kaumātua, and contributed significantly to the design of the research programme.

The Māori kupu (word) for lungs is pūkahukahu. The pūkahukahu is also the name of the mound at the base of a kauri tree that protects the root system of the tree.

The kauri tree plays an important role in Māoridom and stretches back to the beginning of Te Ao Māori. Tāne Mahuta and his siblings separated their parents, Ranginui (the sky father) and Papatuanuku (the earth mother), creating light and life to exist and prosper. The connection with the pūkahukahu to the kauri tree and breath of mankind makes the name Te Oranga Pūkahukahu a mighty name for this kaupapa.

Te Oranga Pūkahukahu as a name symbolises that lung health is a journey, not only for ourselves but for our whānau and loved ones, so that we can be around to see the next generations grow.

The two-year trial will screen up to 500 Māori at high risk of lung cancer, using low dose CT: a computerised x-ray that uses very small amounts of radiation to produce three dimensional images to detect potentially cancerous nodules. The results will help us to decide if the programme is a viable long-term option for New Zealand.

The trial was made possible following a nearly $2 million grant from the Health Research Council (HRC) of New Zealand, facilitated through the Global Alliance for Chronic Diseases programme.

A further grant of $1.2m was awarded by HRC's Rangahau Hauora Māori investment stream that will expand the trial to include assessment for chronic obstructive pulmonary disease (COPD). COPD is a smoking-related condition that is more common, and causes more harm, among Māori. This study will help us to better understand the prevalence and severity of COPD. It will focus on getting people diagnosed and treated sooner to reduce the impact of COPD on the lives of patients and their whānau.

Improving mental health and wellbeing for everyone

Mental health and addiction problems affect the lives of many people in our district, with around 20% experiencing mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We ensure that practical help and support is available in the community to all people who need it, with good access to mental health support when required.

Improving mental health outcomes

Suicide rates reflect the mental health and social wellbeing of the population.

Fewer deaths from suicide

8.8 deaths from suicide

[PER 1,000,000 POPULATION]

9%

While suicides occur across the lifespan, some groups are disproportionately affected. New Zealand has some of the highest youth suicide rates in the developed world, and Māori have significantly higher rates of suicide than any other ethnic group in the motu. The suicide rate in men is nearly three times that in women.

The most recent data available is based on deaths occurring in the 2018 calendar year*. Five-year combined estimates are produced to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

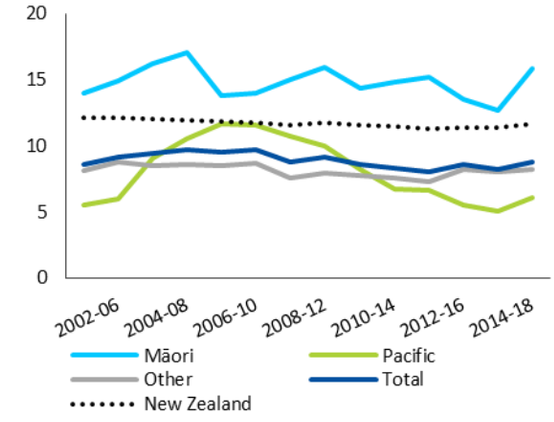
In the five years to December 2018, an average of 47 lives was lost to suicide each year in our district, a rate of 8.8 deaths per 100,000 population. This is lower than the national rate and is declining. Māori are disproportionally affected by suicide, and their rate is increasing.

Our long-term aim is to reduce, if not eliminate, the number of suicides that occur in our communities.

The Waitematā and Auckland DHBs Suicide Prevention and Postvention Action Plan 2020-2023 *Tārai Kore Whakamomori* takes a population health and community development approach to suicide prevention, and highlights priority actions for suicide prevention and postvention in our districts. The plan has four focus areas: Promoting Wellbeing; Responding to suicidal distress; Responding to suicidal behaviour; and Postvention response

Much of our work in 2020/21 focused on providing training and support to help our communities recognise and respond to people experiencing mental health challenges.

SUICIDE RATE
DEATHS FROM SUICIDE, PER 100,000 POPULATION



Six LifeKeepers suicide prevention training programmes and three MH101 mental health support workshops were delivered for community groups, frontline government agencies and whānau. LifeKeepers give people in our communities the skills to recognise and support those at risk of suicide. Participants learn what to look for when someone may be at risk of suicide, strategies for how to kōrero about suicide, respond with confidence, and engage different services for help. MH101 workshops aim to give people the confidence to recognise, relate and respond to others experiencing mental health challenges.

Work has started to train school-based nurses specifically on suicide prevention, so that they can support school counsellors to deal with youth in distress.

We employed a whānau coordinator to provide support for whānau bereaved by suicides. A review of the suicide notification and postvention response was carried out to ensure that this process is effective and appropriate.

*It can take several years for some coronial cases to return verdicts; therefore, data for this indicator is delayed by up to three years.

Improving mental health and wellbeing for everyone

Better access to mental health support

Each year, around one in five individuals experience mental health challenges. We are working to expand services so more people with mental health and addiction needs can access support when and where they need it.

More people are helped by mental health services

3.8% of people accessed mental health services ↑ 12%

In the 12 months to June 2021, 3.8% of the total Auckland DHB population (19,400 people) were seen by DHB and NGO specialist mental health services.

The prevalence of mental distress is much higher in Māori than other ethnicities, and 9.8% of our Māori population accessed mental health services in 2020/21. The proportion of all people accessing mental health services has increased by 12% over the last three years.

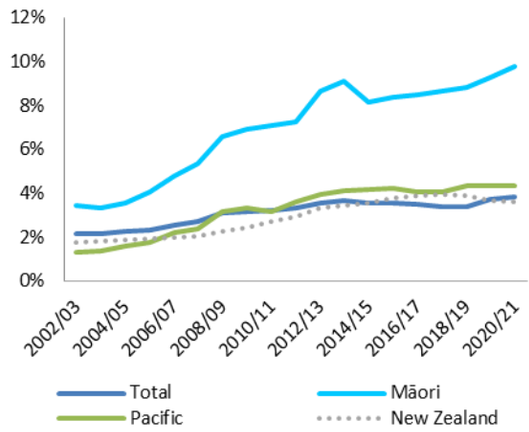
Specialist mental health services continued to operate during COVID-19 lockdowns, although referrals from primary sources slowed as they did not operate or operated in limited conditions. As our population grows, demand for mental health support increases and our services are working to accommodate this demand.

We contract many different community mental health service providers, who saw close to 2,000 clients in 2020/21. In addition, Auckland DHB works with primary care to deliver mental health support programmes through general practice and other community support services.

The Access and Choice initiative evolved from 2019's Wellbeing Budget with a focus on building the wider system to provide free support early to those with low to moderate mental health, wellbeing, or addiction needs.

A key work stream, and the first to be implemented, is the Integrated Primary Mental Health and Addiction (IPMHAS) service. The IPMHAS model provides easy access to mental wellbeing support available in GP sites. Other work streams focus on the expansion and development of kaupapa Māori, Pacific and youth specific services.

PROPORTION OF POPULATION ACCESSING MENTAL HEALTH SERVICES



The IPMHAS model has three roles: health improvement practitioners (HIPs), health coaches (HCs), and Awhi Ora NGO peer and community support workers. HIPs and HCs are members of the primary care team who work in the clinic and see patients on the day they present. Awhi Ora is the expansion of existing NGO walk-alongside support directly matched to GP practices. They sit outside of the practice to provide community and outreach support.

By June 2021, 58 practices across Metro Auckland went live with the service, with more than 27,000 people accessing support. Rollout to 23 more practices is funded for 2021/22, with those with high volumes of priority populations targeted first.

Over 96% of our specialist mental health services are delivered in the community, and our acute inpatient units are a resource to community teams when whaiora require 24/7 care. Referrals to all specialist mental health community services continue to increase, notably by 14% (n = 2,547) in 2020/21; a total of 20,974 referrals were made to community mental health services.

Face-to-face contact hours also increased, by 3,000 hours over the same time period. As clinical FTE remained the same, we meet this demand with on going refinement of models of care, including moving to episodic care.

Excluding the 2020 Alert Level 4, our adult acute inpatient unit averages 97% occupancy. Our adult acute inpatient unit continues to lead nationally on reducing seclusions; our child and family unit is the first acute inpatient unit in the country to be seclusion free. We implemented a project that uses co-design to develop and implement a contemporary, evidence-based, rangatahi-focused model of care to provide a rangatahi-friendly environment in Te Whetū Tāwera.

94% of mental health clients were seen quickly

5%

75% of young people received wellbeing assessments at school

11%

10% of youth ED presentations were alcohol related

Delivering on our priorities

Individuals experiencing mental distress or those with mental health needs do not always require a referral or access to specialist mental health services. However, where a need does arise and people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options, which may include a referral to specialist mental health services.

We aim to ensure that when individuals are referred to specialist mental health services, they are seen quickly.

In 2020/21, 94% of clients referred non-urgently to DHB-provided mental health services were seen within 8 weeks, and 84% were seen within 3 weeks. Young people with alcohol and drug issues are seen even more quickly by DHB and NGO providers, with 95% of 0-19 year olds receiving addiction support within 3 weeks, exceeding the 80% target.

Adolescence is a challenging time, when many emotional and physical changes take place. Most adolescents make it through their teenage years and enter adulthood without major trauma. However, for some teenagers, this may be a dangerous time of experimentation. HEEADSSS is a validated assessment tool commonly used to help assess youth wellbeing through a series of questions relating to home life, education/employment, eating, activities, drugs, sexuality, suicide/depressions and safety. The tool is administered to Year 9 students in a number of schools and provides a mechanism for health professionals to evaluate young people's developmental stage, risk-taking behaviour, risk and protective factors for them and the environment around them.

In the 2020 school year, 75% of eligible Year 9 students in decile 1-5 schools received a HEEADSSS wellbeing assessment. This is lower than previous years due to school closures during COVID-19 lockdowns. School nurses continue to complete assessments for all Māori, Pacific and high risk students who missed out on HEEADSSS in 2020.

Alcohol is deemed to be the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand.

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. All 19,442 young people aged 15-24 years old and admitted to our ED were screened for alcohol in 2020/21, with 1,305 (9.7%) admissions a result of excessive alcohol consumption. This is similar to the result in the previous year.

Support café a haven for our most vulnerable residents

Haven is an after-hours support space that operates from 453 Karangahape Road, Auckland CBD, on the current site of Merge Café, a day-time café run by Lifewise.

Haven support space at Merge Cafe

Originally funded by the Ministry of Health's Acute Drug Harm Response Discretionary Fund, the café was designed specifically to meet the needs of vulnerable populations in Auckland DHB who use synthetic drugs, methamphetamine and/or emerging substances, and those experiencing mental health distress, isolation and loneliness. Designed to provide an accessible alternative to attending ED, the service is staffed entirely by peers with experience in homelessness (Lifewise), drug and alcohol dependence (Odyssey), and mental distress (Mind and Body). Food is available on a koha basis, and includes bread, soup and sandwiches.

The café operates on Friday nights and 8 am to 8 pm on weekends, and provides vital after-hours support to people during episodes of acute drug harm and for those experiencing mental distress and suicidality.

Despite its limited opening hours and COVID-19 lockdowns, in the first year of operation, the café received over 25,000 customers seeking support. On an average weekend, 600-800 people visit the café. Importantly, this service is frequented by the target population. This includes those most affected by synthetic drugs and mental health distress (Māori, Pacific, and homeless), sex workers and members of our rainbow communities, in particular transgender people.

The service also supports people to make lasting change in their lives, and to tackle issues that might be driving their use of drugs, such as homelessness. Peers provide strong recovery role models and demonstrate recovery in action. For example, one customer recently accessed an intensive drug and alcohol residential rehabilitation service after seeing someone they had met in prison who is now working in the café as a peer support worker. A number of people attended while suicidal and suicide prevention plans were put in place to support those in crisis. Others attended while experiencing acute mental health distress and, in at least one instance, supported a person waiting for an inpatient admission; another assisted someone who had become homeless to access their medication, averting further deterioration in their mental health state.

A successful independent evaluation in early 2020 provided strong evidence for the efficacy of this intervention. It identified that the service was meeting a continuum of need, acting as a simple drop-in space through to a place where a range of support options, including treatment, are being accessed. Findings indicate that the emerging outcomes experienced by visitors are supported by several factors, including the respectful and welcoming environment of the café, its accessible setting, the understanding of peers with lived experience, and positive relationships with peers. For the peer workforce, employment at Haven is providing both personal and work-related development.

The evaluation showed that this initiative provides access and choice for service users. It is the only mental health and addictions service available during weekend hours to provide support for those who otherwise may present to ED in crisis. The evaluation and the success of the service in meeting its objectives was responsible for a further three years of funding, provided by the Ministry of Health in mid-2020. Future services could include the development of a rangitahi café to cater for young people and their whānau.

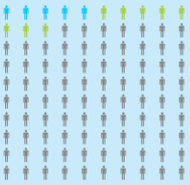
Our people, our performance

Our people in the spotlight

At Auckland DHB | Te Toka Tumai, we take great pride in all of our employees. Here are just a few of the amazing people on our team.

Our Workforce

12,268 people are employed by ADHB



5% Māori
8% Pacific
87% Other

78% female

22% male

19% aged <30
49% aged 30-50
32% aged 50+

42% nursing
20% allied health
18% medical
20% other

Working together for equity

Hineroa Hakiaha and Tracy Silva Garay were appointed Co-Directors of Mental Health and Addiction, an arrangement designed to bring our Te Tiriti o Waitangi partnership to life. They were both exceptional candidates with complementary strengths, and having Māori and pākehā work together in the role is a chance to address some deep-seated problems in a sector that has a high number of Māori clients.

They are strikingly different and unique people. But they both say the same thing: by working together, we can do better for those with mental health issues.

Tracy previously worked as nurse director in mental health and addictions, and more recently as interim director for mental health and addictions, while Hineroa was the directorate's Māori lead service clinical director.

A korowai for Natalie

Natalie Keepa, Charge Nurse for Ward 42, won the Te Kauae Raro award 2020, receiving the korowai (ornamental cloak) from the previous recipient Linda Chalmers. Te Kauae Raro recognises a Māori nurse or midwife who has made a significant contribution to Māori health in our hospitals or community.

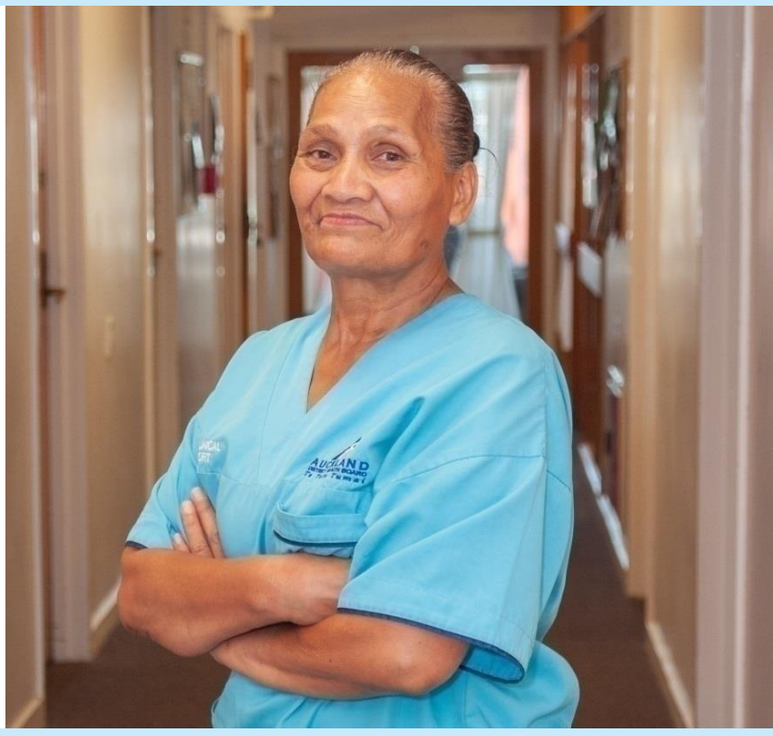
Natalie has a vision to ensure that all of our team are culturally appropriate, have a good understanding of our obligations under Te Tiriti o Waitangi, and can provide culturally safe care to our patients, especially our Māori patients and whānau.

Lavinia Steps Up

Lavinia Paparoa, a cleaner at Greenlane Hospital, was part of a development programme called Step Up, which helps our people gain the confidence to progress their career at Auckland DHB.

Lavinia gave a heartfelt presentation on the impact that COVID-19 had on her cleaning whānau. Presenting in front of her managers and peers was a new experience for Lavinia, but she shone and her honesty and clarity touched a chord with the audience.

Step Up gave Lavinia the confidence to think about other roles within the organisation. "If you put yourself out there, there's someone willing to help you," she says.

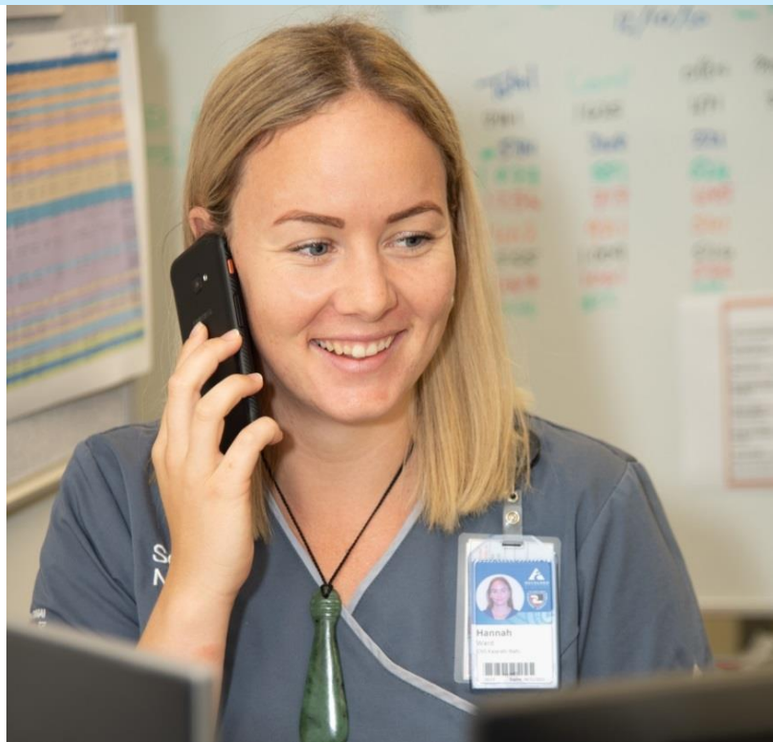


Growing ngā kaimahi Māori

Hannah Ward never wanted to be a nurse, but enrolling in our Rangitahi Programme for young Māori and Pacific people changed that.

"The programme opens your mind to the other roles in health", Hannah says. "The fact is we need more Māori faces everywhere."

After a summer job in the children's ED, she enrolled to study nursing. Hannah is now back at Auckland DHB as a registered nurse, working in the cardiovascular ICU. Initially, she worked as a kaiārahi nāhi (Māori Nurse Navigator) to help facilitate Māori patients into the hospital for planned care.



Being a good employer

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

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

We strive to:

- progress the aims, aspirations, cultural differences and employment requirements of our Māori employees and those from other ethnic or minority groups
- provide an organisational culture, with strong clinical leadership and accountability, where everyone can 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 that promotes the wellbeing of our people
- offer recruitment, selection and induction processes that recognise the employment requirements of women, men and people with disabilities
- provide opportunities for employee development and career advancement.

Leadership, accountability and culture

Our shared organisational values of Haere Mai (Welcome), Manaaki (Respect), Tūhono (Together) and Angamua (Aim High) reflect the priorities of our staff and for our patients. Through a collaborative process, we identified our Values in Action (Te Tino o Mātou | Us at our best), which describe what it looks like when we are at our best in our workplace relationships. These values in action are:

- see me for who I am
- my voice counts
- be kind to each other
- thank you goes a long way
- I have your back
- I am part of the team.

We highlight these Values in Action and embed them in the organisation.

Auckland DHB champions clinician leadership, with accountability for most directorates held by a clinician.

Our managers are supported with a tailor-made management development programme that allows for 'just in time' learning through the Ko Awatea LEARN online platform. This programme is also available to those who want to grow their skills towards a management career.

In early 2021, we opened an Employee Support Centre, which provides a physical space for all of our people to use. The centre offers a range of support services for the holistic wellbeing of our people.

At Auckland DHB, we celebrate the rich diversity in our team, and valuing inclusion is part of who we are. Auckland DHB was re-accredited for the Rainbow Tick this year, which is a certification mark for organisations that complete diversity and inclusion assessment, and ensures that we continue to improve our processes, environment and culture.

We are accredited with the Accessibility Tick, which acknowledges our efforts to make our work place more accessible and inclusive for people with disabilities. This year, we also received accreditation with the Hearing Accredited Workplace programme to further embed policies, practices, activities and supports for employees with hearing impairments.

Recruitment, selection and induction

Our recruitment processes fully comply with safety checking regulations. To create an organisation-wide culture of child protection, all interviews include specific Children's Act questions. In addition, we implemented Workforce Assurance standards into our systems and processes this year.

We are committed to a diverse workforce. Shortlisting of all eligible Māori and Pacific candidates, who meet the minimum requirements for any role, is mandatory. This policy has been in place for the last two years and has gained traction. In some areas, we have 100% shortlisting of Māori and Pacific candidates.

Navigate – Kai Arahi sessions welcome new employees to Auckland DHB. An expo shows what we offer to care for our people and to help them settle in and feel part of our community. Guides for managers and new employees provide information on how to make the most of the first few weeks at Auckland DHB.

Given the challenges that COVID-19 has presented for face-to-face engagements, an online version of Navigate – Kai Arahi is now available.

Our Rangatahi Programme facilitates Māori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce.

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

To Thrive Scholarships are available for members of our cleaning and orderly workforce to undertake internships within Auckland DHB services as part of a career development pathway.

Diversity and Inclusion

Te āheinga ā-ahurea | Cultural competence

Auckland DHB has a planned approach to building workforce capability to uphold Te Tiriti o Waitangi and achieve health equity. This is delivered through learning the history of Aotearoa, Te Tiriti o Waitangi, cultural safety, institutional racism, Māori health equity, and self-awareness. In May 2021, we launched an online hub that delivers learning in these areas. To date, 227 employees have engaged in this learning. Tikanga Best Practice and Culturally and Linguistically Diverse (CALD) modules are also available. We celebrate a variety of cultural events, including Matariki, Diwali, Eid and Ramadan.

Te urupare i te mariu | Addressing bias

This is delivered through the Leading for Equity online module and face-to-face workshop, along with the HQSC modules in 'understanding bias in healthcare'. Hiring managers participate in recruitment and selection workshops that build understanding of how to reduce bias in selection processes. To date, 253 employees have completed this workshop. Our recruitment and talent management processes were redesigned to actively mitigate bias.

Hautūtanga ngākau tuwhera | Inclusive leadership

Leading for Equity is an in-house, online module and workshop delivered within our Management Development Programme. 432 employees completed the online module and nearly 200 employees completed the workshop. In addition, our senior leadership team is deepening their knowledge, understanding and application of Te Tiriti o Waitangi, which builds capability in inclusive leadership within the context of Aotearoa.

Te whakawhanaungatanga | Building relationships

In our Management Development Programme, the Onboarding, Developing People and Team Development workshops focus on the importance of whānaungatanga and building trusting, connected relationships. Psychological safety is a key capability identified in the programme, equipping managers with tools and practices to achieve this. Through the Rainbow Tick, we conduct annual focus groups to better understand the experiences of our Rainbow Community employees, to identify actions to improve upon. Through the Accessibility Tick, we are improving the way in which we ensure that Auckland DHB is a welcoming employer for those who have access needs.

Ngā tūhononga e kōkiritia ana e ngā kaimahi | Employee-led networks

Auckland DHB supports the establishment of employee-led networks across the organisation. This includes ensuring that all managers enable staff to attend meetings where possible and, depending on the network, executive sponsorship. There are currently two well established employee-led networks, with plans for new networks to be established in 2022.

Employee development, promotion and exit

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

- Our employee Kiosk hosts the tracking of performance and development progress and support needs.
- A range of internal training programmes are provided.
- Senior Medical Officers can take sabbatical leave to strengthen clinical knowledge or skills, or undertake a course of study or research.
- The Pacific Nurse Educator provides clinical support, supervision and mentorship for our Pacific nursing and health care assistant students and new graduates.

We are piloting Talent Development and Management programmes in a range of services in our organisation; the first focus for these pilots is our Māori workforce. The aspiration of this work is to identify and grow internal talent into leadership and other roles.

Flexibility and work design

Auckland DHB offers flexible rostering practices where possible, and this is demonstrated by our large part-time workforce. An automated rostering system simplifies rosters for managers and a nursing FTE management tool helps 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 that our employees make to patient care through recognition programmes and/or awards:

- our Local Heroes Awards celebrate those who go above and beyond for our patients
- Matariki Awards recognise and celebrate the dedication of our people to improving Māori health outcomes
- annual profession-specific recognition events are held for Nursing and Midwifery, and Allied Health Scientific and Technical employees
- long-service awards and tributes to retiring staff in NOVA
- a 'shout out' feature is included on our staff intranet (HIPPO), which allows peer recognition to be made publically.

The majority of employees are on transparent Multi Employer Collective Agreements. Annual review of Individual Employment Agreement (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 supports all employees to speak up when they experience, witness or are accused of bullying, discrimination or harassment. A group of Speak Up supporters helps our people to navigate and be supported appropriately through a complaint.

Safe and healthy environment

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

A Wellbeing Steering Group manages the numerous initiatives that contribute to staff wellbeing. Our programme Kia Ora tō Wahi Mahi, a healthy workplace plan for Te Toka Tumai, focuses on activity in the following areas:

- giving employees a voice
- improving connections
- empowering leaders
- enhanced ways of working
- comfortable work spaces
- living our values.

Auckland DHB Board Members

Pat Snedden
Chair

Michelle Atkinson

Michael Quirke

William (Tama) Davis
Deputy Chair

Zoe Brownlie

Peter Davis

Jo Agnew

Bernie O'Donnell

Fiona Lai

Douglas Armstrong, QSO

Ian Ward

Meeting attendance

	Board (8 meetings)	**HAC** (5 meetings)	**FRAC** (7 meetings)	**CPHAC** (3 meetings)	**DiSAC** (3 meetings)
Board members					
Pat Snedden, Board Chair	7	*	6	*	*
Jo Agnew	8	5	7	3	3
Doug Armstrong	7	5	7	-	-
Michelle Atkinson	8	5	6	3	3
Zoe Brownlie	8	4	-	3	2*
Peter Davis	8	4	-	2	-
Tama Davis, Deputy Chair	7	4	3	3	3
Fiona Lai	8	5		3	-
Bernie O'Donnell	7	3	3	2	-
Michael Quirke	8	4	6	3	-
Ian Ward	7	-	6	-	-
Independent committee members					
Dame Paula Rebstock, Chair	-	-	7	-	-
Norman Wong, Deputy Chair	-	-	6	-	-
Teuila Percival, Chair	-	-	-	2	-
Heather Came	-	4	-	3	-
Michael Steadman	-	-	-	1	-

In 2020, the July and August HAC meetings, the July, August and October CPHAC meetings, and September DiSAC meeting were cancelled due to COVID-19. Members not belonging to a committee are denoted with '-'. Ex officio members are denoted with '*'. Zoe Brownlie was appointed to DiSAC in 2021.

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 we provide. 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.

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals, set out in the Improving Health Outcomes section. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Auckland DHB population is now 83.4 years, an increase of 2.0 years over the last decade. The life expectancy gap is 6.7 years for Māori and 7.2 years for Pacific, compared with all other ethnicities. The life expectancy gap has increased by 0.1 years for Māori and 0.5 years for Pacific over the last decade.

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

Output class measures

Outputs are goods or activities provided by the DHB and other entities, and provide a snapshot of the services we deliver. Output measures are intended to reflect our performance for the year. The criteria against which we measure our output performance are applied to assess progress against each indicator in the Output Measures section. A rating is not applied to demand-driven indicators.

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

The following tables include our output measures from the 2020/21 Statement of Performance Expectations by Output Class. The measure type symbols define the type of measure and are included in parentheses after the measure description. For some indicators, we expected performance directions rather than set quantitative targets, and these are assigned with the symbols listed in the target column below.

Measure type		Target symbol	
Q	Measure of quality	Ω	Demand-driven measure, not appropriate to set target or grade the result
V	Measure of volume	↓	A decreased number indicates improved performance
T	Measure of timeliness	↑	An increased number indicates improved performance
C	Measure of coverage	n/a	Not available

Population Projections

Every year, Statistics NZ releases revised population estimates and projections, based on the most recent census. In February 2020, the first data to use 2018 Census counts was released. This resulted in a 13% reduction in the projected population for Auckland DHB, and changes between ethnic groups. The 2021 release was an update on 2020 projections, but the numbers are not significantly different. The changes in 2020 had a substantial impact on measures that use DHB population as the denominator. In 2019/20, we re-calculated many of our prior year's results using the revised population estimates to provide a more accurate comparator. Therefore, some 2018/19 baseline results will differ to those published in our 2018/19 Annual Report.

Output Class 1: Prevention Services

Prevention services help to protect and promote health in our population. These services include health promotion to help prevent the development of disease, statutorily mandated health protection services to shield the public from communicable diseases and toxic environmental risk, and population health protection services, e.g. immunisation and screening services.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Health promotion					
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months (C)	89%	87%	82%[3]	90%	🔴
% 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)	98%	97%	98%	90%	🟢
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	95	154	157	110	🟢
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	100%	100%	99%	95%	🟢
Number of clients engaged with Green Prescriptions (V)	4,398	3,623	3,886	4,250	🟡
% of clients engaged with Green Prescriptions (C)					
- Māori	13%	13%	12%	11%	🟢
- Pacific	21%	22%	21%	17%	🟢
- South Asian	17%	15%	17%	18%	🔵
Immunisation					
% of pregnant women receiving pertussis vaccination in pregnancy (C)	57%	60%	64%	50%	🟢
- Māori	32%	34%	34%[4]	50%	🔴
- Pacific	38%	42%	44%[4]	50%	🔴
- Asian	65%	71%	74%	50%	🟢
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness[5] (C)	17%	20%	33%	30%[7]	🟢
- Māori	9%	10%	26%[6]	30%[7]	🔴
- Pacific	12%	14%	26%[6]	30%[7]	🔴
% of eight months olds will have their primary course of immunisation on time (C)	94%	93%	92%	95%	🔵
- Māori	84%	85%	78%[8]	95%	🔴
- Pacific	92%	91%	88%[8]	95%	🔴
% of five year olds will have their primary course of immunisation on time (C)	89%	89%	88%[8]	95%	🔴
- Māori	89%	84%	80%[8]	95%	🔴
- Pacific	86%	89%	87%[8]	95%	🔴
- Asian	91%	91%	90%	95%	🔵
Rate of HPV immunisation coverage (C)	74%	86%	90%[9]	75%	🟢

[3] Primary care activity was limited at times due to COVID-19 restrictions and resources continue to be directed towards the COVID-19 response, with less focus on other conditions, such as smoking.

[4] Coverage was affected by COVID-19 as many clinic appointments were delivered virtually, removing the opportunity for vaccination. Health promotion campaigns were launched to raise awareness for Māori and Pacific pregnant mothers.

[5] All results are for the calendar year preceding the financial year.

[6] Immunisation rates are increasing and we continue to support PHOs with lists of children to recall; in 2021, we collaborated on a postcard for eligible parents to raise awareness.

[7] The target originally included in the 2020/21 Annual Plan (15%) has since been changed to 30%, it is correct in the published SPE

[8] COVID-19 lockdowns and high demand on workforce capacity affected immunisation coverage. Some families were fearful to attend GPs or receive home visits for vaccinations. An action plan targeting Māori and Pacific was approved by MoH and is being implemented.

[9] The denominator used for this measure is eligible girls born in 2007, based on census estimates.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Population-based screening					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	68%	67%	53%[10]	70%	🔴
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	70%	69%	69%[11]	80%	🔴
HEEADSSS assessment coverage in DHB funded school health services[5] (C)	90%	84%	75%[12]	95%	🔴
% of four year olds receiving a B4 School Check (C)	89%	65%	83%	90%	🟡
% of newborn babies offered and received completed hearing screening within 1 month (V)	96%	95%	96%	90%	🟢
Auckland Regional Public Health Service (ARPHS)[13]					
Number of tobacco retailer compliance checks conducted (V)	432	184	5[14]	300	🔴
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into (V)	4,153	3,625	2,921[15]	Ω	n/a
% of smear-positive pulmonary tuberculosis cases contacted by the public health nurse within 3 days of clinical notification (Q)	83%	95%	98%	90%	🟢
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	89%	96%	100%	95%	🟢
% of compliance assessments conducted of large and medium networked drinking water supplies (Q)	100%	100%	n/a[16]	100%	n/a

[10] Screening continues to be affected by COVID-19 restrictions and was further impacted by a change in the lead provider. Initiatives to promote screening continue, targeting those at highest risk; improvements from a Māori campaign will be reviewed for other ethnicities.

[11] Local and national rates continue to decline, despite small gains in Q4. We continue to work with primary care to target screening in Māori and Pacific women.

[12] Performance affected by extended school closures in 2020. Auckland DHB-funded schools are supported by a roaming nurse to catch-up HEEADSSS; school nurses continue to complete assessments for Māori, Pacific and high risk students who missed out on HEEADSSS in 2020.

[13] Services delivered by Auckland Regional Public Health Service on behalf of the three Metro Auckland DHBs; results are for all three DHBs.

[14] Smokefree compliance work is on hold due to resourcing pressures from COVID-19 deployments and the increased level of alcohol applications received. FTE is being redistributed and recruitment is planned to increase capacity.

[15] Previously, ARPHS inquire into all alcohol license applications received, and the number of applications processed was the same as the number of applications inquired into. A risk assessment step was introduced to prioritise license applications, and these numbers now differ. For trend comparisons, the number of applications processed is 3,923.

[16] This regulatory function was transferred by the Ministry of Health to 'Wai Comply' to alleviate workload pressure on public health units (PHUs); consequently, ARPHS is unable to report on this measure.

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. They 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 enable patients to maintain their functional independence and reduce complications or acute illness, reducing the need for specialist intervention.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Primary health care					
Rate of primary care enrolment in Māori (C)	80%	82%	82%	90%	
Number of referrals to Primary Options for Acute Care (POAC) (V)	5,984	4,945	5,401[17]	6,036	
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices who does not have an HbA1c recorded in the last 15 months (C)	10%	11%	13%[18]	<12.0%	
- Māori	13%	16%	18%[18]	<12.0%	
- Pacific	12%	12%	15%[18]	<12.0%	
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol (Q)	61%	61%	60%[18]	65%	
- Māori	50%	50%	47%[18]	65%	
- Pacific	49%	49%	47%[18]	65%	
% of Māori patients with prior CVD who are prescribed triple therapy (Q)	59%	56%	62%[18]	70%	
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds (Q)	3,762	3,458	3,671	<3,635[19]	
- Māori	7,205	6,663	7,062	<6,743[19]	
- Pacific	8,311	7,704	8,081	<8,151[19]	
Pharmacy					
Number of prescription items subsidised (V)	7,073,711	7,387,260	8,020,795	Ω	n/a
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	31,562	26,739	31,525	Ω	n/a
Number of community laboratory tests (V)	3,408,529	3,213,918	3,614,812	Ω	n/a

[17] The target for this measure is an estimate based on the previous annual clinical cost of the service, therefore is indicative only. The total clinical cost of the POAC service exceeded budget in 2020/21.

[18] The capacity for routine diabetes care was and continues to be affected by COVID-19; work continues to re-engage in BAU where possible.

[19] Targets were not included in the 2020/21 published SPE, those included in 2020/21 Annual Plan are incorrect. Correct targets (as included in the 2020/21 SLM Plan) reported here.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Oral health[5]					
% of preschool children enrolled in DHB-funded oral health services (C)	94%	97%	100%	95%	
- Māori	77%	77%	82%[20]	95%	
- Pacific	89%	92%	94%	95%	
- Asian	92%	93%	95%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.65	0.63	0.49	<0.63[22]	
- Māori	0.87	0.81	0.57	<0.63	
- Pacific	1.04	0.93	0.72[21]	<0.63	
- Asian	0.56	0.58	0.43	<0.63	
% of children caries free at five years of age (Q)	62%	58%	48%[21]	61%	
- Māori	49%	46%	35%[21]	61%	
- Pacific	33%	30%	27%[21]	61%	
- Asian	57%	55%	47%[21]	61%	
Utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including age 17 years (C)	81%	87%	74%[23]	85%	

[20] Work continues to improve data capture of newborns and the ethnicity of both parents. The introduction of the National Child Health Platform is expected to improve access to oral health services, including in Māori children.

[21] Provision of non-urgent oral health services were severely limited by COVID-19 restrictions in 2020. Work is on going to support attendance and improve service efficiency and effectiveness. Māori and Pacific children are targeted for initiatives such as topical fluoride application and shorter recall intervals.

[22] These targets were agreed with the MOH after the SPE was published so differ from those in the 2020/21 SPE.

[23] Service delivery in 2020 was disrupted several times by COVID-19, particularly due to school closures and schools postponing mobile visits. We continue to track and trace non-attendees and work with service providers to re-enrol them back in the service.

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.

Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality, and elective surgery restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Acute services					
Number of ED attendances (V)	121,946	109,215	116,756	Ω	n/a
% of ED patients discharged, admitted or transferred within six hours of arrival (T)	91%	87%	88%	95%	🟡
Rate of alcohol-related ED admissions for 15-24 year olds (Q)	10.7%[24]	9.6%[24]	9.7%	↓	🔵
% 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)	93%	96%	94%	90%	🟢
% of DHB-domiciled patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (service provision 24/7) (C)	New indicator	14%	14%	12%	🟢
% of ACS inpatients receiving coronary angiography within 3 days (T)	84%	84%	86%	70%	🟢
Maternity					
Number of births in Auckland DHB hospitals (V)	6,594	6,634	6,446	Ω	n/a
Elective (inpatient/outpatient)					
Number of Planned Care interventions (V)	New indicator	21,578	23,642	24,338[25]	🔵
- Inpatient surgical discharges		13,466	14,636	16,253	n/a
- Minor procedures		8,111	9,005	7,818	n/a
- Non-surgical interventions		1	1	267	n/a
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	95%	96%	96%	90%	🟢
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	59%	39%	58%[26]	70%	🔴
% of patients waiting longer than 4 months for their first specialist assessment (T)	0.6%	15.5%	3.0%[26]	0%	🟡
% of accepted referrals receiving their CT scan within 6 weeks (T)	93%	85%	75%[26]	95%	🔴
% of accepted referrals receiving their MRI scan within 6 weeks (T)	71%	52%	67%[26]	90%	🔴

[24] These baseline results differ from those published in the 2019/20 Annual Report and 2020/21 SPE and Annual Plan, which were for the 10-24 year-old age group. The results for the 15-24 year-old age group are provided here and align to the target.

[25] Targets for this indicator were agreed with the MOH after the publication of the 2020/21 Annual Plan, so were not included in the AP or SPE.

[26] COVID-19 disruptions have led to increased numbers of patients waiting for assessment and diagnosis. We continue to prioritise patients based on waiting time, equity and clinical risk, and undertake additional clinics wherever possible.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Quality and patient safety					
% of opportunities for hand hygiene taken (Q)	86%	86%[27]	87%	80%	
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.26	0.23	0.27[28,29]	<0.25	
% of older patients assessed for the risk of falling (Q)	81%	86%[29]	85%[29]	90%	
% of falls risk patients who received an individualised care plan (Q)	79%	91%[29]	91%[29]	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	9.5	5.9	1.9	<9.7	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	98%	98%[29]	97%	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	97%	97%[29]	97%	95%	
Surgical site infections per 100 hip and knee operations (Q)	1.24	0.54[29]	0.92[29]	<0.97	
% of respondents who rate their care and treatment as very good or excellent (Auckland DHB survey) (Q)					
- Inpatients	87%	85%	86%	90%	
- Outpatients	89%	90%	89%	90%	
Mental health					
% of population who access Mental Health services (C)					
- Age 0-19 years	3.44%	3.38%	3.60%	≥3.15%	
- Māori	6.35%	5.93%	6.35%	≥6.11%	
- Age 20-64 years	4.13%	3.95%	4.01%	≥3.50%	
- Māori	12.12%	11.76%	12.21%	≥10.90%	
- Age 65+ years	3.11%	3.17%	3.12%	≥2.92%	
- Māori	4.16%	4.33%	4.39%	≥3.64%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental health	66%	69%	76%	80%	
- Addictions	82%	97%	95%	80%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental health	94%	81%	87%	95%	
- Addictions	100%	100%	98%	95%	

[27] July 2019 to February 2020 result. In response to COVID-19, the HQSC suspended the requirement to report on manually collected quality and safety marker measures from 23/03/2020 to 30/06/2020, so data for this period is not available.

[28] The national rate has also continued to increase and HQSC is investigating a potential causal relationship with the use of vascular access devices. We will support and progress this project as COVID-19 workload permits.

[29] Q1-Q3 result.

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination (NASC) Services for services including palliative care, home-based support and residential care. By helping to restore function and independent living, the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. Effective support services make a major contribution to enabling people to live at home for longer, improving their wellbeing and reducing the burden of institutional care costs on the health system.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
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)	96%	96%[29]	97%	95%	●
Palliative care					
Total number of contacts in the community (nurse) (V)	7,265	6,291	19,610[30]	Ω	n/a
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	2%	0%	0.6%	<5%	●
Residential care					
ARC bed days (V)	952,854	997,066	1,010,883	Ω	n/a

[30] In 2020/21, phone and video consults were counted as contacts – these were not included in the prior years' results.

COVID-19 Vaccination

This information has been provided by the Ministry of Health.

Auckland DHB resident population aged 12+, fully vaccinated as at 30 June 2021

Ethnicity	Proportion fully vaccinated
Asian	12.59%
European or other	13.10%
Māori	11.46%
Pacific peoples	11.03%
Unknown	41.43%
Total	**12.72%**

*Note 1,5

Age	Proportion fully vaccinated	Age	Proportion fully vaccinated
12 to 15	_	55 to 59	16.08%
16 to 19	3.26%	60 to 64	17.34%
20 to 24	8.79%	65 to 69	22.75%
25 to 29	10.30%	70 to 74	25.31%
30 to 34	10.24%	75 to 79	24.06%
35 to 39	9.51%	80 to 84	23.43%
40 to 44	9.34%	85 to 89	22.40%
45 to 49	10.10%	90+	27.26%
50 to 54	12.21%	**Total**	**12.72%**

*Note 1,5

Vaccine doses administered by Auckland DHB, as at June 30 2021

Ethnicity	Dose 1	Dose 2	Total
Asian	25,566	16,965	42,531
European or other	56,498	34,930	91,428
Māori	5,118	3,686	8,804
Pacific peoples	7,998	5,170	13,168
Unknown	820	506	1,326
Total	**96,000**	**61,257**	**157,257**

	Dose 1	Dose 2	Total
Group 1	7,692	7,279	14,971
Group 2	54,811	39,935	94,746
Group 3	23,982	10,144	34,126
Group 4	9,516	3,898	13,414
Total	**96,001**	**61,256**	**157,257**

Age	Dose 1	Dose 2	Total	Age	Dose 1	Dose 2	Total
12 to 15	2	0	2	55 to 59	7,721	5,343	13,064
16 to 19	1,209	770	1,979	60 to 64	7,652	4,728	12,380
20 to 24	4,478	3,412	7,890	65 to 69	10,361	5,613	15,974
25 to 29	6,302	4,944	11,246	70 to 74	9,470	5,111	14,581
30 to 34	6,462	5,040	11,502	75 to 79	7,190	3,651	10,841
35 to 39	5,600	4,155	9,755	80 to 84	5,917	2,945	8,862
40 to 44	4,839	3,504	8,343	85 to 89	4,027	2,055	6,082
45 to 49	5,147	3,787	8,934	90+	3,687	1,974	5,661
50 to 54	5,936	4,225	10,161	**Total**	**96,000**	**61,257**	**157,257**

Notes regarding vaccination performance information

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population) . The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Auckland DHB population estimate based on HSU as at 30 June 2020 is 492,099. This is 13,601 below the Stats NZ projected population of 505,700 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Auckland DHB population	HSU	Stats NZ	Difference
Māori	35,190	41,100	(5,910)
Pacific	58,651	55,600	3,051
Asian	150,423	172,700	(22,277)
Other	247,835	236,300	11,535
Total	492,099	505,700	(13,601)

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions; and disabled people living in the Counties Manukau DHB area . Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

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.

Health Quality and Safety markers	Oct-Dec 2019[31]	2020/21
80% compliance with good hand hygiene practice	86%[32]	87%[33]
Falls		
90% of older patients are given a falls risk assessment	84%	85%[29]
% of patients assessed at risk of falling who received an individualised care plan	92%	91%[29]
Safe surgery		
100% of hip and knee arthroplasty primary procedures given correct antibiotic in the hour before incision	98%	97%
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	98%	97%
100% of cardiac patients receiving antimicrobial prophylaxis as a single dose 0-60 minutes before incision	Adult: 99% Paediatric: 99%	Adult: 97%[29] Paediatric: 98%[29]
95% of cardiac patients given right antibiotic in right dose	Adult: 99% Paediatric: 97%	Adult: 99%[29] Paediatric: 99%[29]
100% of cardiac patients received an alcohol-based skin antispesis	Adult: 99% Paediatric: 100%	Adult: 100%[29] Paediatric: 100%[29]
95% of audits of surgical safety checklist engagement score levels of 5 or higher	Sign in: 97% Time out: 98% Sign out: 96%	Sign in: 97% Time out: 93% Sign out: 96%
Patient deterioration		
% of early warning score calculated correctly	90%	93%
% of patients who triggered an escalation of care and received the appropriate response	89%	78%
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1,000 admissions	1.8	1.6
Rate of rapid response escalations per 1,000 admissions	40	49
Pressure injuries		
% of patients with a documented and current pressure injury risk assessment	89%	90%
% of at-risk patients with a documented and current individualised care plan	94%	93%
% of patients with hospital-acquired pressure injury	0.8%	2.3%
% of patients with a non-hospital-acquired pressure injury	0.0%	0.8%
Safe use of opioids		
% of patients whose sedation levels are monitored and documented following local guidelines	100%	100%
% of patients who have had bowel function activity recorded in relevant documentation	77%	74%
% of patients prescribed an opioid who have uncontrolled pain	7%	23%
% of surgical episodes of care with opioid-related harm	0.6%	1.0%

[31] Due to COVID-19, the requirement to submit data was suspended in the first half of 2020 therefore we will present the quarter ending Dec-19 as the comparator period.

[32] November 2019 to February 2020 result.

[33] November 2020 to June 2021 result.

Cost of Service Statement – for year ended 30 June 2021

Summary of revenues and expenses by output class	Plan 2020/21 $'000s	Actual 2020/21 $'000s	Actual 2019/20 $'000s
Prevention			
Total revenue	37,500	37,856	31,329
Total expenditure	65,362	94,795	62,895
Net surplus/(deficit)	**(27,862)**	**(56,939)**	**(31,566)**
Early detection			
Total revenue	523,688	555,365	514,895
Total expenditure	482,232	474,736	436,471
Net surplus/(deficit)	**41,456**	**80,629**	**78,424**
Intensive assessment and treatment			
Total revenue	1,762,075	1,799,987	1,691,705
Total expenditure	1,800,116	1,883,306	1,835,042
Net surplus/(deficit)	**(38,041)**	**(83,319)**	**(143,337)**
Rehabilitation and support			
Total revenue	270,810	286,487	258,557
Total expenditure	291,406	323,099	265,846
Net surplus/(deficit)	**(20,596)**	**(36,612)**	**(7,289)**
Overall			
Total revenue	2,594,073	2,679,696	2,496,486
Total expenditure	2,639,116	2,775,925	2,600,253
Consolidated surplus/(deficit)	**(45,043)**	**(96,229)**	**(103,767)**

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 2020/21 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Ministerial directions

Directions issued by a Minister 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
- The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID‑19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand. Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction
- Direction to support a whole-of-government approach to pay restraint issued on 28 April 2021 under s.95(c) of the Public Service Act 2020. https://www.publicservice.govt.nz/our-work/er/public-service-pay-guidance-2021/

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 2019/20 appropriations is detailed below.

Appropriations allocated and scope

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

What is intended to be achieved with this appropriation?

This appropriation is intended to achieve services provided by the DHB that align with: Government priorities; the strategic direction set for the health sector by the Ministry of Health; the needs of the district's population; and regional considerations.

How performance will be assessed and end-of-year reporting

Each DHB has a statutory responsibility to prepare:

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

These documents are brought together into a single DHB Annual Plan with the Statement of Intent and Statement of Performance Expectations, and are known as the 'Annual Plan'. The Statement of Performance Expectations provides specific measures/targets for the coming year, with comparative prior year and current year forecast (at a minimum).

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

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

Amount of appropriations

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

	2019/20			2020/21
	Final budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,391,484	1,391,484	1,488,802	1,488,802
Supplementary estimates		30,667		1,323
Addition to the supplementary estimates		3,328		
Total appropriation revenue	1,391,484	1,425,479	1,488,802	1,490,125

Asset performance

Introduction

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

Auckland DHB is designated as a Tier 1 entity for the purposes of the Investor Confidence Rating (ICR)[34] and is required to report annually on the performance indicators, which include asset Condition, Utilisation and Functionality for each of its main asset portfolios, comprising: Property, Clinical Equipment and Information Communication Technology (ICT).

Asset management is a core business function for Auckland DHB and continuous improvement in the DHB's asset management maturity is pursued across all asset portfolios. This includes implementing asset replacement plans, asset maintenance plans, managing asset data, systems and processes. A 10-year Asset Management Plan is in place and is reviewed to ensure this remains current regarding description of assets we currently use (owned and leased), their condition, utilisation, functionality, any risks associated with them, the major maintenance programmes, plans for refurbishments, upgrades or renewal of these assets and associated costs.

As a member of the northern region, Auckland DHB participates in regional programmes including development and updates of the 20-year Northern Region Long Term Investment Plan (NRLTIP) and the Information Systems Strategic Plan (ISSP). These key documents outline current and future services/asset gaps and the key strategic investments required to address Northern Region asset condition, quality, compliance issues and risks, increase capacity and improve technology. Asset performance measures enable us to monitor effectiveness and adequacy of our assets in delivering expected levels of service and to allow for timely upgrades and/or replacement.

Auckland DHB's Asset Portfolios

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

Asset portfolio, description and purpose	Capacity
Property Book Value 30 June 2021 - $1.018 billion (2020 - $969m). Replacement Cost (Indicative) $2.5 billion. The performance of our property portfolio is a key enabler for the: efficient movement of people through our campuses and buildings; sustained delivery and quality of our water, electricity, steam, heating, cooling, ventilation, fresh air, lighting and medical gasses; control and management of infections. It is important that our infrastructure, buildings, plant and services comply with relevant legislation and regulations, meet accreditation requirements, are fit for purpose and are properly maintained. Well maintained and performing facilities translates to improved patient care and shorter days stayed in hospital for our patients.	Includes land, infrastructure, buildings and related plant and services, mainly located at Auckland City Hospital, Starship Children's Hospital, Greenlane Clinical Centre and Point Chevalier. These facilities currently deliver the following capacity: • 1,198 inpatient beds, including ICU, HDU, CCU, PICU and maternity; • 44 surgical theatres, 38 procedure rooms and 100 day bed/chairs; • 177 Emergency Department beds/trolleys and treatment rooms; • 143 mental health beds; • Cancer: 81 chemotherapy beds/chairs, 1 brachytherapy; • Renal: 5 dialysis units; • 12 dental clinics; • 37 community-based properties leased by Auckland DHB. **Key infrastructure:** includes main site incomers for gas and electricity, site HV electrical rings, site steam and hot water networks, site services tunnels and plant rooms, and site water bores. **Key plant:** includes gas boilers, cogeneration plant, central plant chillers and cooling towers, and emergency power generators. **Key building services:** includes domestic hot and cold water and waste water networks, fire protection systems, medical gas reticulation, heating, ventilation and air-conditioning systems, and electrical networks.

[34] The ICR was implemented by the NZ Treasury in 2016 in response to the Cabinet Circular C0(15) 5: Investment Management and Asset Performance in the State Services, superseded by Cabinet Circular CO (19) 6 in 2019. The Circular gives effect to Cabinet's intention for there to be active stewardship of government resources and strong alignment between individual investments and the government's long-term priorities.

Asset portfolio, description and purpose	Capacity
Clinical equipment Book Value 30 June 2021 - $82m (2020 - $79m). Replacement Cost (Indicative) $300m. Clinical equipment is a key enabler for: patient care and comfort; timely interventions, quality analysis and diagnostics and, surgical procedures Most of the clinical equipment (87%) is maintained in-house by our resident clinical engineering team with the balance under external maintenance agreements. All equipment is managed under a preventative maintenance programme of regular inspections and testing. Equipment is maintained to a high standard to meet our own internal clinical quality standards and also to ensure they fully comply with national electrical, radiation safety regulations.	Clinical Equipment includes a wide range of equipment fleets and single item assets. Auckland DHB is also a provider of last resort with specialist services and equipment not used in other DHBs, e.g. national organ transplants, paediatric services. Our clinical equipment includes: • 6 linear accelerators (LINACs) • 3 MRIs • 6 CT scanners • 95 ultrasounds • 102 x-ray machines • 126 ventilators • 700+ patient physiological monitors. There are more than 30,000 items of clinical equipment in our asset management information systems.
Information Communications Technology (ICT) Book Value 30 June 2021 - $5m (2020 - $4m). Replacement Cost (Indicative) $10m. ICT is a key enabler supporting both the clinical service delivery to our patients and the non-clinical aspects of running a hospital. 24/7 availability, accessibility and functionality of critical clinical applications and information systems is a key priority for our staff. Fast, reliable and quality information facilitates timely decision making which also translates to improved patient care and shorter days stayed in hospital for our patients.	There are over 10,000 ICT users at Auckland DHB and in total 26,000 healthcare workers over the northern region supported by healthAlliance (our shared service agent). The majority of our ICT assets are owned and managed by healthAlliance and are not included in the book or replacement values shown here. Auckland DHB ICT assets which form part of the book and replacement values include: • clinical and business applications • hard wired and Wi-Fi networking infrastructure • IT devices.

Auckland DHB has other assets not included above, which are less significant in value and criticality but play an important role in our service delivery, e.g. vehicle fleet of 349, including 10 special purpose vehicles.

Property Asset Performance

Auckland DHB has a range of buildings on its campuses, some dating back to the late 1800s. The age and condition of the DHB's critical infrastructure, plant, building services and some buildings was previously identified as a major risk to the continuity of our services. We are currently implementing Tranches 1 and 2 ($567M cost) of a 5 Tranches Facilities Infrastructure Remediation Programme (FIRP) ($1 billion, 10-year programme) for renewing our aged critical infrastructure.

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

Asset Performance Measures are provided below, including comparatives.

Measure	Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
Building floor space utilised versus total floor space available % of floor space utilised in buildings on all campuses versus total space available in buildings on all campuses (space is identified in Asset Revaluation reports)	Utilisation	85%	98%	85%	97%
Building condition grading measured by floor space % of campus floor space graded as Average to Very Good to total campus floor space. Condition Grading levels are: Very Poor, Poor, Average, Good and Very Good; refer to comments in opening paragraph	Condition	85%	67%	85%	67%
Building condition grading measured by meeting building compliance requirements % of Buildings used with valid Building Warrant of Fitness (BWOF) to total buildings in the portfolio. BWOF is a compliance requirement	Condition	100%	100%	100%	100%
Seismic compliance % of floor space assessed as being earthquake prone (i.e. 33% or less of New Building Strength (NBS))	Condition	0%	1%	0%	1%
Building Functionality grading measured by floor space % of buildings (by floor space) graded as Moderate to Full functionality. Functionality Grading levels are: Unfit, Partial, Moderate, Good and Full	Functionality	65%	68%	65%	68%

ICT Asset Performance

healthAlliance owns, manages and maintains the Northern Region DHBs' ICT assets. In 2018, the Information Systems Strategic Plan (ISSP) was released as part of the NRLTIP and this identifies the ICT investment plan, which includes a strategic project prioritised for the Auckland DHB Hospital Administration Replacement System (HARP); the HARP business case was approved at a cost of $55m and implementation planning is underway.

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

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

Asset performance measure and description	Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
% of devices compliant with asset age replacement policy >75% of devices are within the DHB asset age replacement policy	Condition	>75%	86.09%	>75%	94.58%
% of SOEs compliant with security update policy >80% of EUD have signature updates that are <30 days as at the end of the quarter	Condition	>80%	96.28%	>80%	58.2%
% of apps with installed version no older than n-1 >55% of apps with installed version no older than n-1 across 'Top 55' (Critical Tier) apps	Condition	>55%	71%	>55%	63%
Number of SLA breaches ('service interruptions') recorded against application asset over a 12-month period >80% of 'Top 55' apps did not experience 2 or more SLA breaches over the last 12 months	Condition	>80%	99.99%	>80%	94%
Number of Apps Is asset architected for redundancy or resiliency >30% of 'Top 55' apps are deployed compliant with TIER 1 architecture guidelines	Functionality	>30%	41.93%	>30%	38.7%
Number of Apps Is asset supportable under TIER 1 SLA guidelines >30% of 'Top 55' apps can be supported under TIER 1 SLA guidelines	Functionality	>30%	59.06%	>30%	54.4%
% of Windows systems checked and patched, across all PROD and non-PROD environments >75% of technology platforms is patched to 13 weeks or less	Condition	>75%	93%	>75%	73%
Number of SLA breaches ('service interruptions') recorded against application asset over a 12-month period An average of <20 unplanned service interruptions	Condition	<20	1.3	<20	6.71
% staff have accessed clinical/non-clinical system platforms remotely >35% of users have accessed Citrix/remote platform in the last 12 months	Utilisation	>35%	54.18%	>35%	50.1%

Clinical Equipment Asset Performance

Auckland DHB implemented the nationally developed clinical equipment criticality and asset performance measures framework in its asset management system and this is now subject to validation by services. The framework will improve the ability to review and compare all assets at a glance and will assist in prioritising our replacement planning at an enterprise level across this portfolio. The following asset performance measures apply to critical clinical equipment items in our Cancer and Blood and Radiology Services.

Asset performance measure and description	Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
LINAC fleet: maintenance hours Number of units needing a sustained increase in maintenance hours	Condition	0	4	0	0
LINAC fleet: performance against Auckland DHB equipment specifications for patient treatment LINAC fleet to pass the comprehensive QA programme and be operable for work for ≥98% of the planned treatment hours	Functionality	98%	97%	98%	97%
LINAC fleet: performance against physical capacity of the fleet LINAC fleet % of total downtime hours ≤13% of the operable hours	Utilisation	13%	12%	13%	12%
MRI fleet: average condition grading using Auckland DHB criteria MRI scanner fleet condition graded as ≤3 on a scale of 1-10 (1 = best; 10 = worst)	Condition	3	6.3	3	6.3
MRI fleet: average functionality grading using Auckland DHB criteria MRI scanners fleet functionality (fit for purpose) graded ≤2.5 on a scale of 1-5 (1 = new; 2 = operationally sound; 3 = old technology; 4 =discontinued; 5 =obsolete)	Functionality	2	3.3	2.5	2.7
MRI fleet: total fleet unplanned downtime for the MRI scanner portfolio <25.6 hours (1%) of operable hours are spent on unplanned maintenance	Utilisation	28 hours	56 hours	26 hours	73 hours
CT scanner fleet: average condition grading using Auckland DHB criteria CT scanners fleet condition graded as <3 on a scale of 1-10 (1 = best; 10 = worst)	Condition	3	3	3	5.8
CT scanner fleet: average functionality grading using Auckland DHB criteria CT scanner fleet functionality (fit for purpose) graded as ≤2.5 on a scale of 1-5 (1 = new; 2 = operationally sound; 3 = old technology; 4 =discontinued; 5 =obsolete).	Functionality	2.5	2.0	2.5	2.8
CT scanner fleet: total fleet unplanned downtime for the CT scanner portfolio <34.6 hours (1%) of operable hours are spent on unplanned maintenance	Utilisation	35 hours	67 hours	35 hours	86 hours

Financial performance

FINANCIAL PERFORMANCE

Statement of Responsibility

We are responsible for the preparation of the Auckland DHB 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 DHB 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 operation of the Auckland DHB for the year ended 30 June 2021.

Signed on behalf of the Board:

Pat Snedden

Chair

Dated: 15 December 2021

William (Tama) Davis

Deputy Chair

Dated: 15 December 2021

Statement of comprehensive revenue and expense for the year ended 30 June 2021

	Notes	Group			Parent		
		Budget 2021 $000	Actual 2021 $000	Actual 2020 $000	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Revenue							
Patient care revenue	2i	2,509,743	2,586,953	2,410,472	2,509,743	2,586,953	2,410,472
Interest Revenue		1,184	2,408	4,159	2,723	2,064	3,681
Other revenue	2ii	83,147	90,335	82,005	80,779	87,960	81,559
Total revenue		**2,594,073**	**2,679,696**	**2,496,636**	**2,593,245**	**2,676,977**	**2,495,712**
Expenses							
Personnel costs	3	1,184,076	1,265,566	1,211,109	1,183,489	1,265,012	1,210,527
Depreciation and amortisation costs	13,14	60,632	59,045	55,495	60,632	59,045	55,495
Outsourced services		153,967	181,284	155,094	153,967	181,284	155,094
Clinical Supplies		302,856	310,746	290,998	302,856	310,746	290,998
Infrastructure and non-clinical expenses		89,864	97,374	87,115	89,864	97,307	86,498
Other district health boards		114,856	104,768	103,143	114,856	104,768	103,143
Non-health board provider expenses		635,023	660,241	599,022	635,023	660,241	599,022
Capital charge	4	45,686	33,661	45,993	45,686	33,661	45,993
Interest expense	18	1,184	704	562	1,184	704	562
Other expenses	5	50,972	62,636	52,284	51,390	62,200	52,588
Total expenses		**2,639,116**	**2,776,025**	**2,600,253**	**2,638,947**	**2,774,968**	**2,599,920**
Share of surplus of associate and joint venture surplus/(deficit)	15	-	100	(150)	-	-	-
Surplus/(deficit)		**(45,043)**	**(96,229)**	**(103,767)**	**(45,703)**	**(97,991)**	**(104,208)**
Other comprehensive revenue and expense							
Item that will not be reclassified to surplus/(deficit)							
Gains/(Losses) on property revaluations	20	-	44,837	-	-	44,837	-
Total other comprehensive revenue and expense		**-**	**44,837**	**-**	**-**	**44,837**	**-**
Total comprehensive revenue and expense		**(45,043)**	**(51,392)**	**(103,767)**	**(45,703)**	**(53,154)**	**(104,208)**

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 2021

	Notes	Group Actual			Parent		
		Budget 2021 $000	Actual 2021 $000	Actual 2020 $000	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Assets							
Current Assets							
Cash and cash equivalents	6	19,504	202,468	135,902	13,359	190,411	129,757
Investments	7	15,000	-	15,000	15,000	-	15,000
Trust/special funds	8	15,086	10,707	15,018	-	-	-
Restricted trust funds	9	1,308	-	1,376	1,308	-	1,376
Receivables	10	98,937	121,311	111,917	101,151	125,060	114,127
Prepayments		6,835	5,919	4,622	6,835	5,919	4,622
Inventories	11	27,511	16,275	15,396	27,511	16,275	15,396
Total Current Assets		**184,181**	**356,680**	**299,231**	**165,164**	**337,665**	**280,278**
Non-Current Assets							
Investments	7	-	-	-	-	-	-
Trust/special funds	8	15,970	17,577	15,970	-	-	-
Property, plant and equipment	13	1,288,234	1,206,860	1,131,133	1,287,295	1,205,868	1,130,141
Intangible assets	14	18,645	10,046	9,300	18,645	10,046	9,300
Investments in joint ventures & associates	15	75,057	79,677	75,057	74,539	79,060	74,539
Total Non-Current Assets		**1,397,905**	**1,314,160**	**1,231,460**	**1,380,478**	**1,294,974**	**1,213,980**
Total Assets		**1,582,086**	**1,670,840**	**1,530,691**	**1,545,642**	**1,632,639**	**1,494,258**
Liabilities							
Current Liabilities							
Payables & deferred revenue	16	184,981	242,596	195,411	178,654	235,579	188,429
Employee benefits	17	505,323	593,837	505,323	505,296	593,783	505,240
Provisions	18	-	3,451	1,742	-	3,451	1,742
Borrowings	19	1,925	2,828	1,925	1,925	2,828	1,925
Restricted trust funds	9	1,308	1,410	1,384	1,308	1,410	1,384
Total Current Liabilities		**693,536**	**844,122**	**705,785**	**687,183**	**837,051**	**698,720**
Non-Current Liabilities							
Employee benefits	17	88,931	93,269	88,932	88,931	93,269	88,932
Borrowings	19	16,945	14,046	10,136	16,945	14,046	10,136
Total Non-Current Liabilities		**105,876**	**107,315**	**99,068**	**105,876**	**107,315**	**99,068**
Total Liabilities		**799,412**	**951,437**	**804,853**	**793,059**	**944,366**	**797,788**
Net Assets		**782,675**	**719,403**	**725,838**	**752,584**	**688,273**	**696,470**
Equity							
Contributed Capital	20	1,019,413	964,384	919,427	1,019,413	964,384	919,427
Accumulated surplus/deficit	20	(865,357)	(919,379)	(821,488)	(865,981)	(920,099)	(822,108)
Property revaluation reserve	20	599,151	643,988	599,151	599,151	643,988	599,151
Trust/special funds	20	29,468	30,410	28,748	-	-	-
Total Equity		**782,675**	**719,403**	**725,838**	**752,584**	**688,273**	**696,470**

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 2021

GROUP	Notes	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Balance as at 1 July		**727,731**	**725,838**	**799,558**
Total comprehensive income/(expense) for the period		**(45,043)**	**(51,392)**	**(103,767)**
Owner Transactions				
Capital contributions from the Crown		99,986	44,957	30,047
Repayment of capital to the Crown		-	-	-
Balance as at 30 June	20	**782,675**	**719,403**	**725,838**

PARENT	Notes	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Balance as at 1 July		**698,302**	**696,470**	**770,631**
Total comprehensive income/(expense) for the period		**(45,703)**	**(53,154)**	**(104,208)**
Owner Transactions				
Capital contributions from the Crown		99,986	44,957	30,047
Repayment of capital to the Crown		-	-	-
Balance as at 30 June	20	**752,584**	**688,273**	**696,470**

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 2021

	Notes	Group Actual			Parent Actual		
		Budget 2021 $000	Actual 2021 $000	Actual 2020 $000	Budget 2021 $000	Actual 2021 $000	Actual 2020 $000
Cash flows from operating activities							
Cash receipts from Ministry of Health and patients		2,487,997	2,580,830	2,380,642	2,487,997	2,580,830	2,380,642
Other Receipts		100,440	99,513	101,487	96,237	94,577	94,994
Cash paid to employees		(1,184,663)	(1,170,803)	(1,095,334)	(1,184,081)	(1,170,221)	(1,094,808)
Cash paid to suppliers		(1,349,593)	(1,384,403)	(1,279,967)	(1,346,260)	(1,380,854)	(1,278,318)
GST (net)		-	(1,812)	3,842	-	(1,954)	3,731
Payments for Capital Charge		(45,686)	(33,661)	(45,993)	(45,686)	(33,661)	(45,993)
Net cash inflow from operating activities		**8,495**	**89,664**	**64,677**	**8,206**	**88,717**	**60,248**
Cash flows from investing activities							
Interest received		5,220	2,408	4,159	5,220	1,945	3,743
Proceeds from sale of property, plant and equipment		-	90	162	-	90	162
Decrease/(Increase) in investments and restricted trust funds		-	16,358	11,731	290	11,856	10,379
Purchase of property, plant and equipment		(222,268)	(87,874)	(68,091)	(222,268)	(87,874)	(68,039)
Purchase of intangible assets		(13,456)	(3,147)	(2,313)	(13,456)	(3,147)	(2,313)
Acquisition of investments		-	-	-	-	-	-
Net cash (outflow) from investing activities		**(230,504)**	**(72,165)**	**(54,352)**	**(230,215)**	**(77,130)**	**(56,068)**
Cash flows from financing activities							
Interest paid		(1,184)	(704)	(562)	(1,184)	(704)	(562)
Proceeds from borrowings/finance leases		4,983	6,358	3,444	4,983	6,358	3,444
Repayment of borrowings/ finance leases		1,826	(1,544)	(1,544)	1,826	(1,544)	(1,544)
Proceeds from capital contributed/(repaid)		99,986	44,957	30,047	99,986	44,957	30,047
Net cash inflow/(outflow) from financing activities		**105,611**	**49,067**	**31,385**	**105,611**	**49,067**	**31,385**
Net (decrease)/increase in cash and cash equivalents		**(116,398)**	**66,566**	**41,710**	**(116,398)**	**60,654**	**35,565**
Cash and cash equivalents at start of the year		**135,902**	**135,902**	**94,192**	**129,757**	**129,757**	**94,192**
Cash and cash equivalents at end of the year	**6**	**19,505**	**202,468**	**135,902**	**13,359**	**190,411**	**129,757**

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 2021 (continued)

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

	Notes	Group Actual		Parent Actual	
		2021 $000	2020 $000	2021 $000	2020 $000
Reported net surplus/(deficit) for the year		**(96,229)**	**(103,767)**	**(97,991)**	**(104,208)**
Add non-cash items:					
Share of associate and joint venture surplus	15	(100)	150	-	-
Depreciation and amortisation expense		59,044	55,495	59,044	55,495
Unrealised loss/(gain) on cash flow hedging instrument		-	-	-	-
Add items classified as investing activities:					
Net loss/(gain) on disposal of fixed assets		256	68	256	68
Net loss/(gain) on disposal of financial assets		(1,893)	(288)	(97)	-
Net interest shown in investing and financing activities		(1,703)	(3,597)	(1,359)	(3,119)
Add movements in statement of financial position items:					
(Increase)/Decrease in debtors and other receivables		(9,295)	(25,048)	(9,277)	(24,932)
(Increase)/Decrease in prepayments		(1,297)	(3,626)	(1,297)	(3,626)
(Increase)/Decrease in inventories		(880)	(1,039)	(880)	(1,039)
Increase/(Decrease) in creditors and other payables		47,201	31,469	45,730	26,805
Increase in provision		1,709	(78)	1,709	(78)
Increase/(Decrease) in employee entitlements		92,851	114,938	92,879	114,882
Net cash inflow/(outflow) from operating activities		**89,664**	**64,677**	**88,717**	**60,248**

Notes to the financial statements

1 Significant accounting policies

REPORTING ENTITY

The Auckland District Health Board (DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown. Auckland DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes.

The consolidated financial statements of Auckland DHB for the year ended 30 June 2021 comprise Auckland DHB and its subsidiaries (together referred to as 'group') and Auckland DHB's interest in associates and jointly controlled entities. The Auckland DHB group consists of the parent, Auckland DHB, Auckland DHB Charitable Trust and Auckland Health Foundation. Joint ventures are healthAlliance N.Z. Limited (25%) and Health Source NZ Limited (40%). 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 include delivering health and disability services through its internal provider arm, shared services including Funding and Planning administration, as well as funding services purchased from external providers (e.g. from non-governmental organisations and other community services). The group's primary objective is to deliver health, disability, and mental health services to the community within its district as well as to deliver regional and national services. The group does not operate to make a financial return. The group is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

The financial statements for the DHB are for the year ended 30 June 2021, and were approved by the Board on 15 December 2021.

BASIS OF PREPARATION

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB and group will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB and group for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 17 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

Statement of compliance

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

1 Significant accounting policies (continued)

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), with the exception of some remuneration disclosures in note 3.

Changes in accounting policies

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

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

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE IPSAS 41 Financial Instruments

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2022. Auckland DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. Assessment will be completed for 2021/22 reporting.

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.

The group financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, expenses, and cash flows of entities in the group on a line-by-line basis. All intra-group balances, transactions, revenue and expenses are eliminated on consolidation.

The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances. The consolidation of an entity begins from the date the DHB obtains control of the entity and ceases when the DHB loses control of the entity.

The investment in subsidiaries is carried at cost in Auckland DHB's parent entity financial statements. The Auckland District Health Board Charitable Trust and Auckland Health Foundation are controlled by the DHB.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into New Zealand 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.

1 Significant accounting policies (continued)

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.

Cost allocation

The cost of outputs has been determined 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
- Estimated useful life of property, plant and equipment – refer to Note 13
- Estimated useful life of intangible assets – refer to Note 14
- Measuring long service leave and retirement gratuities – refer to Note 17
- Estimated liability to comply with the Holidays Act pay – refer to Note 17.

Critical judgements in applying accounting policies

- Classification of leases – refer to Note 19
- Identifying agency relationships – refer to discussion 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 demographics 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 termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

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

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

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

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

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

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

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

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

2 Revenue (continued)

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	
	2021	2020	2021	2020
	$000	$000	$000	$000
Health & disability services (Crown appropriation revenue)	1,490,125	1,425,479	1,490,125	1,425,479
Other MoH and Government revenue	308,349	238,966	308,349	238,966
ACC contract revenue	25,791	24,078	25,791	24,078
Interdistrict patient inflows	733,031	686,267	733,031	686,267
Revenue from other district health boards	17,625	14,912	17,625	14,912
Other patient care related revenue	12,032	20,770	12,032	20,770
Total patient care revenue	**2,586,953**	**2,410,472**	**2,586,953**	**2,410,472**

ii Other revenue	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Donations and bequests	12,585	14,120	12,822	14,193
Gain on sale of property, plant & equipment	25	-	25	-
Gain on financial assets	1,796	288	-	-
Rental revenue	8,243	9,766	8,243	9,766
Accommodation revenue	864	907	864	907
Direct charges revenue	33,271	26,701	33,271	26,701
Drug trial revenue	493	874	493	874
Research grants	17,890	15,508	17,095	15,277
Other revenue	15,168	13,841	15,147	13,841
Total other revenue	**90,335**	**82,005**	**87,960**	**81,559**

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	2021	2020
	$000	$000
Not later than one year	5,262	6,085
Later than one year and not later than five years	9,126	14,403
Later than five years	-	-
Total non-cancellable operating lease commitments as lessor	**14,388**	**20,488**

The DHB and group 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/renewal date of 30 June 2024
- NZ Blood Service with an expiry/renewal date of 30 June 2024
- Oranga Tamariki with an expiry/renewal date of 1 July 2023.

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 and group makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme. Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme.

Breakdown of personnel costs and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Salaries and wages	1,132,766	1,060,638	1,132,183	1,060,056
Defined contribution plan employer contributions	38,159	35,533	38,159	35,533
Increase/(decrease) in liability for employee benefit	92,851	114,938	92,880	114,938
Restructuring expense for employee exit costs	1,790	-	1,790	-
Total personnel costs	**1,265,566**	**1,211,109**	**1,265,012**	**1,210,527**

3 Personnel costs (continued)

Employee remuneration

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

Remuneration range	Actual 2021	Actual 2020	Remuneration range	Actual 2021	Actual 2020
$100,000-$109,999	813	709	$480,000-$489,999	5	1
$110,000-$119,999	487	409	$490,000-$499,999	7	2
$120,000-$129,999	303	208	$500,000-$509,999	2	1
$130,000-$139,999	209	176	$510,000-$519,999	5	6
$140,000-$149,999	151	138	$520,000-$529,999	4	4
$150,000-$159,999	120	115	$530,000-$539,999	2	3
$160,000-$169,999	106	94	$540,000-$549,999	3	3
$170,000-$179,999	93	85	$550,000-$559,999	4	1
$180,000-$189,999	68	61	$560,000-$569,999	3	3
$190,000-$199,999	64	48	$570,000-$579,999	1	
$200,000-$209,999	49	60	$580,000-$589,999		3
$210,000-$219,999	61	60	$590,000-$599,999		2
$220,000-$229,999	41	39	$600,000-$609,999	5	1
$230,000-$239,999	36	39	$610,000-$619,999	1	2
$240,000-$249,999	52	42	$630,000-$639,999	1	1
$250,000-$259,999	47	50	$640,000-$649,999	1	2
$260,000-$269,999	44	40	$650,000-$659,999	1	2
$270,000-$279,999	41	33	$670,000-$679,999	1	1
$280,000-$289,999	32	31	$680,000-$689,999	1	1
$290,000-$299,999	39	28	$690,000-$699,999	1	1
$300,000-$309,999	30	28	$700,000-$709,999	1	1
$310,000-$319,999	35	38	$710,000-$719,999	2	
$320,000-$329,999	28	17	$730,000-$739,999		1
$330,000-$339,999	18	19	$750,000-$759,999		2
$340,000-$349,999	27	29	$810,000-$819,999	1	
$350,000-$359,999	32	26	$830,000-$839,999	1	1
$360,000-$369,999	24	12	$840,000-$849,999		1
$370,000-$379,999	11	16	$860,000-$869,999		2
$380,000-$389,999	9	11	$870,000-$879,999		1
$390,000-$399,999	25	21	$910,000-$919,999		1
$400,000-$409,999	20	15	$960,000-$969,999	1	
$410,000-$419,999	13	10	$970,000-$979,999	2	
$420,000-$429,999	9	12	$1,010,000-$1,019,999		1
$430,000-$439,999	12	2	$1,040,000-$1,049,999	2	
$440,000-$449,999	6	8	$1,200,000-$1,209,999		1
$450,000-$459,999	5	8	$1,250,000-$1,259,999		1
$460,000-$469,999	9	6	$1,430,000-$1,439,999	1	
$470,000-$479,999	4	6			
			Grand Total	3,232	2,802

During the year ended 30 June 2021, 104 (2020:126) employees received compensation and other benefits in relation to cessation totalling $2,495,360 (2020: $3,034,197).

Note:

During the Year Ended 30 June 2021, the above numbers of employees received remuneration of at least $100,000 on an annualised basis. Of these employees, 2,892 (2020: 2,505) are clinical positions for Medical, Nursing and Allied staff and 340 (2020: 297) are Management and Support staff.

3 Personnel costs (continued)

Board member remuneration

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

	Actual 2021 $000	Actual 2020 $000
Pat Snedden (Chair from 5 Jun 18)	65.02	59.25
Tama Davis* (Deputy Chair)	42.70	23.93
Bernie O'Donnell	33.76	19.09
Doug Armstrong	34.76	32.71
Fiona Lai	33.76	18.59
Ian Ward	33.51	18.84
Jo Agnew	36.45	33.03
Michael Quirke	35.26	19.09
Michelle Atkinson	36.32	32.25
Peter Davis	33.26	18.59
Zoe Brownlie	34.01	30.46
Gwen Tepania-Palmer *	-	13.05
Robyn Northey*	-	11.55
Sharon Shea*	-	12.43
Judith Bassett*	-	12.18
Dr Lee Mathias *	-	13.05
Total board member remuneration	418.80	368.08

*Local Body election effected change in membership in December 2019.

Co-opted committee members

	Actual 2021 $000	Actual 2020 $000
Norman Wong	13.00	4.06
Dame Paula Rebstock	9.10	4.84
Graeme Bell	7.94	
Fiona Lai	1.75	
Brian Dackers	5.64	
Ian Ward	1.50	
Heather Came	1.25	
Shehara Farik	0.25	
Fafita Finau	0.25	
Lovely Mahe	0.25	
Jennifer Alison	0.25	
Michael Steedman	0.25	
Total co-opted committee members	41.92	8.90

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $41,920 (2020:$8,900).

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 (2020: $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 and group pay 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 2021 was 5% (2020:6%).

5 Other expenses

Accounting policy

Operating leases

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

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

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

Breakdown of other expenses and further information

	Group Actual		Parent Actual	
	2021 $000	2020 $000	2021 $000	2020 $000
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	342	330	342	330
- prior period under/ (over) provision	(12)	(32)	(12)	(32)
- fees to Audit New Zealand for audit of financial statements (Auckland DHB Charitable Trust & Auckland Health Foundation)	36	36	36	36
Fees for other Audit services	317	(3)	317	(3)
Operating leases	11,494	9,558	11,494	9,558
Impairment of debtors/(provision released)*	(839)	(10)	(839)	(10)
Bad debts	4,175	3,528	4,175	3,528
Board members' fees	419	368	419	368
(Gains)/Loss on disposal of property, plant and equipment	318	68	318	68
Foreign currency loss (gains)/losses	(79)	(35)	(78)	(34)
Other financial assets (gains)/losses	(63)	(50)	(63)	(50)
Impairment of FPIM (previously NOS) rights	-	(29)	-	(29)
Other expenses	46,528	38,556	46,091	38,859
Total other expenses	**62,636**	**52,284**	**62,200**	**52,588**

* Please refer to note 10.

Non-cancellable operating lease commitments as lessee

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

GROUP and PARENT	2021 $000	2020 $000
Not later than one year	4,162	3,495
Later than one year and not later than five years	5,664	6,073
Later than five years	660	622
Total non-cancellable operating lease commitments as lessee	**10,486**	**10,190**

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

The details of the main property leases are as follows:

- 160 Grafton Road (First floor) is leased with an expiry date of 31 July 2023
- Secure Parking, 67 Symonds Street is leased with an expiry date of 31 May 2022
- 161 Grafton Road (Ground floor) is leased with an expiry date of 31 May 2024
- Community Mental Health Clinic is leased with an expiry date of 31 Jan 2027
- Taylor Centre is leased with an expiry date of 31 Oct 2021
- Carbine Road is leased with an expiry date of 30 Sep 2021.

6 Cash and cash equivalents

Accounting policy

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

Breakdown of cash and cash equivalents and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$0	$0	$0	$0
Current assets				
Bank balance & cash on hand	89	96	89	96
Bank balance & cash on hand (Trust/Special)	12,057	6,145	-	-
Bank balance & cash on hand (Restricted Trust)	1,410	8	1410	8
NZ Health Partnerships Limited	188,912	129,653	188,912	129,653
Cash & cash equivalents in the statement of cash flows	**202,468**	**135,902**	**190,411**	**129,757**

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 2021, this limit was $150.035m (2020:$140.681m).

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

7 Investments

Accounting policy

Bank term deposits

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

Breakdown of investments and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Current assets				
Term deposits	-	15,000	-	15,000
Non-Current assets				
Term deposits	-	-	-	-
Total Investments	**-**	**15,000**	**-**	**15,000**

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 (2020: Nil). The fair value has been calculated based on discounted cash flows, using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments. There is no loss allowance for investments.

8 Trust/special fund assets

Accounting policy

Trust/special fund assets

The assets are funds held by the Auckland DHB Charitable Trust, and comprise donated and research funds. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds are recognised in the surplus or deficit, and is transferred from/to trust funds in equity.

8 Trust/special fund assets (continued)

Breakdown of trust/special fund assets and further information

	Group Actual		Parent Actual	
	2021 $000	2020 $000	2021 $000	2020 $000
Current assets				
Cash & cash equivalent				
Cash at bank and on hand (restricted)	-	-	-	-
Term deposits with maturities less than 3 months (restricted)	-	-	-	-
Cash & cash equivalent total (restricted)	-	-	-	-
Term deposits (restricted)	10,500	14,500	-	-
Investment Bonds (at market)/(restricted)	207	518	-	-
Portfolio Investments (restricted)	-	-	-	-
	10,707	**15,018**	**-**	**-**
Non – current assets				
Term deposits (restricted)	-	-	-	-
Investment Bonds (at market)/(restricted)	1,104	1,354	-	-
Portfolio Investments (restricted)	16,473	14,616	-	-
	17,577	**15,970**	**-**	**-**
Total trust/special fund	**28,284**	**30,988**	**-**	**-**

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, investment bonds and portfolio investments with remaining maturities in excess of 12 months is $17.577m (2020: $15.970m). The fair values are based on discounted cash flows using market quoted interest rates for term deposits with terms to maturity similar to the relevant investments. There is no loss allowance for investments.

9 Restricted trust funds

Accounting policy

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

Breakdown of Restricted fund assets and further information

	Group Actual		Parent Actual	
	2021 $000	2020 $000	2021 $000	2020 $000
RESTRICTED TRUST FUNDS				
Current assets				
Restricted fund deposit (to be reinvested)	-	1,376	-	1,376
	-	**1,376**	**-**	**1,376**
Current liabilities				
Restricted fund deposit	1,410	1,384	1,410	1,384
	1,410	**1,384**	**1,410**	**1,384**

10 Receivables

Accounting policy

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

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

10 Receivables (continued)

Breakdown of receivables and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Receivables from MoH	61,985	67,203	61,985	67,200
Other receivables	28,215	24,217	25,499	22,749
Other accrued income	33,602	23,828	40,067	27,509
Less: Allowance for credit losses	(2,491)	(3,331)	(2,491)	(3,331)
Total receivables	**121,311**	**111,917**	**125,060**	**114,127**

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

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

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

Group receivables

Receivable days past due	Gross	Credit loss allowance	Gross	Credit loss allowance
	2021	2021	2020	2020
	$000	$000	$000	$000
Not past due	112,714	(48)	99,048	(274)
Past due 0-30 days	2,967	(512)	3,685	(1,059)
Past due 31-90 days	3,085	(301)	5,533	(430)
Past due 91-360 days	2,425	(512)	5,044	(775)
Past due more than 1 year	2,611	(1,118)	1,938	(793)
Total	**123,802**	**(2,491)**	**115,248**	**(3,331)**

Parent receivables

Receivable days past due	Gross	Credit loss allowance	Gross	Credit loss allowance
	2021	2021	2020	2020
	$000	$000	$000	$000
Not past due	117,673	(48)	102,075	(274)
Past due 0-30 days	2,418	(512)	3,431	(1,059)
Past due 31-90 days	2,641	(301)	5,220	(430)
Past due 91-360 days	2,208	(512)	4,801	(775)
Past due more than 1 year	2,611	(1,118)	1,931	(793)
Total	**127,551**	**(2,491)**	**117,458**	**(3,331)**

Movement in the allowance for credit losses is as follows:

	Group		Parent	
	2021	2020	2021	2020
	Actual	Actual	Actual	Actual
	$000	$000	$000	$000
Balance 1 July	3,331	3,341	3,331	3,341
Additional allowances made/ (released)	(840)	(10)	(840)	(10)
Balance at 30 June	**2,491**	**3,331**	**2,491**	**3,331**

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

Group and Parent	2021 Actual $000	2020 Actual $000
Pharmaceuticals	2,343	2,196
Surgical and medical supplies	13,932	13,200
Total Inventories	**16,275**	**15,396**

The amount of inventories recognised as an expense during the year was $289.700m (2020: $268.756m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense. The write-down of inventories amounted to $783k (2020: $754k). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2020: $nil). However, some inventories are subject to retention of title clauses.

12 Non-current assets held for sale

Accounting policy

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell. Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale. There are no non-current assets held for sale (2020: nil).

13 Property, plant and equipment

Accounting policy

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

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

Owned Assets

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

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

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

Additions

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

13 Property, plant and equipment (continued)

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

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

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

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

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

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

- Buildings (including components) 4-137 years 0.73%-25%
- Plant, equipment and vehicles 5-20 years 5.00%-20%

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

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

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

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

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

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount.

The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Critical accounting estimates and assumptions
Estimating the fair value of land and buildings

Valuation
The most recent valuation of land was performed by an independent registered valuer, Evan Gamby (M PROP STUD Distn, DIP UV, FNZIV (Life), LPINZ, FRICS) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2021.

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, 2 Kari Street and 99 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).

13 Property, plant and equipment (continued)

Adjustments have been made to the "unencumbered' land value for land where there is a designation or the use of the land is restricted, including where the land is subject to section 148 of the Act. The adjustments ranged from 5% to 14%.

Rates per square metre used for valuing the DHB's land range from $465 per square metre to $4,286 per square metre, depending on location.

Restrictions on the DHB and group's ability to sell land would normally not impair the value of the land because the DHB and group has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

Buildings

Buildings, fit out and infrastructure were revalued at 30 June 2019 by Telfer Young (Auckland) Ltd. Specialised buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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

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

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

- Office market rents range from $245 to $260 per square metre
- Capitalisation rates are market-based rates of return and range from 3.00% to 7.50%.

Estimating useful lives and residual values of property, plant, and equipment

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

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. The DHB and group minimise 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 and group have not made significant changes to past assumptions concerning useful lives and residual values.

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

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

GROUP	Land	Buildings	Plant, equipment and vehicles	Leased improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2019	347,121	621,749	339,873	3,017	52,223	1,363,983
Additions/ (Transfers)	-	-	-	-	67,531	67,531
Additions from Work in Progress	-	25,361	21,217	35	(46,560)	53
Disposals	-	-	(10,333)	-	-	(10,333)
Transfers	-	(370)	370	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Balance at 30 June 2020	**347,121**	**646,740**	**351,127**	**3,052**	**73,194**	**1,421,234**
Cost						
Balance at 1 July 2020	347,121	646,740	351,127	3,052	73,194	1,421,234
Additions/ (Transfers)	-	-	-	-	87,856	87,856
Additions from Work in Progress	5,131	31,997	24,586	2,739	(64,453)	-
Disposals	-	(4)	(7,310)	-	-	(7,314)
Transfers	-	(1,983)	1,983	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	44,836	-	-	-	-	44,836
Balance at 30 June 2021	**397,088**	**676,750**	**370,386**	**5,791**	**96,597**	**1,546,612**
Depreciation and impairment losses						
Balance at 1 July 2019	-	-	(244,954)	(1,642)	-	(246,596)
Depreciation charge for the year	-	(31,671)	(21,715)	(227)	-	(53,613)
Disposals	-	-	10,112	-	-	10,112
Transfers	-	-	-	-	-	-
Reclassifications	-	-	(4)	-	-	(4)
Revaluations	-	-	-	-	-	-
Balance at 30 June 2020	-	**(31,671)**	**(256,561)**	**(1,869)**	**-**	**(290,101)**
Depreciation and impairment losses						
Balance at 1 July 2020	-	(31,671)	(256,561)	(1,869)	-	(290,101)
Depreciation charge for the year	-	(34,108)	(22,248)	(286)	-	(56,642)
Disposals	-	-	6,991	-	-	6,991
Transfers	-	-	-	-	-	-
Reclassifications	-	(1)	1	-	-	-
Revaluations	-	-	-	-	-	-
Balance at 30 June 2021	-	**(65,780)**	**(271,817)**	**(2,155)**	**-**	**(339,752)**

GROUP						
Carrying Amounts						
At 1 July 2019	347,121	621,749	94,919	1,375	52,223	1,117,387
At 30 June 2020	**347,121**	**615,069**	**94,566**	**1,183**	**73,194**	**1,131,133**
Carrying Amounts						
At 1 July 2020	347,121	615,069	94,566	1,183	73,194	1,131,133
At 30 June 2021	**397,088**	**610,970**	**98,569**	**3,636**	**96,597**	**1,206,860**

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

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

PARENT	Land	Buildings	Plant, equipment and vehicles	Leased Improve-ments	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 2019	347,121	621,749	338,934	3,017	52,223	1,363,044
Additions	-	-	-	-	67,531	67,531
Additions from Work in Progress	-	25,361	21,164	35	(46,560)	-
Disposals	-	-	(10,333)	-	-	(10,333)
Transfers	-	(370)	370	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Balance at 30 June 2020	**347,121**	**646,740**	**350,135**	**3,052**	**73,194**	**1,420,242**
Cost						
Balance at 1 July 2020	347,121	646,740	350,135	3,052	73,194	1,420,242
Additions	-	-	-	-	87,856	87,856
Additions from Work in Progress	5,131	31,997	24,586	2,739	(64,453)	-
Disposals	-	(4)	(7,310)	-	-	(7,314)
Transfers	-	(1,983)	1,983	-		-
-	-	-	-	-	-	-
Revaluations	44,836	-	-	-	-	44,836
Balance at 30 June 2021	**397,088**	**676,750**	**369,394**	**5,791**	**96,597**	**1,545,620**
Depreciation and impairment losses						
Balance at 1 July 2019	-	-	(244,954)	(1,642)	-	(246,596)
Depreciation charge for the year	-	(31,671)	(21,715)	(227)	-	(53,613)
Disposals	-	-	10,112	-	-	10,112
Transfers	-	-	-	-	-	-
Reclassifications	-	-	(4)	-	-	(4)
Revaluations	-	-	-	-	-	-
Balance at 30 June 2020	-	**(31,671)**	**(256,561)**	**(1,869)**	**-**	**(290,101)**
Depreciation and impairment losses						
Balance at 1 July 2020	-	(31,671)	(256,561)	(1,869)	-	(290,101)
Depreciation charge for the year	-	(34,108)	(22,248)	(286)	-	(56,642)
Disposals	-	-	6,991	-	-	6,991
Transfers	-	-	-	-	-	-
Reclassifications	-	(1)	1	-	-	-
Revaluations	-	-	-	-	-	-
Balance at 30 June 2021	**-**	**(65,780)**	**(271,817)**	**(2,155)**	**-**	**(339,752)**

PARENT						
Carrying Amounts						
At 1 July 2019	347,121	621,749	93,980	1,375	52,223	1,116,448
At 30 June 2020	**347,121**	**615,069**	**93,574**	**1,183**	**73,194**	**1,130,141**
Carrying Amounts						
At 1 July 2020	347,121	615,069	93,574	1,183	73,194	1,130,141
At 30 June 2021	**397,088**	**610,970**	**97,577**	**3,636**	**96,597**	**1,205,868**

Leased assets

The DHB and group 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	2021 $000	2020 $000
Capital commitments		
Buildings, fitouts and infrastructure	25,928	29,347
Plant and Equipment	1,368	864
Total capital commitments	**27,296**	**30,211**

Work in progress

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

GROUP AND PARENT	2021 $000	2020 $000
Buildings, fitouts and infrastructure	70,139	54,161
Plant, equipment and vehicles	26,458	19,033
Non-Current Assets	**96,597**	**73,194**

14 Intangible assets

Accounting policy

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Business combination and goodwill

Business combinations are accounted for using the acquisition method. This method involves recognising at acquisition date, separately from goodwill, the identifiable assets acquired and the liabilities assumed. The identifiable assets acquired and the liabilities assumed are measured at their acquisition date fair values. When the Group acquires a business, it assesses the financial assets and liabilities assumed for appropriate classification and designation in accordance with the contractual terms, economic conditions, the Group's operating or accounting policies and other pertinent conditions as at the acquisition date. Goodwill is initially measured at cost, being the excess of the aggregate of the consideration transferred and the amount recognised for non-controlling interests over the net identifiable assets acquired and liabilities assumed. After initial recognition, goodwill is measured at cost less any accumulated impairment losses. Goodwill is tested annually for
impairment.

Information technology shared services rights

The DHB and group 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%)
- FPIM rights 15 years (6.67%).

Indefinite life intangible assets are not amortised, and are tested annually for impairment.

14 Intangible assets (continued)

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

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

GROUP and PARENT	FPIM rights	Software and development	WIP-FPIM rights	
	Cost	Cost	Cost	Total
	$000	$000	$000	$000
Cost				
Balance at 1 July 2019	6,714	7,832	-	14,546
Additions	29	1,526	1,107	2,662
Disposals	-	(69)	-	(69)
Reclassifications	-	(5)	-	(5)
Balance at 30 June 2020	**6,743**	**9,284**	**1,107**	**17,134**
Balance at 1 July 2020	6,743	9,284	1,107	17,134
Additions	1,107	2,040	-	3,147
Additions to Work in Progress	1,107	-	(1,107)	-
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2021	**8,957**	**11,324**	**-**	**20,281**
Amortisation & Impairment Losses				
Balance at 1 July 2019	-	(6,022)	-	(6,022)
Amortisation charge for the year	(766)	(1,112)	-	(1,878)
Disposals	-	62	-	62
Reclassifications	-	4	-	4
Balance at 30 June 2020	**(766)**	**(7,068)**	**-**	**(7,834)**
Amortisation & Impairment Losses				
Balance at 1 July 2020	(766)	(7,067)	-	(7,833)
Amortisation charge for the year	(896)	(1,506)	-	(2,402)
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2021	**(1,662)**	**(8,573)**	**-**	**(10,235)**
Carrying Amounts				
At 1 July 2019	6,714	1,810	-	8,524
At 30 June 2020	**5,977**	**2,216**	**1,107**	**9,300**
At 1 July 2020	5,977	2,216	1,107	9,300
At 30 June 2021	**7,295**	**2,751**	**-**	**10,046**

FPIM rights - NZ Health Partnership Limited investment
The FPIM rights were previously tested annually for impairment as this was considered to be an intangible asset with an indefinite life. Further to an accounting opinion obtained by NZHPL, Auckland DHB elected to amortise its investment in the FPIM Application asset under the Class B Share funding model, over its estimated useful life of 15 years. The amortisation amounts per year will mirror the NZHPL amortisation schedule of the Auckland DHB FPIM investment. The amortisation for the year ended 30 June 2021 was $896k (2020: $766k).

15 Investments in joint ventures and associates

Accounting policy

Joint Arrangements
Investments in joint arrangements are classified as either joint ventures or joint operations. The classification depends on the contractual rights and obligations of each investor.

Joint Venture
A joint venture is a binding arrangement whereby two or more parties are committed to undertake an activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. The consolidated financial statements include Auckland DHB's joint interest in jointly controlled entities, using the equity method, from the date that joint control commences until the date that joint control ceases. Investments in jointly controlled entities are carried at cost in the DHB's parent entity financial statements.

Joint Operation
A joint operation is a joint arrangement whereby the parties that have joint control of the arrangement recognise their direct right to the assets, liabilities, revenues and expenses of joint operations and their share of any jointly held or incurred assets, liabilities, revenues and expenses. These have been incorporated in the financial statements under the appropriate headings.

Associates
An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. Associates are accounted for at the original cost of the investment plus Auckland DHB's share of the change in the net assets of associates on an equity accounted basis, from the date that the power to exert significant influence commences until the date that the power to exert significant influence ceases. When Auckland DHB's share of losses exceeds its interest in an associate, Auckland DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Auckland DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

General Information		Interest held	
		2021	2020
Name of joint ventures	***Principal Activity***		
healthAlliance N.Z. Limited	Provider of shared services	25%	25%
HealthSource New Zealand Limited	Provider of shared services	40%	40%
Name of associate	***Principal Activity***		
Northern Regional Alliance Limited	Provision of health support services	33%	33%

NZ Health Partnerships Limited
Auckland DHB has a 5% interest in New Zealand Health Partnerships Limited. This interest is not regarded as having a joint arrangement status due to the low level of interest and lack of joint control. The investment in the Finance, Procurement and Information Management System (FPIM) asset is recorded as an Intangible asset (refer to Note 14).

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

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

Year end 30 June 2021 (unaudited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/(Deficit) $000
healthAlliance N.Z. Limited	236,992	39,041	197,951	145,279	(81)
HealthSource New Zealand Limited	8,997	8,286	711	42,265	76
Northern Regional Alliance Limited	26,653	21,889	4,764	18,576	1,207
Total Investments	**272,642**	**69,216**	**203,426**	**206,120**	**1,202**
Year end 30 June 2020	**Assets $000**	**Liabilities $000**	**Equity $000**	**Revenues $000**	**Surplus/(Deficit) $000**
healthAlliance N.Z. Limited	224,840	34,321	190,519	137,813	(1,575)
NZ Health Innovation Hub Management Limited	8,194	7,558	636	34,131	(41)
Northern Regional Alliance Limited	23,770	20,211	3,559	18,223	1,101
Total Investments	**256,804**	**62,090**	**194,714**	**190,167**	**(515)**

15 Investments in joint venture and associates (continued)

The 2021 financial information is unaudited. The 2020 financial information has been restated to reflect the final result.

healthAlliance N.Z. Limited
Auckland DHB's ownership interest in healthAlliance N.Z. Limited is determined by its 25% A Class shareholding and its rights to the distributions of capital or income and dividends is determined by its C Class shareholding interest. healthAlliance N.Z. Limited is a joint venture company that exists to provide a shared services agency to the four northern region DHBs in respect to information technology.

HealthSource New Zealand Limited
In June 2020, Auckland DHB purchased a 40% shareholding in HealthSource New Zealand Limited from healthAlliance N.Z. Limited. Healthsource N.Z. Limited is a joint venture company that exists to provide a shared services agency to the four northern region DHBs in respect to procurement, supply chain and financial processing.

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

Breakdown of investment in joint ventures and associates and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus/(deficit)	100	(150)	-	-
Non -Current Assets				
Investments in Joint Ventures & Associates				
Class A Shares in healthAlliance N.Z. Limited (joint venture)	200	200	200	200
Class A Shares in HealthSource New Zealand Limited (joint venture)	271	271	271	271
Class C Shares in healthAlliance N.Z. Limited (joint venture)	78,587	74,067	78,588	74,067
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	618	518	-	-
Total investments in joint ventures and associates	**79,677**	**75,057**	**79,060**	**74,539**

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 2021 is $78.587m (2020: $74.067m), which represents the baseline value of funding for IT projects implemented by healthAlliance and for IT projects implemented by Auckland DHB, with the resulting assets being transferred to healthAlliance on completion of the project.

16 Payables and deferred revenue

Accounting policy

Payables

Short-term payables are recorded at their face value.

Breakdown of payables and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Current				
Payables under exchange transactions				
Creditors	177,362	144,530	178,752	143,703
Income in Advance	12,261	10,109	4,007	3,851
Total payables under exchange transactions	**189,623**	**154,639**	**182,759**	**147,554**
Payables under non-exchange transactions				
GST, PAYE & FBT payable	34,286	34,203	34,133	34,306
Capital charge due to Crown	-	-	-	-
Income in advance	18,687	6,569	18,687	6,569
Total payables under non exchange transactions	**52,973**	**40,772**	**52,820**	**40,875**
Total payables and deferred revenue	**242,596**	**195,411**	**235,579**	**188,429**

Creditors and other payables are non-interest bearing and are normally settled on 30-day term. Therefore, the carrying value of creditors and other payables approximates their fair value.

17 Employee entitlements

Accounting policy

Short-term employee entitlements

Employee benefits due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, sick leave, sabbatical leave, long service leave and retirement gratuities. A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences. A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that created a contractual obligation and a reliable estimate of the obligation can be made.

Long-term entitlements

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

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

Presentation of employee entitlements

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

Critical accounting estimates and assumptions

Long service leave and retirement gratuities

The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating these liabilities are the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor was determined after considering historical salary inflation patterns and obtaining advice from an independent actuary.

17 Employee entitlements (continued)

A discount rate of 0.79% for Long Service Leave and 2.46% for Retirement Gratuities (2020: 0.22% in year one, 0.25% in year two and an average discount rate of 1.63% p.a. in years three and above). Salary increase rates used 3.5% p.a. (2020: 2.5% p.a.). The discount rates used are those advised by the Treasury. The salary inflation factor is the group's best estimate forecast of salary increments.

The average retirement used is 68 years old with 20% probability of early retirement at each age from 65 to 67. If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated $16.8m higher/$13.4m lower. If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the long service leave and retirement gratuities obligations would be an estimated $16.5m higher/$13.4m lower.

Continuing medical education leave
In the past, continuing medical education leave liability was able to be accumulated up to three years based on the annual entitlement. However, due to the restrictions on travel to attend conferences, etc. as a result of covid, some employee groups can now accumulate up to 5 years (2020: 3 years) before any forfeiture of unused leave will occur. Any staff that leave the DHB's employment will forfeit their unused balance on exit and a provision of 5% has been provided to allow for this as at June 2021 (2020: 10% forfeiture for both non utilisation of leave after 3 years and for staff exits).

Breakdown of employee entitlements

	Group Actual		Parent Actual	
	2021 $000	2020 $000	2021 $000	2020 $000
Current portion				
Liability for long service leave	3,440	3,277	3,437	3,273
Liability for sabbatical leave	750	750	750	750
Liability for retirement gratuities	7,131	6,496	7,131	6,496
Liability for annual leave	484,129	429,619	484,110	429,592
Liability for sick leave	845	641	822	604
Liability for continuing medical leave and expenses	44,896	29,283	44,896	29,283
Salaries and wage accrual	52,646	35,257	52,637	35,242
Total current	**593,837**	**505,323**	**593,783**	**505,240**
Non Current				
Liability for long service leave	5,034	4,142	5,034	4,142
Liability for retirement gratuities	88,235	84,790	88,235	84,790
Liability for continuing medical leave and expenses	-	-	-	-
Total non-current	**93,269**	**88,932**	**93,269**	**88,932**
Total employee entitlements	**687,106**	**594,255**	**687,052**	**594,172**

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 $52.6m (2020: $35.2m) salaries and wages accrual includes $19.8m (2020: $381k) backpay provision related to unsettled Multi Employer Collective Agreement (MECA) agreements and $27.6m (2020: $31.3m) which is made up of two major elements: unpaid days of $25.2m (2020: $20.2m) and salaries and wages for June paid in July of $2.3m (2020: 10.1m).

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

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

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining the additional payment is time consuming and complicated. Auckland DHB is working jointly with the two other Auckland Metro DHBs on a two year Holidays Act Remediation and Rectification programme which will result in compliance with the Holidays Act.

17 Employee entitlements (continued)

The liability recognised at 30 June 2021 is $319m (2020: $279m). The liability as at 30 June 2020 was estimated based on:

- selecting a sample of current and former employees;
- Calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result across all current and former employees.

The liability as at 30 June 2021 was estimated by extrapolating the liability for another 12 months to 30 June 2021. This liability amount is the DHB's best estimate at this stage of the outcome from the Auckland Metro Remediation and rectification programme. However, until the project has progressed further, there remain significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

18 Provisions

Accounting policy

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event;
- it is probable that an outflow of future economic benefits will be required to settle the obligation; and
- a reliable estimate can be made of the amount of the obligation.

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

Restructuring

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

Legal and onerous contracts

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

ACC Accredited Employers Programme

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

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

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

18 Provisions (continued)

Breakdown of provisions and further information

		Group Actual		Parent Actual	
		2021	2020	2021	2020
		$000	$000	$000	$000
Current Portion					
ACC Partnership Programme		1,661	1,630	1,661	1,630
Litigation		-	112	-	112
Restructuring		1,790	-	1,790	-
Total Provisions		**3,451**	**1,742**	**3,451**	**1,742**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,630	1,592	1,630	1,592
Additional provisions made during year		1,232	896	1,232	896
Charged against provision for the year		(1,201)	(858)	(1,201)	(858)
Unused amounts reversed during year		-	-	-	-
Closing balance	(i)	**1,661**	**1,630**	**1,661**	**1,630**
Litigation & Onerous Contracts Provision					
Opening balance		112	228	112	228
Additional provisions made during year		-	112	-	112
Charged against provision for the year		(112)	(228)	(112)	(228)
Unused amounts reversed during year		-	-	-	-
Closing balance	(ii)	**-**	**112**	**-**	**112**
Restructuring Provision					
Opening balance		-	-	-	-
Additional provisions made during year		1,790	-	1,790	-
Charged against provision for the year		-	-	-	-
Unused amounts reversed during year		-	-	-	-
Closing balance	(iii)	**1,790**	**-**	**1,790**	**-**

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent Actuary, Simon Ferry, has calculated the liability as at 30 June 2021. The Actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the Actuary's report.

Risk margin

A prudential margin of 11.6% (2020:11.6%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. A 'prudential margin' is required in terms of NZ IFRS 4 (PBE) and 11.6% is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are:

- an average assumed rate of inflation of 1.85% p.a. for 30 June 2021 and for the next five years;
- an average discount rate of 0.5% p.a. for 30 June 2021 and the same has been applied to future payment streams over the next 5 years. The discount rates used are Treasury-issued risk-free future rates as at 31 January 2021; and
- the expected future Average Claim Payment per accident is $3,184.

Insurance risk

The DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit. The DHB is responsible for managing claims for a period of up to 48 months following the end of the 12 months period of cover in which the claim has occurred. At that time the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

A stop loss limit of 220% of the DHB Standard Levy is used (i.e. 250% of the risk). The stop loss limit means the DHB will carry the total cost of all claims up to a total of $10.08m ($9.34m in 2019/20) at 220% of standard levy incurred in the cover period from 1 April 2020 to 31 March 2021 (2020/21 ACC Claim Year). Auckland DHB has also contracted a High Cost Claims Cover with an excess of $1,500,000 per event.

18 Provisions (continued)

(ii) Litigation and onerous contracts

There are no onerous contracts as at 30 June 2021 (2020: nil). There are a number of matters of a legal nature to which the DHB may have an exposure. The amounts involved are not considered to be material and if required to be settled, would be expensed in the year of settlement. Legal provision for 2021: nil (2020:nil)

(iii) Restructuring provisions

A total provision of $1.790m has been made, as follows:

$850k - Restructuring and a transition to a new model for some support services has resulted in a provision being made for the obligation to pay employee redundancy costs;

$620k -The Mental Health Directorate undertook a significant change and redesign process which proposed a revised structure to ensure that the administration function is fit for purpose. The restructuring plan for the administration function was approved by the ADHB Senior Leadership Team (SLT) to proceed to the consultation phase. This provision is being made for the obligation to pay employee redundancy costs;

$320k - Transitioning to new service delivery model in Corporate services has resulted in a provision for the redundancy cost.

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 and group have an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Overdraft facility

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

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Critical judgements in applying accounting policies

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

Leases classification

Determining whether a lease agreement is finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

19 Borrowings (continued)

Breakdown of borrowings and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Current portion				
Secured loans				
Loan -Energy Efficiency and Conservation Authority	97	97	97	97
Finance Leases	2,731	1,828	2,731	1,828
Total current portion	**2,828**	**1,925**	**2,828**	**1,925**
Non-current				
Secured loans				
Loan -Energy Efficiency and Conservation Authority	97	195	97	195
Finance Leases	13,949	9,941	13,949	9,941
Total non-current portion	**14,046**	**10,136**	**14,046**	**10,136**
Total Borrowings	**16,874**	**12,061**	**16,874**	**12,061**

Security and terms

The Energy Efficiency and Conservation Authority loan is interest free.

Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. Interest paid amounts to 2021: $704k (2020: $562k, which was previously reported in Infrastructure and Non-Clinical Expenses and has been reclassified this year for comparative reporting purposes).

Fair Value

The fair value of finance leases is $16.680m (2020: $11.769k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date ranging from 3% to 5%.

Analysis of finance leases

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
Minimum lease payments payable				
No later than one year	3,474	2,319	3,474	2,319
Later than one year and not later than five years	11,567	7,828	11,567	7,828
Later than five years	4,444	3,817	4,444	3,817
Total minimum lease payments	**19,485**	**13,964**	**19,485**	**13,964**
Future finance charges	(2,805)	(2,195)	(2,805)	(2,195)
Present value of minimum lease payments	**16,680**	**11,769**	**16,680**	**11,769**
Present value of minimum lease payments payable				
No later than one year	2,731	1,797	2,731	1,797
Later than one year and not later than five years	9,768	6,466	9,768	6,466
Later than five years	4,181	3,506	4,181	3,506
Total present value of minimum lease payments	**16,680**	**11,769**	**16,680**	**11,769**

19 Borrowings (continued)

Description of finance leasing arrangements

The group entered into finance leases for the lease of:

- CT scanner. The lease is for an initial period of five years ending March 2022
- Ultrasounds. The lease is for a period of 6 years ending May 2024
- Gastro Olympus scopes. The lease is for a period of 5 years ending July 2024
- Elekta Linear Accelerator. The lease is for a period of 10 years ending Oct 2024
- Four ultrasounds. The lease is for a period of 6 years ending October 2024
- Three iltrasounds. The lease is for a period of 6 years ending October 2024
- Six ultrasounds. The lease is for a period of 6 years ending October 2025
- Seven ultrasounds. The lease is for a period of 6 years ending September 2026
- Eight ultrasounds. The lease is for a period of 6 years ending September 2026
- Five ultraosounds. The lease is for a period of 6 years ending October 2026
- Laboratory ddPCR Machine. The lease is for a period of 8 years ending December 2026
- Stryker Power Tools. The lease is for a period of 7 years ending December 2026
- Two image intensifiers. The lease is for a period of 8 years ending March 2027
- ddPCR Machine. The lease is for a period of 8 years ending June 2027
- Mobile x-ray. The lease is for a period of 8 years ending November 2027
- 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
- CT scanner. The lease is for a period of 8 years ending May 2028
- Digital x-ray equipment. The lease is for a period of 10 years ending June 2028
- Catalyst and Perfraction. The lease is for a period of 10 years ending July 2028
- Mass spectrometry. The lease is for a period of 8 years ending July 2028
- Gamma camera. The lease is for a period of 10 years ending September 2028
- CT scanner. The lease is for a period of 10 years ending November 2028
- Mass spectrometry. The lease is for a period of 8 years ending March 2029
- Gamma camera. The lease is for a period of 10 years ending April 2029
- FISH equipment. The lease is for a period of 10 years ending October 2029
- CT scanner. The lease is for a period of 10 years ending August 2030.

The net carrying amount of the leased items within each class of property, plant, and equipment is shown in Note 13. There are no restrictions placed on the group by any of the finance leasing arrangements. Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

20 Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Contributed capital;
- Accumulated surplus/(deficit);
- Reserves - property revaluation; and
- Trust funds.

Property Revaluation Reserves

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

Trust funds

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

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

20 Equity (continued)

Breakdown of equity and further information

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
A Contributed Capital				
Opening balance 1 July	919,427	889,380	919,427	889,380
Contributions from/(repayment to) the Crown	44,957	30,047	44,957	30,047
Balance at 30 June	**964,384**	**919,427**	**964,384**	**919,427**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(821,488)	(717,130)	(822,108)	(717,900)
Operating surplus/(deficit)	(96,229)	(103,767)	(97,991)	(104,208)
Transfer to trust/special funds	(1,662)	(591)	-	-
Balance at 30 June	**(919,379)**	**(821,488)**	**(920,099)**	**(822,108)**
C Property revaluation reserves				
Opening balance 1 July	599,151	599,151	599,151	599,151
Net Movement	44,837	-	44,837	-
Balance at 30 June	**643,988**	**599,151**	**643,988**	**599,151**
D Trust/special funds				
Opening balance 1 July	28,748	28,157	-	-
Transfer from accumulated deficits (Note 6b)	1,662	591	-	-
Balance at 30 June	**30,410**	**28,748**	**-**	**-**
Total Equity	**719,403**	**725,838**	**688,273**	**696,470**
Property revaluation reserves consist of				
Land	381,652	336,815	381,652	336,815
Buildings	262,336	262,336	262,336	262,336
Total property revaluation reserves	**643,988**	**599,151**	**643,988**	**599,151**

Capital management

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

Contributions from/ (repayment to) the Crown

This relates to funding from the Crown for Crown approved capital projects.

Property revaluation reserves

The revaluation reserve movement relates to the independent valuation of land as at 30 June 2021 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 Scheme
The group is a participating employer in the DBP Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the scheme, the group could be responsible for any deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme, the group could be responsible for an increased share of any deficit.

As at 31 March 2021, the Scheme had a past service surplus of $1.3m for the year (2020: deficit $2.8m and 4.1% of the past service liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This deficit was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

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

Contingent Assets

There are no contingent assets at 30 June 2021 (2020: 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 (2020: $nil)

Key management personnel compensation

GROUP and PARENT	2021	2020
Board Members		
Remuneration	$419k	$368k
Full-time equivalent members	1.7	1.5
Leadership Team		
Remuneration	$9.187m	$9.773m
Full-time equivalent members	22	21.7
Total key management personnel remuneration	**$9.606m**	**$10.141m**
Total full time equivalent personnel	**23.7**	**23.2**

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

Covid-19 Delta community emergence – on 17 August 2021 New Zealand entered a level 4 lockdown following the identification of community cases within Auckland. This has impacted on the DHB's operations through additional unbudgeted expenditure being incurred which the DHB expects will be funded by MoH. Some services have also been disrupted as a result of the level 4 restrictions which may have a flow on impact on revenue and expenses with significant impacts on Planned care and IDF revenue that is subject to wash-ups. Depending on the duration of this outbreak or any future outbreaks, it is highly likely that the DHB may not be able to achieve some financial and non-financial performance measures in the subsequent financial year. Covid impacts are reported to the Ministry of Health each month and historically, a significant portion of Covid impacts have been funded by the Ministry of Health.

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	
	2021	2020	2021	2020
	$000	$000	$000	$000
Financial assets measured at amortised cost				
Cash and cash equivalents	202,468	135,902	190,411	129,757
Investments-term deposits	-	15,000	-	15,000
Trust/special funds - bank balances, term deposits	10,500	14,500	-	-
Receivables	121,311	111,917	125,060	114,127
Patient and restricted trust funds	-	1,376	-	1,376
Total financial assets measured at amortised cost	**334,279**	**278,695**	**315,471**	**260,260**
Financial assets measured at fair value through surplus or deficit				
Investment bonds and portfolio investments	17,784	16,488	-	-
Total financial assets measured at fair value through surplus or deficit	**17,784**	**16,488**	**-**	**-**
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	177,362	144,530	178,752	143,703
Borrowings	16,874	12,061	16,874	12,061
Patient and restricted trust funds	1,410	1,384	1,410	1,384
Total financial liabilities measured at amortised cost	**195,646**	**157,975**	**197,036**	**157,148**

24 Financial Instruments (continued)

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 2021					
Financial Assets					
Portfolio Investments	8	16,473	16,473	-	-
Investment bonds	8	1,311	1,311	-	-
GROUP 30 June 2020					
Financial Assets					
Portfolio Investments	8	14,616	14,616	-	-
Investment bonds	8	1,872	1,872	-	-

24c Financial Instrument risks

The DHB and group's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB and group have 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 and group have 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 and group's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as bank deposits are generally held to maturity.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB and group'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 2021, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, there would have been an insignificant impact on the deficit for the year.

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 and group had no direct exposure to foreign currency risk (2020: nil).

Sensitivity analysis

As at 30 June 2021, if the New Zealand dollar had weakened/strengthened against any foreign currency, there would have been an insignificant impact on the deficit for the year. The DHB and group have no outstanding foreign denominated payables at balance date (2020: $nil).

24 Financial Instruments (continued)

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 at 43% (2020: 52%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit quality of financial assets

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

	Group Actual		Parent Actual	
	2021	2020	2021	2020
	$000	$000	$000	$000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits & investment bonds				
A+	-	-	-	-
AA-	25,367	38,997	1,499	16,480
Total counterparties with credit ratings	**25,367**	**38,997**	**1,499**	**16,480**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL - no defaults in the past	188,912	129,653	188,912	129,653
Portfolio Investments-no defaults in the past	16,473	14,616	-	-
Receivables				
Exiting counterparty with no defaults in the past	121,311	111,997	125,060	114,118
Exiting counterparty with defaults in the past	-	-	-	-
Total counterparties without credit ratings	**326,696**	**256,266**	**313,972**	**243,771**

24 Financial Instruments (continued)

Liquidity risk

Management of liquidity risk

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

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

Contractual maturity analysis of financial liabilities, excluding derivatives

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include interest cash outflows.

GROUP

2021	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	16,874	19,679	1,798	1,775	3,501	8,162	4,443
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	177,362	177,362	177,362	-	-	-	-
Total	**194,236**	**197,041**	**179,160**	**1,775**	**3,501**	**8,162**	**4,443**

2020	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	12,061	14,255	1,209	1,208	2,394	5,628	3,816
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	144,530	144,530	144,530	-	-	-	-
Total	**156,591**	**158,785**	**145,739**	**1,208**	**2,394**	**5,628**	**3,816**

PARENT

2021	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	16,874	19,679	1,798	1,775	3,501	8,162	4,443
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	178,752	178,752	178,752	-	-	-	-
Total	**195,626**	**198,431**	**180,550**	**1,775**	**3,501**	**8,162**	**4,443**

2020	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	12,061	14,255	1,209	1,208	2,394	5,628	3,816
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	143,703	143,703	143,703	-	-	-	-
Total	**155,764**	**157,958**	**144,912**	**1,208**	**2,394**	**5,628**	**3,816**

25 Patient Trust

Auckland DHB does not administer funds on behalf of patients.

26 Major variances from budget

Statement of Comprehensive Revenue and Expense

Auckland DHB recorded a deficit of $96.229m which was unfavourable to the budgeted deficit of $45.043m. The key drivers for the deficit are an increase in Auckland DHB's provision for non-compliance with the Holidays Act ($39.7m - refer variance explanation for Personnel costs) and unfunded COVID-19 impacts ($14.7m - described below).

COVID-19 Impacts

Healthcare services were (and continue to be) the front line in the response to the COVID-19 pandemic.

The COVID-19 pandemic has continued to impact DHB operations across the continuum of health care from primary care and community NGOs to acute and planned care services on all hospital and health care sites as well as by private healthcare facilities that provide some services to Auckland DHB.

In response to the advent of Covid-19 and ongoing waves, Auckland DHB responded in many ways including:

- Implementing an incident management team to coordinate COVID-19 response activities locally and in collaboration with the regional emergency management response
- Implementing swabbing stations within general practice and in many locations across the Auckland region
- Postponing non-acute planned care to reduce the risk of COVID-19 spreading and to create capacity that may have been required for patients suffering from COVID-19 related illness as well as to redeploy staff to support our regional response
- Implementing telehealth and virtual appointments to ensure continuity of planned care where possible and appropriate
- Re-purposing facilities to be able to manage a potential surge of patients with COVID-19 infection
- Supporting COVID-19 laboratory testing
- Release of non-clinical staff and non-acute clinical staff to work in other areas supporting the community effort and regional co-ordination
- Conducting preparedness assessments of age care, mental health and disability residential care facilities and responding to outbreaks in facilities, including deploying staff to support
- Establishing additional on-call rosters to enable teams to 'split', as well as having dedicated teams for COVID-19 suspect and positive patients
- Implemented additional triage and screening of all patients and visitors, including visitor screening stations and triage tents.
- Implementing work from home policies where possible and implementing other wellbeing and welfare initiatives for our employees

COVID-19 has continued to have an on-going impact on the health system and Auckland DHB, with a significant proportion of the impacts in the 2020/21 financial year funded by the Ministry. Overall, Covid related revenue impacts for the year amounted to $73m, partially offsetting $88m Covid-19 related expenditure and leaving an unfunded impact of $14.7m.

Major revenue variances

Patient care revenue is higher than budget, mainly funding from the Ministry of Health for funded initiatives which include funding for COVID-19 pandemic.

Major expenditure variances

- **Personnel costs $81m over budget:** mainly driven by a $39.7m increase in the liability for non-compliance with the Holidays Act, $27m Covid-19 related personnel costs and increase in staff liabilities.
- **Outsourced services $27m over budget:** $11m of this relates to Covid-19 and the balance reflects outsourced staff to cover leave and absences and outsourced clinical and other services.
- **Clinical supplies costs $8M over budget:** mainly due to $4m Covid impacts (with offsetting revenue for Covid related laboratory costs) and other price and demand driven variances in business as usual operations.
- **Infrastructure and non-clinical expenses $8M over budget:** mainly reflecting $14m Covid-19 impacts, partially offset by favourable movements in underlying business as usual operations. **Other district health boards $10m below budget and Payments to other district health boards and non-health board providers $25m greater than budget:** These costs mainly relate to services provided by other DHBs for Auckland DHB-domiciled people and services provided by community providers. The costs reflect demand driven nature of expenditure, uncommitted initiatives, one off prior year adjustments, favourable National IDF outflow wash-ups, post budget service changes and PHO wash-ups, which partially offset COVID-19 related Funder expenditure (also with funding offsets).
- **Capital Charge $12m favourable:** mainly due to the reduction in the capital charge rate (from 6% to 5%) and a reduction in Crown equity due to the impact of the Holidays Act liability on the DHB's financial result.

26 Major variances from budget (continued)

Cash and Cash Equivalents over budget

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

Current and Non-current Investments over budget

$15m term deposit matured in the financial year and has not yet been reinvested.

Receivables over budget

Receivables are impacted by the timing of billings to and receipts from MOH.

Prepayments over budget

Prepayments include prepaid costs made towards the FPIM Programme during the financial year.

Property, Plant and Equipment variance below budget

Property, plant and equipment variance reflects capital expenditure tracking below budget for 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.

Payables & deferred revenue over budget

Payables & deferred revenue being over budget is due to higher costs accrued at end of the year, mainly driven by timing and expected increases in costs.

Employee benefits over budget

Employee benefits over budget is driven by increase in the Holidays Act non-compliance provision

Borrowings under budget

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

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Auckland District Health Board and Group's financial statements and performance information for the year ended 30 June 2021

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

We have audited:

- the financial statements of the Health Board and Group on pages 58 to 98, that comprise the statement of financial position as at 30 June 2021, 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 15 to 20, 22 to 24, 26 to 28, 37 to 46, 48 and 50.

Opinion

In our opinion:

- the financial statements of the Health Board and Group on pages 58 to 98, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; 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.
- the performance information of the Health Board and Group on pages 15 to 20, 22 to 24, 26 to 28, 37 to 46, 48 and 50:
    - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2021, 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 17 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. 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.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 63 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity is expected to come into effect on 1 July 2022. The Health Board and Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003
Note 17 on pages 85 and 86 outlines that the Health Board and Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board and Group has estimated a provision of $319 million as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Health Board and Group is reliant on financial support from the Crown
Note 1 on page 63 outlines that Crown support would be required if the Health Board and Group was required to settle the estimated historical Holidays Act 2003 liability prior to the Health Board's disestablishment. The Health Board and Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board and Group with financial support, where necessary.

HSU population information was used in reporting COVID-19 vaccine strategy performance results
Notes 1 to 5 on page 46 outline the information used by the Health Board and Group to report on its COVID-19 vaccine coverage. The Health Board and Group use the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in Note 2. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board and Group have provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of COVID-19
Note 23 on page 93 and note 26 on pages 97 and 98 of the financial statements, and pages 15 to 20, 22 to 24, 26 to 28, and 37 to 46 of the performance information outline the impact of COVID-19 on the Health Board and Group.

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. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board and Group's statement of performance expectations. We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board and Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the Group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 3 to 13, 21, 25, 29 to 36, 47, 49 and 51 to 57, but does not include the financial statements and the performance information, and our auditor's report thereon.
Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

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

Other than the audit, we have no relationship with, or interests in, the Health Board or any of its subsidiaries.

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