AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Annual Report 2021|22

Auckland District Health Board

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

Contents

An incredible team effort

Dr Mike Shepherd
Interim District Director
Te Toka Tumai Auckland

Kia Ora tatou,

It has been a challenging year for the health sector as we responded to COVID-19. We managed the Delta outbreak while delivering a comprehensive community vaccination programme, and then the highly transmissible Omicron variant of COVID-19. This placed significant pressure on our system and on our kaimahi (staff), who were also impacted by sickness, isolation and caring for whānau.

It is an honour to work with our kaimahi here at Te Toka Tumai (Auckland DHB), who did a fantastic job in delivering care to our community through these times.

Managing the pressure during COVID-19 had an impact on planned care. Along with the rest of the health system across Aotearoa, we are trying to reset our planned care. There has been a phenomenal amount of work done by our teams to get patients booked for surgery or assessment. As we do this, we have had a very strong focus on equity for our community and it is good to see this work demonstrating outcomes now.

One of the incredible features of Te Toka Tumai is our people and our teams working together every day. I really cannot say enough about the massive team effort put in to get us through the last two and half years. Our teams have shown great resilience, been prepared to work differently, and supported each other through it all.

Alongside responding to COVID-19, we continued to focus on Te Tiriti o Waitangi. We introduced Māori health leads for each Directorate and developed a system of Māori health leadership within Te Toka Tumai (He Awa Whiria). We clearly still have much work to do, but this approach is ensuring that we are partnering with Māori and developing services and approaches that reflect Te Tiriti o Waitangi.

In July, we became part of a new health system, Te Whatu Ora | Health New Zealand, which aims to create a unified, more equitable and people-centred health system across Aotearoa. This will be particularly relevant to our regional and national services here at Te Toka Tumai.

This change meant that we farewelled the Auckland DHB Board. The Board, in particular our Board Chair Pat Snedden, has been a huge support and I would like to acknowledge my thanks to them.

I also want to acknowledge and thank everyone who has worked at Auckland DHB over the last 21 years. For many of our kaimahi, this is more than a job, and I know their dedication and commitment to patients, our community and our people will continue as we become part of Te Whatu Ora.

Working in partnership with Te Aka Whai Ora | Māori Health Authority, the move to Te Whatu Ora is a really great opportunity to further evolve and develop a healthcare system that works for everyone. I look forward to the changes ahead and further improvements that follow.

Dr Mike Shepherd
Interim District Director, Te Toka Tumai Auckland

A unified approach to pae ora

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

A new future awaits as DHBs transition into one single national entity, Te Whatu Ora | Health New Zealand, which will work directly alongside Te Aka Whai Ora | Māori Health Authority.

The underlying spirit of this Tiriti-based partnership reflects the same principles that initially led to the formation of Kōtui Hauroa, a desire to put iwi at the same table as those entrusted with the planning and delivery of healthcare to Māori to ensure equity is a key consideration of all decision-making.

I am proud to reflect on yet another year of that kaupapa in action throughout Te Tai Tokerau, including, for the purpose of this report, Auckland DHB.

COVID-19 again dominated the landscape, particularly with the emergence of the more highly transmissible Omicron variant.

With the support of Kōtui Hauora, our iwi partners provided necessities and home-based care to many thousands of households, employing 90 kaimanaaki to engage with whānau across the greater northern region. This, in turn, enabled them to provide whānau with evidence-based vaccination information to counter some of the myths circulating in various communities. Ngā kaimanaaki also initiated over 5,000 wellbeing assessments and helped whānau to access healthcare and social support.

Meanwhile, Māori-led pop-up clinics, outreach support services and community-based testing sites worked tirelessly with some of our most remote whānau to ensure as many people as possible had access to the same opportunities as their city-based whānau.

As of 30 June 2022, 89% of the eligible Māori (aged 12+ years) living in our catchment area had received their initial two doses of COVID-19 vaccination, and 61% of Māori over the age of 18 years had received a booster. This important work to lessen the impact of COVID-19 and reduce the possibility of hospitalisation will continue and we are also focusing attention on influenza and MMR vaccinations for our tamariki and rangatahi.

I extend my thanks to everyone involved in this crucial mahi: DHBs, primary care and NGO stakeholders, iwi representatives and role models in our communities who continually strive to break down the various barriers to full engagement with the health system.

Much is being achieved by the specialist Māori pipeline project team to improve health outcomes for Māori. I am especially pleased to see the Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) screening programme being extended to Northland DHB, as requested by Kōtui Hauora. This innovative programme was first trialled by Waitematā DHB in Warkworth in 2015 and later expanded into Auckland DHB.

Another pipeline initiative to gain traction in the last 12 months is the new Te Oranga Pūkahukahu Lung Cancer Screening Research Programme, which achieved a milestone point in May, with the completion of its first 50 screens. Among these was the first-ever screen-detected lung cancer in Aotearoa New Zealand.

This Māori-led programme has a chronic obstructive pulmonary disease (COPD) component to it and also involves Auckland DHB and the University of Otago. Like AAA/AF screening, it targets specific health concerns known to have a disproportionate impact on Māori.

Early detection, coupled with swift intervention, saves lives and we are pleased to see projects of this nature attract funding and gain traction in our communities.

With that in mind, I acknowledge and thank Gwen Tepania-Palmer for her dedication to whānau, hapū and iwi in her role as Independent Chair to Kōtui Hauora and its inaugural beginnings, and in steering the course for Board members to where we are now. I also acknowledge all those who will continue this work under the auspices of a new health system and a unified vision of pae ora.

Kia pūmau tā tātou hononga, kia haere tonu ā tātou mahi (our partnership will endure and our work will continue).

Nicole Anderson
Acting Chair, Kōtui Hauora

About Te Toka Tumai

Who we are and what we do

Te Toka Tumai | Auckland DHB is the Government's funder and provider of health services to 498,000 residents living in the Auckland district.

Our population is diverse. Eight per cent of Auckland residents are Māori, 11% are Pacific, and 35% are Asian. The health status of the majority of our population is very good and we are a relatively affluent population. We have one of the highest life expectancies in New Zealand at 83.8 years (2019-21), an increase of 3.5 years since 2001.

More than 12,600 people are employed by Auckland DHB. Auckland DHB operates the largest teaching hospital and research centre in New Zealand. We provide many highly specialised services to the whole country. Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Starship Children's Hospital (also New Zealand's largest), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. We also provide community child health and disability services, community mental health services and district nursing.

Our expenditure budget in 2021/22 was $2.9 billion.

Our strategy for health, wellbeing and equity

We have five strategic priorities:

Under each domain, we align our work in our provider and in our community-based services. This includes elements of a future vision, metrics and key actions. These plans operate at different levels to cover the spectrum of large strategic programmes, portfolios, and/or operational business.

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

1. Pūmanawa Tangata – People, culture and values
2. Quality, Safety and Risk
3. Commissioning services to meet our people's needs
4. Financial sustainability.

To deliver our priorities, we work in partnership with our MOU partner Te Runanga o Ngāti Whatua. 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 is committed to achieving health equity for all those in our community, in particular for Māori. We are developing strong partnerships focused on health equity.

Māori and Pacific communities in our region experience inequalities in health outcomes with ethnicity as the strongest equity parameter. While Māori and Pacific groups combined account for fewer than one in five (18%) of our total population, much larger proportions (27% of our Māori and 40% of our Pacific populations) live in areas ranked as highly deprived (NZDep13). These areas are located mainly in the east, from Glen Innes south to Mt Wellington and Otahuhu.

Our established Te Tiriti o Waitangi-based partnership board, Kōtui Hauora, with iwi from Tāmaki and Te Tai Tokerau, lead work to improve Māori health outcomes for Northland, Waitematā and Auckland DHBs. The focus in 2021/22 centred on the priority areas of child and youth health, mental health, and primary health care.

The Māori Health Pipeline is a dedicated and expanding group of projects to accelerate Māori health gain. In 2021/22, the pipeline work programme included: Te Oranga Pūkahukahu Lung Cancer Screening Research Programme, Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) screening, HPV self-testing implementation studies, and the Hepatitis C Lookback and Reoffer programme.

Key achievements

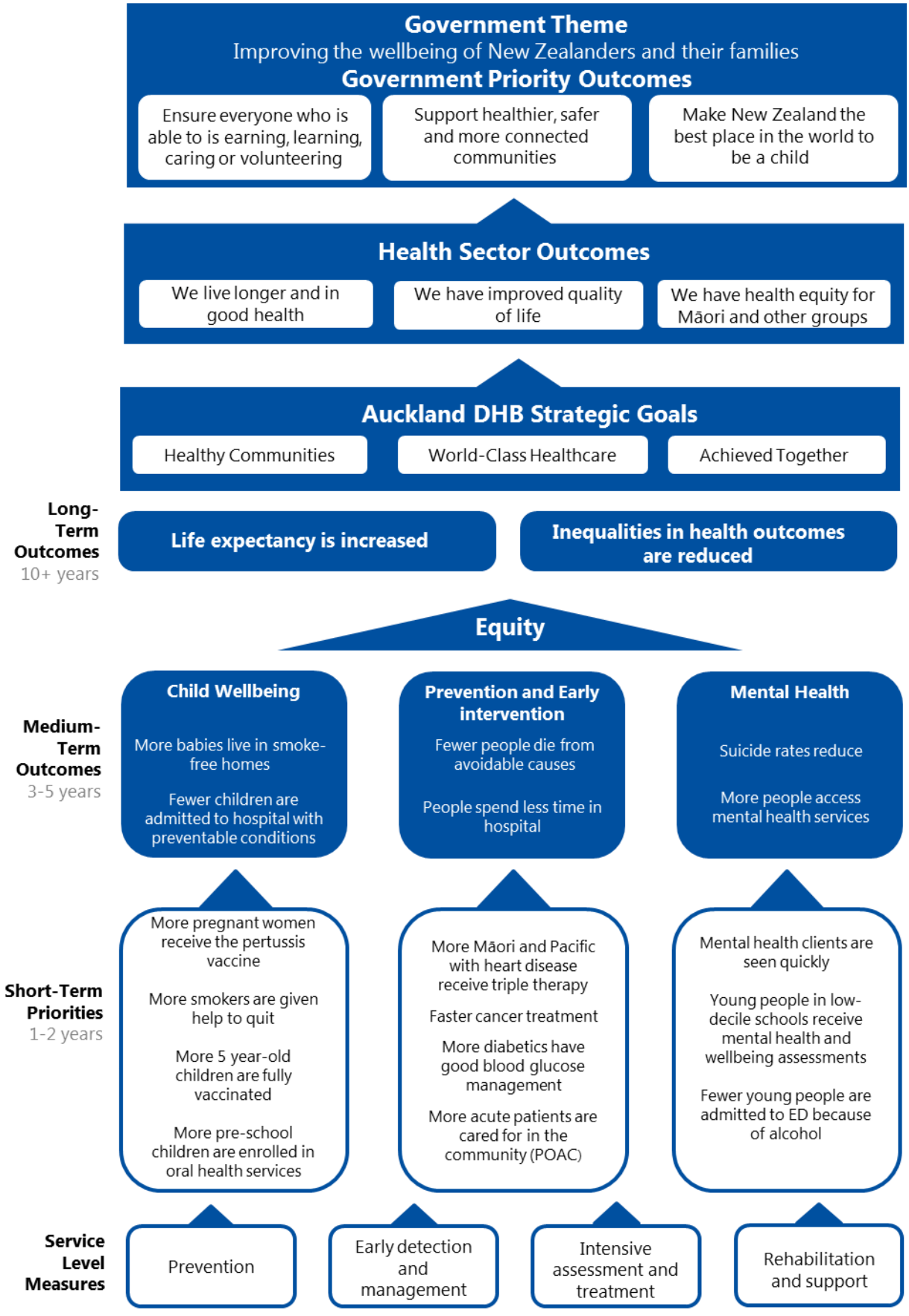
Although results for many of our performance measures were adversely affected by COVID-19, Auckland DHB remains one of the healthiest communities in New Zealand, performing well against our key population health indicators.

Our achievements in 2021/22 include:

- The life expectancy of our population is one of the highest in New Zealand, and is increasing for all ethnicity groups.
- Amenable mortality rates have declined by nearly 30% over the past decade, with a 46% decrease seen for Māori.
- Our smoking rate (10%) is the lowest in New Zealand and has decreased since the 2013 census. We continue to help more smokers to quit.
- Our children receive a great start to life, resulting in fewer hospitalisations. The number of preschool children admitted to hospital for conditions that are considered ambulatory sensitive (i.e. potentially avoidable though primary healthcare) such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall, and are reducing.
- People are spending less time in hospital and are receiving higher quality care. Acute bed days have reduced by 3% since June 2019, and our patients are receiving timely care for cancer, stroke and cardiac conditions.
- Our patients are cared for by a culturally aware workforce that reflects our communities. Our Māori workforce has increased to a current total of 707 Māori employees, or 7.4% of our workforce. We are on track to reach parity with the proportion of Māori and Pacific people in our working age population by 2025.
- We are working hard to manage COVID-19. As at June 2022, 92% of residents aged 12 years and over have completed their primary vaccination course (two doses), and 76% of those eligible have received a booster.

Performance and intervention framework

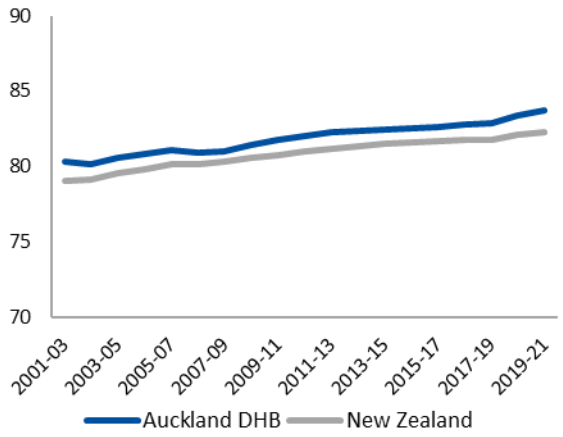
Our performance framework demonstrates how the services we fund or provide contribute to achieving our longer-term outcomes and the expectations of the Government. Our outcome measures (life expectancy and the life expectancy gap between Māori and Pacific, and other ethnicities) are long-term indicators; 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.



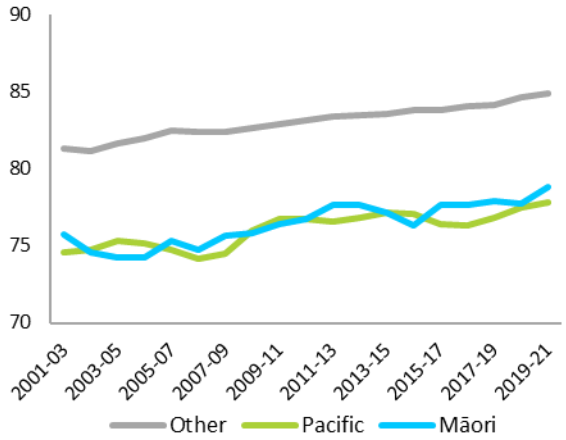
Long-term outcomes

Increasing life expectancy (measured by life expectancy at birth) and reducing inequalities between different ethnicity groups (measured by the ethnicity gap in life expectancy) are our two overall long-term objectives for our population. These outcome measures are long-term indicators; the aim is for a measurable change in health status over time, rather than a fixed target.

LIFE EXPECTANCY AT BIRTH – 3-YEAR COMBINED ESTIMATE



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



Life expectancy at birth (LEB) is recognised as an overall measure of population health status. Life expectancy at birth is defined as how long, on average, a newborn is expected to live, if current death rates do not change.

We have one of the highest life expectancies in New Zealand at 83.8 years (2019-21[1]), which is 1.5 years higher than New Zealand as a whole. Life expectancy for our overall population has increased slightly over the last year, and shows an increase of 2 years over the last decade. Around half of this increase can be attributed to the reduction in deaths from potentially amenable conditions.

Life expectancy differs significantly between ethnicity groups in our district. Māori and Pacific people have a lower life expectancy than other ethnicity groups, with a gap of 6.1 years for Māori and 7.1 years for Pacific.

Life expectancy for our Māori population increased by 2.4 years over the past decade and the gap in life expectancy is gradually closing. Māori now have a life expectancy of 78.8 years, but this is 6 years lower than other ethnicities (excluding Pacific).

Life expectancy for Pacific remains significantly lower than other ethnicities at 77.8 years (7 years lower than other ethnicities, excluding Māori). Pacific life expectancy has increased by only 1.1 years over the past decade, a slower rate of increase than that seen for Māori and other ethnicities, therefore the life expectancy gap is getting wider for Pacific.

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.

[1] The most recent life expectancy data available is for deaths occurring in the 2021 calendar year. Three-year combined estimates were produced to reduce the effect of year-to-year variations in death rates, which is particularly relevant due to smaller numbers seen at the ethnicity level.

Medium-term outcome measures

Our medium-term outcome goals and short-term priorities support our overall long-term objectives and allow us to measure the difference we are making for our population. 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.

Measure	Baseline result 2018/19	Current year result	% change
% of WCTO[2] registered babies living In smokefree homes at 6 weeks post-partum	67%	63%[3]	**7.0%**
Ambulatory sensitive hospital admissions in those aged 0-4 years, per 100,000 population	7,930	6,019	**24.1%**
- Māori	7,988	7,774	**2.7%**
- Pacific	15,724	11,564	**26.5%**
- Other	6,099	4,459	**26.9%**
Mortality rate from conditions considered amenable, per 100,000 population	70[4]	71[4]	**1.9%**
Acute hospital bed days rate per 1,000 population	445	433	**2.7%**
- Māori	681	716	**5.1%**
- Pacific	811	779	3.9%
- Other	384	369	**3.9%**
Rate of suicide per 100,000 population	8.5[5]	8.8[5]	**3.5%**
Proportion of population accessing mental health services	3.4%	3.6%	**5.9%**

Note: a **green** % change indicates the result has improved over the last three years, a **red** % change indicates the current result is worse than three years ago.

For each medium-term outcome measure, annual improvement milestones were set and performance over three years reported (i.e. the baseline period is 2018/19). To help identify equity gaps and measure progress, we monitor all medium-term outcomes by ethnicity. 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. For our short-term priorities, movement from the previous year is reported.

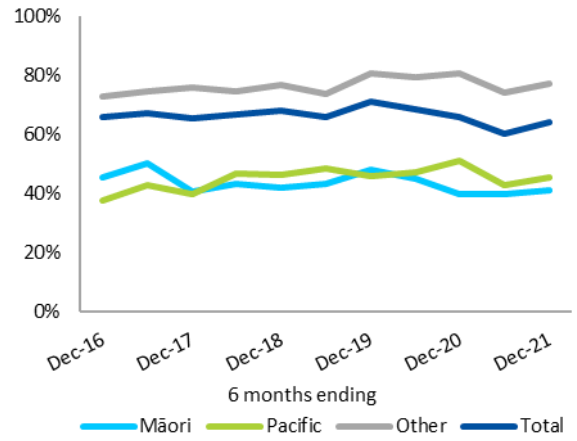
The COVID-19 pandemic had a significant impact on the performance of many of our shorter-term priorities. Restrictions imposed by the lengthy Delta lockdown in the second half of 2021, and the capacity constraints as a result of the increased workload and staff sickness due to the Omicron variant in 2022, meant that many improvement milestones were not reached.

[2] Well Child Tamariki Ora service.
[3] Six months ending in December 2021 (the latest available data).
[4] Baseline result based on 2016 deaths data, current result based on 2018 deaths data (as 2019 data delayed).
[5] Baseline result 2012-16 deaths, current result 2018 deaths (as 2019 data delayed).

Child Wellbeing

More babies live in smokefree homes

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



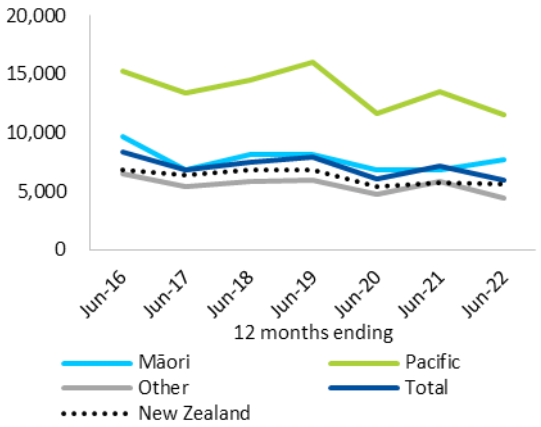
This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment and encouraging an integrated approach between maternity, community and primary care.

In the 12 months to December 2021 (the latest available data), 63% of 6-week-old babies in our district lived in smokefree homes. This is a slight decrease from the December 2018 result.

The percentage of babies living in smokefree homes is improving for most ethnicities; however, there has been little improvement for Pacific. Programmes like the maternal incentives smoking cessation programme aim to improve performance against this indicator and reduce the inequities for our Māori and Pacific populations.

Fewer children are admitted to hospital with preventable conditions

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



Ambulatory sensitive hospitalisations (ASH) are unplanned hospital admissions for a defined set of conditions that are potentially avoidable through prevention or management in primary care. In children, these conditions are primarily respiratory illnesses, gastroenteritis, dental and skin conditions. ASH rates are higher for Māori and much higher for Pacific children. Access to primary and community health care programmes can help to reduce ASH rates, but underlying determinants of health (e.g. housing, poverty and exposure to smoking) also influence the incidence of ASH.

New Zealand's first 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 decline in ASH rates in 2019/20.

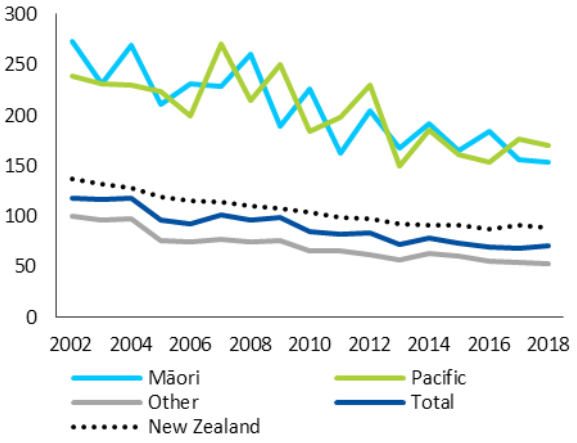
More recent ASH rates are rising slightly but remain much lower than pre-COVID-19 levels. ASH rates for our total population of 0-4 year olds are now 24% lower (i.e. better) than in June 2019. Rates have reduced even further for our Pacific children (27%). Despite this significant reduction, Pacific ASH rates are nearly twice as high as those for other ethnicities.

Short-term priorities	Prior year result	Current year result	% change
% of pregnant women receiving pertussis vaccination in pregnancy	64%	66%	3%
% of pregnant women receiving influenza vaccination in pregnancy	51%	47%	8%
% of children who are fully vaccinated by 5 years of age	88%	81%	8%
% of smokers receiving cessation support in primary care	29%	24%	17%
% of preschool children enrolled in DHB-funded oral health services	100%	99%	1%

Prevention and Early Intervention

Fewer people die from avoidable causes

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



*It can take several years for some coronial cases to return verdicts, meaning data for this indicator is delayed by up to three years. The release of the 2019 mortality data was further delayed by a large number of outstanding coronial cases; therefore, there is no update to the amenable mortality results previously reported in 2020/21.

Amenable mortality rates measure deaths in those 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.

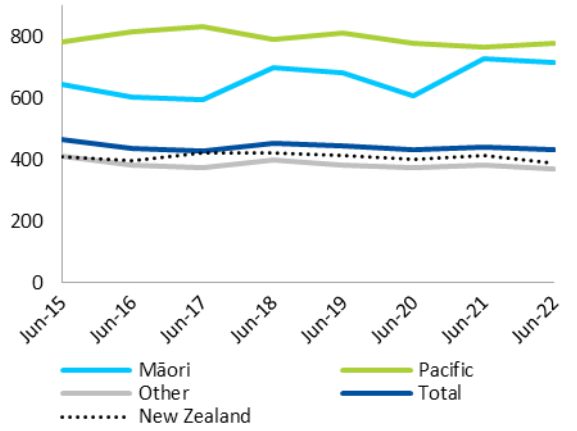
In 2018* (the latest available data), an estimated 418 deaths (44% of all deaths in those aged under 75 years) in Auckland DHB were amenable; this is a rate of 71 deaths per 100,000 population and reflects 4% fewer deaths than in 2015.

The largest 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.

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 annual fluctuations, as the smaller numbers of Māori and Pacific people in our community mean any natural variation appears to be more obvious.

People spend less time in hospital

ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



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

In the 12 months to June 2022, Auckland residents spent more than 200,000 days in hospital receiving acute care, with a total of 62,782 acute admissions. This equates to 433 days in hospital for every 1,000 people in our population (standardised for age), and this is a reduction of 2.7% on the June 2019 result.

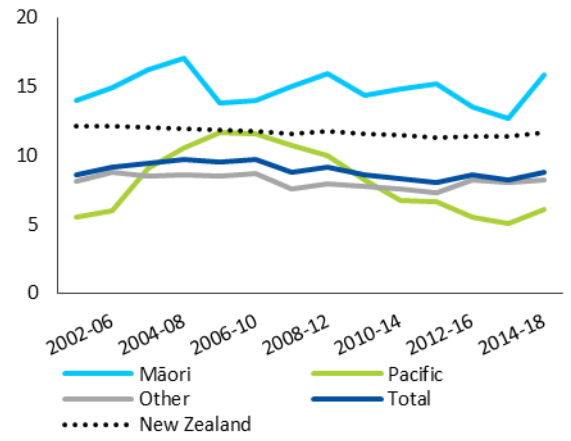
Although our overall standardised rate of acute bed days is slowly declining (i.e. improving), it remains higher than the national rate (390 per 1,000 population). The rate of acute bed day use is significantly higher for Māori (716 per 1,000) and Pacific people (779 per 1,000).

Short-term priorities	Prior year result	Current year result	% change
% of Māori patients with a prior CVD event who are prescribed triple therapy	62%	61%	2%
% of Pacific patients with a prior CVD event who are prescribed triple therapy	71%	67%	6%
% of cancer patients who receive treatment within 62 days of referral	94%	93%	1%
% of PHO-enrolled diabetics with good blood sugar management (HbA1c ≤64 mmol/mol)	60%	60%	-
Number of referrals to Primary Options for Acute Care (POAC)	5,401	5,784	7%

Mental health

Suicide rates reduce

SUICIDE RATE - DEATHS FROM SUICIDE, PER 100,000 POPULATION



* It can take several years for some coronial cases to return verdicts, meaning data for this indicator is delayed by up to three years. The release of the 2019 mortality data was further delayed by a large number of outstanding coronial cases; therefore, there is no update to the amenable mortality results previously reported in 2020/21.

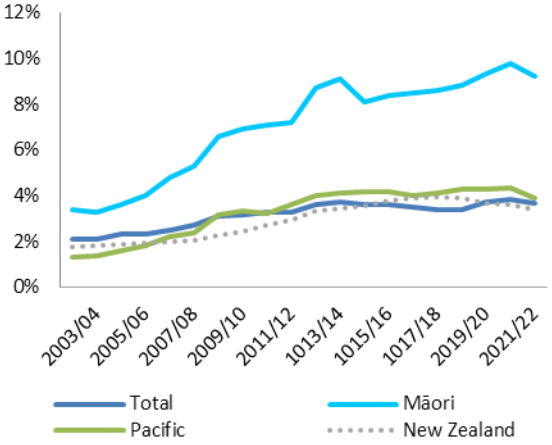
Suicide rates reflect the mental health and social wellbeing of the population. Reducing suicide requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress.

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 were 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.

More people access mental health services

MENTAL HEALTH ACCESS RATE - PROPORTION OF POPULATION ACCESSING MENTAL HEALTH SERVICES



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

In the 12 months to June 2022, 3.6% of the total Auckland DHB population (17,777 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 8.9% of our Māori population accessed mental health services in 2021/22. The proportion of all people accessing mental health services has increased by 8% 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.

Short-term priorities	Prior year result	Current year result	% change
% of referrals to non-urgent mental health services seen within 8 weeks	94%	97%	3%
% of eligible Year 9 students receiving HEEADSSS assessment	75%	61%	19%
Alcohol related ED admissions for youth aged 10-24 years	945	582	38%

Overview

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

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 of this report. The two high-level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Auckland DHB population is now 83.8 years, an increase of 2.0 years over the last decade. The life expectancy gap is 6.1 years for Māori and 7.1 years for Pacific, compared with all other ethnicities. This is a decrease of 0.4 years for Māori, but an increase of 1.0 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 2021/22 Statement of Performance Expectations by Output Class. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators expected performance directions rather than set quantitative targets, and these were assigned with the below symbols in the target column.

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

Impact of COVID-19

The COVID-19 pandemic had a significant impact on the performance reported for many of our output measures. Restrictions imposed by the lengthy Delta lockdown in the second half of 2021 in Auckland meant that fewer patients were seen face-to-face in primary care, and for a time many non-urgent services were unable to operate at all. Many staff were deployed to work on the vaccination rollout. During the Omicron outbreak in 2022, many staff were diverted away from routine health promotion/prevention work to focus on the care of COVID-19 patients, and the large number of both patients and staff infected and/or isolating led to delays in the provision of some services.

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.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Health promotion					
% of PHO-enrolled patients who smoke are offered brief advice to stop smoking in the last 15 months (C)	87%	82%	74%[6]	90%	🔴
% of PHO-enrolled patients who smoke and are referred to smoking cessation providers (Q)	9%	1.8%	1.6%[6]	6%	🔴
% of PHO-enrolled patients who smoke and are prescribed smoking cessation medications (Q)	8%	11.4%	9.9%[6]	12%	🔴
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	154	157	70[7]	110	🔴
Number of clients engaged with Green Prescriptions (V)	3,623	3,886	2,306[8]	4,030	🔴
% of clients engaged with Green Prescriptions (C)					
- Māori	13%	12%	13%	11%	🟢
- Pacific	22%	21%	22%	17%	🟢
- South Asian	15%	17%	18%	17%	🟢
Immunisation					
% of pregnant women receiving pertussis vaccination (C)	60%	64%	66%	50%	🟢
- Māori	34%	34%	31%[9]	50%	🔴
- Pacific	42%	44%	37%[9]	50%	🔴
- Asian	71%	74%	73%	50%	🟢
% of pregnant women receiving influenza vaccination (C)	51%	51%	47%[9]	50%	🔴
- Māori	34%	34%	28%[9]	50%	🔴
- Pacific	42%	42%	31%[9]	50%	🔴
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness[10] (C)	20%	33%	13%[11]	30%	🔴
- Māori	10%	26%	5%[11]	30%	🔴
- Pacific	14%	26%	9%[11]	30%	🔴
% of eight months olds will have their primary course of immunisation on time (C)	93%	92%	89.0%[12]	95%	🔴
- Māori	85%	78%	74.8%[12]	95%	🔴
- Pacific	91%	88%	82.3%[12]	95%	🔴
% of five year olds will have their primary course of immunisation on time (C)	89%	88%	81%[12]	95%	🔴
- Māori	84%	80%	69%[12]	95%	🔴
- Pacific	89%	87%	79%[12]	95%	🔴
- Asian	91%	90%	84%[12]	95%	🔴
Rate of HPV immunisation coverage (C)	86%	90%	48%[13]	75%	🔴

[6] The COVID-19 outbreak and ongoing response in the Auckland region since August 2021 significantly affect PHOs and practices ability to focus on providing brief advice to quit smoking and cessation support.
[7] The COVID-19 outbreak and ongoing response in the Auckland region since August 2021 significantly affected the services that usually refer. In addition a number of key roles were re-deployed to help with the response or were vacant for a period of the year.
[8] Result is due to a significant decrease in referrals from primary care due to their focus on the COVID-19 response.
[9] 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.
[10] All results are for the calendar year preceding the financial year.
[11] Low uptake due to winter illnesses; we continue to support PHOs with lists of eligible children to recall. Hospital-level services are actively checking for this cohort of children and engaging with families.
[12] Lockdowns, COVID-19 restrictions and high demand on workforce capacity affected immunisation coverage. Some families were fearful to attend GPs, and winter illnesses led to a high volume of cancellations/re-bookings. A recovery plan targeting Māori and Pacific was approved by MoH and is being implemented.
[13] The denominator for this measure is eligible girls born in 2008, based on census estimates; therefore, coverage rate is for girls instead of both girls and boys. COVID-19 led to challenges for School-Based Immunisation Programme roll-out due to school closures and student absenteeism.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Population-based screening					
% of women aged 45-69 years having a breast cancer screen in the last 2 years (C)	67%	53%	50%[14]	70%	🔴
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	69%	69%	65%[14]	80%	🔴
HEEADSSS assessment coverage in DHB-funded school health services[10] (C)	84%	75%	61%[15]	95%	🔴
% of four year olds receiving a B4 School Check (C)	65%	83%	44%[16]	90%	🔴
% of newborn babies offered and received completed hearing screening within 1 month (V)	95%	96%	96%	90%	🟢
Bowel cancer screening					
% of people aged 60-74 years invited to participate who returned a correctly completed kit[17] (Q)	New indicator	New indicator	49%[18]	60%	🔴
- Māori			42%[18]	60%	🔴
- Pacific			34%[18]	60%	🔴
- Asian			48%[18]	60%	🔴
- Other			52%[18]	60%	🔴
% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system (T)	New indicator	New indicator	98%	95%	🟢
Auckland Regional Public Health Service (ARPHS)[19]					
Number of alcohol licence applications and renewals (on, off club and special) that were processed (V)	3,625	2,921	3,011	Ω	n/a
Number of tobacco/vaping retailer compliance checks conducted (V)	184	5	0[20]	300	🔴
% of smear-positive pulmonary tuberculosis cases contacted by a public health nurse within 3 days of clinical notification (T)	95%	98%	96%	90%	🟢
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	96%	100%	100%	90%	🟢
% of COVID-19 confirmed cases that started isolation/quarantine within 48 hours after notification (time case notification to isolation/quarantine of contact P002) (T)	New indicator	New indicator	n/a[21]	≥80%	n/a

[14] Screening continues to be affected by COVID-19, including staff availability. Although inequity remains significant, work continues to prioritise high risk women.
[15] Extended school closures during the Auckland COVID-19 delta lockdown Aug-Dec 2021 meant the provision of school-based health services were significantly reduced in 2021/22.
[16] COVID-19 has had a significant impact on performance reported for this indicator. B4 school checks were unable to be performed during the Delta lockdown and the ongoing Omicron COVID-19 outbreak has seen many checks delayed as whānau or staff were sick or isolating.
[17] % of people invited to take part in the programme who were screened in the two years prior to the end of the reporting period, or in the case of Auckland DHB, since the programme launch.
[18] The bowel screening programme was launched in Auckland DHB only in early 2021, so invitees are not yet familiar with the testing process and our communications campaigns have had to compete for attention with COVID-19 and influenza health promotion messages. We continue to promote the importance of screening via targeted publicity using ethnicity-specific languages for priority populations.
[19] Services delivered by Auckland Regional Public Health Service on behalf of the three Metro Auckland DHBs; results are for all three DHBs.
[20] During the COVID-19 response, public health staff resources were prioritised. Re-engagement with tobacco retailers, with a focus on high deprivation areas (NZ Dep 7-10), is to be reinitiated in 2022/23.
[21] This indicator is not applicable as ARPHS is no longer solely responsible for the delivery of this service due to national changes in approaches to manage COVID-19 outbreaks throughout the reporting period.

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Primary health care					
Rate of primary care enrolment in Māori (C)	82%	82%	82%[22]	95%	🔴
% of newborn babies enrolled with a general practice or primary health organisation (PHO) at 3 months of age (C)	91%	89%	85%	85%	🟢
- Māori	80%	73%	66%[23]	85%	🔴
- Pacific	85%	83%	76%[23]	85%	🔴
Primary Options for Acute Care (POAC) utilisation rate (Q)	0.91%	1.07%	1.08%[24]	3%	🔴
% 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)	11%	13%	12.7%[25]	<8.0%	🔴
- Māori	16%	18%	17.0%[25]	<8.0%	🔴
- Pacific	12%	15%	15.6%[25]	<8.0%	🔴
% 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%	60%	60%	60%	🟢
- Māori	50%	47%	49%[25]	60%	🔴
- Pacific	49%	47%	47%[25]	60%	🔴
Number of highest priority (priority 1) patients who are not known to retinal screening, in Auckland DHB clinics[26] (C)	810[27]	715	926[28]	≤406	🔴
- Māori	99[27]	118	130[28]	≤50	🔴
- Pacific	500[27]	441	564[28]	≤250	🔴
- Asian	132[27]	106	163[28]	≤66	🔴
- Other	79[27]	50	69[28]	≤40	🔴
% of patients with prior CVD who are prescribed triple therapy (Q)					
- Māori	56%	62%	61%[25]	70%	🔴
- Pacific	65%		67%	70%	🔵
Pharmacy					
Number of prescription items subsidised (V)	7,387,260	8,020,795	7,797,203	Ω	n/a
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	26,739	31,525	25,451	Ω	n/a
Number of community laboratory tests (V)	3,213,918	3,614,812	3,455,719	Ω	n/a

[22] Primary care enrolment has historically been lower for Māori than other ethnicities. We continue to work with providers that serve communities with low levels of primary care enrolment.
[23] Competing demands of COVID-19 continue and particularly affected Māori and Pacific providers and whānau. We are working with the Northern Region and Te Whātua Ora on strategies to reduce the barriers for newborn enrolment.
[24] Data for calendar year 2021. The 3% referral target is arbitrary, and was intended to support awareness of variations in POAC referrals in primary care, rather than aiming for each practice (or the DHB as a whole) to meet the target.
[25] The impact of COVID-19 (Delta lockdown and ongoing Omicron COVID-19 outbreak) has impacted the ability of primary care to provide routine diabetes and CVD care. Work continues to re-engage in BAU where possible.
[26] This measure was incorrectly described as a % in the 2021/22 Annual Plan
[27] Baseline is data as at March 2021.
[28] The impact of COVID-19 (Delta lockdown and ongoing Omicron COVID-19 outbreak) has impacted the ability of primary care to provide routine diabetes and CVD care, including engaging and activating retinal screening referrals. We are continuing to work with PHOs to encourage referrals into retinal screening and undertake a retinal screening data match every three months to identify people with diabetes who are enrolled with a GP practice but are not known to retinal screening services.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Oral health[10]					
% of preschool children enrolled in DHB-funded oral health services (C)	97%	100%	99%	95%	
- Māori	77%	82%	88%	95%	
- Pacific	92%	94%	103%[29]	95%	
- Asian	93%	95%	92%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.63	0.49	0.40	<0.55[31]	
- Māori	0.81	0.57	0.73[30]	<0.55[31]	
- Pacific	0.93	0.72	0.64	<0.55[31]	
- Asian	0.58	0.43	0.36	<0.55[31]	
% of children caries free at five years of age (Q)	58%	48%	54%	57.7%[31]	
- Māori	46%	35%	42%[30]	57.7%[31]	
- Pacific	30%	27%	29%[30]	57.7%[31]	
- Asian	55%	47%	54%	57.7%[31]	
Utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including age 17 years (C)	87%	74%	60%[32]	85%	

[29] The numerator is the actual number of children enrolled with oral health services and the denominator is an estimated population projection (from Stats NZ). The projected population is likely to be less accurate at the ethnicity level, in this case resulting in a denominator lower than the numerator.
[30] Despite service interruptions and challenges related to COVID-19, ARDS continues to improve service delivery and community awareness, including a focus on high risk children.
[31] Target differs from that published in our 2021/22 Annual Plan, as changed by MoH.
[32] COVID-19 restrictions and school closures in 2021 affected service delivery. Initiatives continue to improve utilisation, including ARDS following priority booking model to continue to maximize the use of mobile facilities in high-needs areas where children experience more barriers to accessing 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	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Acute services					
Number of ED attendances (V)	109,215	116,756	108,984	Ω	n/a
% of ED patients discharged, admitted or transferred within six hours of arrival (T)	87%	88%	80%[33]	95%	🔴
% 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)	96%	94%	93%	90%	🟢
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7) (C)	14.3%	14%	16.6%	12%	🟢
% of ACS inpatients receiving coronary angiography within 3 days (T)	84%	86%	81%	70%	🟢
Maternity					
Number of births in Auckland DHB hospitals (V)	6,634	6,446	6,272	Ω	n/a
Elective (inpatient/outpatient)					
Number of Planned Care interventions (V)	21,578	23,642	20,409[34]	24,338[35]	🔴
- Inpatient surgical discharges	13,466	14,636	11,801	16,070[35]	n/a
- Minor procedures	8,111	9,005	8,607	8,001[35]	n/a
- Non-surgical interventions	1	1	1	267[35]	n/a
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	96%	96%	98%	90%	🟢
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	39%	58%	60%[36]	70%	🔴
% of patients waiting longer than 4 months for their first specialist assessment (T)	15.5%	3.0%	22%[37]	0%	🔴
% of accepted referrals receiving their CT scan within 6 weeks (T)	85%	75%	85%[38]	95%	🔴
% of accepted referrals receiving their MRI scan within 6 weeks (T)	52%	67%	77%[38]	90%	🔴

[33] Barriers to achieving the target include unfilled staff vacancies, in particular nursing roles, and high hospital occupancy.
[34] Surgical capacity is currently constrained due to insufficient clinical staff, both in theatres and across wards. We continue to treat high risk patients and long waiting patients, with a focus on prioritising Māori and Pacific.
[35] Target is updated from our 2021/22 Annual Plan, as agreed with MoH.
[36] Staff availability and capacity continue to be affected by COVID-19. We continue to prioritise endoscopy lists over clinics when possible and are working regionally on a recovery plan and outsourcing..
[37] COVID-19 disruptions increased patient waiting lists. We prioritise based on clinical risk, focus on those waiting the longest and prioritise Māori and Pacific patients. We are providing additional clinics wherever possible to reduce the waiting times.
[38] 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	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Quality and patient safety					
% of opportunities for hand hygiene taken (Q)	86%[39]	87%	87%[40]	80%	●
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	98%	97%[41]	99%	100%	●
% of hip and knee procedures given right antibiotic in right dose (Q)	97%	97%[41]	97%	95%	●
% of patients audited for pressure injury risk who received a score (Q)	92%	90%	91%	90%	●
% of patients with a hospital-acquired pressure injury (Q)	1.8% (CY2019)	2.3%	1.6%	<3.0%	●
% of 'yes, always' responses to the HQSC Adult Hospital survey question: 'Was your name pronounced properly by those provided your care?' (Q)	89.1% (Nov 2020 to Feb 2021)	89.4%[42]	87.6%[42]	≥89.1%	●
% of 'very good' and 'excellent' responses to the Auckland DHB inpatient survey question: 'How would you rate the coordination of your care between the hospital, home and other health services after you were discharged from hospital?' (Q)	67%	87%	86%	70%	●
Mental health					
% of population who access Mental Health services (C)					
- Age 0-19 years	3.38%	3.60%	3.43%	≥3.38%	●
- Māori	5.93%	6.35%	5.88%	≥6.00%	●
- Age 20-64 years	3.95%	4.01%	3.72%	≥3.92%	●
- Māori	11.76%	12.21%	11.1%	≥11.46%	●
- Age 65+ years	3.17%	3.12%	3.05%	≥3.11%	●
- Māori	4.33%	4.39%	3.85%	≥3.64%	●
% of people aged 0-24 years old who access specialist mental health services within 3 weeks of referral[43]	74%	80%	83%	n/a	n/a

[39] 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.
[40] 9 months ending March 2022
[41] Q1-Q3 2019/20 result
[42] 12 months ending May (as this indicator not reported every month)
[43] This indicator was not included in the 2021/22 Statement of Intent. As a target was not agreed in the SPE results only are reported.

Output Class 4: Rehabilitation and Support Services

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Home-based support					
% of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	n/a[44]	97%	98%	95%	●
Palliative care					
Number of community contacts (nurses) (V)	6,291[45]	19,610	20,480	Ω	n/a
% of patients acutely referred who waited >48 hours for a hospice bed (T)	0%	0.6%	0.7%	<5%	●
Residential care					
ARC bed days (V)	997,066	1,010,883	1,018,814	Ω	n/a

[44] Due to COVID-19, service provision in Q4 2019/20 was reduced to minimise transmission risk, and providers were switched to fixed funding rather than fee for service, thus accurate data is not available for 2019/20.
[45] Updated from the result published in our 2021/22 Annual Plan.

Health System Indicators

The baseline timeframe used by the Ministry of Health for these indicators is the year ending December 2019. This differs to the baseline of 2019/20 as set in our 2021/22 Annual Plan and as shown in the Statement of Performance tables, which was set prior to the release of the Health System Indicators by the MoH.

Health System Indicators	Time period	Māori	Pacific	Other	Total
Improving child wellbeing					
ASH rate in 0-4 years olds per 100,000 population, non-standardised	Baseline	8,407	14,836	6,291	7,989
	2021/22	7,764	11,564	4,459	6,109
Immunisation at 2 years of age	Baseline[46]	93.1%	95.4%	95.5%	95.2%
	12 m to Jun 2022	71.9%	78.5%	91.5%	86.8%
Improving mental health					
People aged 0-24 years old who access specialist mental health services within 3 weeks of referral	Baseline	82.3%	84.7%	77.1%	79.1%
	2021/22	85.3%	87.7%	81.5%	83.1%
Access to primary mental health and addiction services	Indicator currently under development by MoH				
Improving wellbeing through prevention					
ASH rate in 45-64 years olds per 100,000 population, standardised (SNZ)	Baseline	6,881	8,317	2,872	3,709
	2021/22	7,650	7,086	2,752	3,559
Participation in the bowel screening programme	Indicator currently under development by MoH				
Strong and equitable public health system					
Planned Care	Baseline	n/a	n/a	n/a	95.9%
	2021/22	n/a	n/a	n/a	
Acute hospital bed days per 1,000 population, standardised, by DHB of domicile	Baseline	642	834	378	442
	2021/22	716	779	369	433
Better primary care					
People who report they can get care when they need it, by DHB of domicile; weighted results	Baseline[47]	78.2%	83.3%	84.8%	84.2%
	2021/22[48]	79.0%	82.4%	84.5%	82.9%
People who report they feel involved in their care and treatment, by DHB of domicile; weighted results	Baseline[47]	88.9%	91.7%	89.6%	89.7%
	2021/22[48]	89.3%	88.4%	91.1%	89.8%
Financially sustainable health system					
Annual deficit	MoH data not available				
Actual deficit result	MoH data not available				

[46] 3 months ending December 2019
[47] 3 months ending May 2021
[48] 12 months ending May 2022

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	2020/21	2021/22
Hand hygiene		
80% compliance with good hand hygiene practice	87%[49]	87%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	0.27[50]	0.23
Falls		
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	3.7[51]	10.0
Safe surgery		
Ratio of actual : expected number of deep vein thrombosis/pulmonary embolism cases	1.31[52]	1.03[53]
Patient deterioration		
% of early warning score calculated correctly	93%	92%
% of patients who triggered an escalation of care and received the appropriate response	78%	86%
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1,000 admissions	1.6	1.4
Rate of rapid response escalations per 1,000 admissions	49	58
Pressure injuries		
% of patients with a documented and current pressure injury risk assessment	90%	91%
% of at-risk patients with a documented and current individualised care plan	93%	94%
% of patients with hospital-acquired pressure injury	2.3%	1.6%
% of patients with a non-hospital-acquired pressure injury	0.8%	0.9%
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	74%	99%
% of patients prescribed an opioid who have uncontrolled pain	23%	17%
% of surgical episodes of care with opioid-related harm	1.0%	0.9%

[49] Nov-20 to Jun-21 result
[50] Q1-Q3 2020/21 result
[51] This result was incorrectly reported in the 2020/21 Annual Report
[52] Result as at Q4 2020/21.
[53] Result as at Q2 2021/22.

COVID-19 Vaccination

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, the Ministry of Health have provided additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy. The complete information provided by the MoH can be found in Appendix One of this document. The data below is a summary of our vaccination coverage as at the end of 2021/22 (using the 2021 HSU as the denominator), and the vaccinations administered by our DHB in 2021/22.

Auckland DHB residents aged 12+ years vaccinated as at 30 June 2022, by ethnicity

Ethnicity	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	132,909	91%	131,496	90%	90,718	74%	253	6%
Māori	27,173	91%	26,396	89%	14,205	61%	103	8%
European/other	209,450	93%	207,785	92%	156,660	82%	2,105	14%
Pacific peoples	44,740	90%	43,632	88%	23,146	60%	65	4%
Unknown	7,195	212%	6,912	204%	3,613	55%	7	3%
Total	**421,467**	**93%**	**416,221**	**92%**	**288,342**	**76%**	**2,533**	**11%**

Note: Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021 and 30 June 2022.

COVID-19 vaccine doses administered by Auckland DHB, by dose type and year

Year	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[54]
2020/21	82,904	50,385	0	0	133,289
2021/22	352,272	370,240	289,400	2,731	1,014,643
Total	**435,176**	**420,625**	**289,400**	**2,731**	**1,147,932**

See Appendix One for notes and additional information relating to COVID-19 vaccination.

[54] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

Cost of Service Statement – for year ended 30 June 2022

Prospective summary of revenues and expenses by output class	2021/22 Plan $000	2021/22 Actual $000	2020/21 Actual $000
Prevention			
Revenue	124,949	134,061	37,856
Expenditure	137,458	192,117	94,795
Net surplus/(deficit)	**(12,509)**	**(58,056)**	**(56,939)**
Early detection			
Revenue	518,044	558,733	555,365
Expenditure	516,937	516,771	474,736
Net surplus/(deficit)	**1,107**	**41,963**	**80,629**
Intensive assessment and treatment			
Revenue	1,917,753	2,314,007	1,799,987
Expenditure	1,964,971	2,167,458	1,883,306
Net surplus/(deficit)	**(47,218)**	**146,549**	**(83,319)**
Rehabilitation and support			
Revenue	288,657	79,272	286,487
Expenditure	303,037	213,324	323,099
Net surplus/(deficit)	**(14,380)**	**(134,053)**	**(36,612)**
Consolidated surplus/(deficit)			
Revenue	2,849,403	3,086,073	2,679,696
Expenditure	2,922,403	3,089,670	2,775,925
Consolidated surplus/(deficit)	**(73,000)**	**(3,597)**	**(96,229)**

Being a good employer

Our organisation is in good heart, with strongly held values and a high commitment to manaaki and being of service. People within our organisation are passionate and dedicated to making a difference.

Our amazing people make Te Toka Tumai the place it is. Pūmanawa Tāngata, our people plan to 2023, puts people at the centre, provides a path, and reminds us what's important. Pūmanawa Tāngata means we will have the capability to support the hauora aspirations of our population. Pūmanawa Tāngata is the name gifted by Kahurangi Rangimarie Naida Glavish of Ngāti Whātua, Chief Advisor Tikanga. It means gifted and talented people. It speaks to the purpose and intensity we bring to our work here at Te Toka Tumai. Pūmanawa Tāngata symbolises relationships, growth, development and the connection to a beginning. This means that as we move forward, we also honour the past and our commitment to tangata whenua and Te Tiriti o Waitangi.

Te Toka Tumai 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:

- Continue to strengthen our organisational culture and values, building an inclusive and accessible organisation for all
- Build workforce capability to uphold Te Tiriti o Waitangi and cultural safety to achieve health equity
- Grow and develop ngā Kaimahi Māori
- Create a healthy workplace that promotes the wellbeing of our people
- Build pipelines, attract and retain the talent we need to deliver a workforce that is fit for the future
- Make it easier to work here – improving the manager and employee experience of people processes
- Provide opportunities for development, career advancement and leadership development

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 kaimahi 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.

These are the values and culture we hold ourselves accountable to and embed them in everything we do.

At Te Toka Tumai champions clinician leadership, with accountability for most directorates held by a clinician.

Our managers are supported with a custom-designed management development programme, comprised of 16 online modules and 6 face to face workshops. It is a great programme available to Managers and aspiring Managers. We invest in coaching workshops for our Managers to support them to have great conversations with their team members. This year the Māori Leadership Development Programme was launched. Centred on wairuatanga, the programme takes an innovative wayfinding approach to tackling wicked problems such as institutional racism and promotes rangatira Māori taking lead on matters most impactful to Māori communities. Enabling expertise of Māori in senior roles to directly benefit whānau in our health system is well researched and highly relevant for Māori workforce retention and job satisfaction.

Awhi Oranga, the Employee Support Centre was opened in 2021. It is a physical space for our people to use to support their holistic wellbeing. Since its opening, offerings have continued to grow over 2022 to ensure we support our people in meaningful ways. During COVID, these offerings were particularly important to ensure we were keeping connected with our people and providing welfare support.

Te Toka Tumai, we celebrate the rich diversity in our team, and valuing inclusion is part of who we are.

We are accredited with the Accessibility Tick which acknowledges our efforts to make our workplace more accessible and inclusive for people with access needs. The Tick is renewed on an annual basis and we're committed to continuously improving year on year. We have created a number of tools, guides and resources to support Managers and colleagues on supporting those with access needs or who are neurodivergent in the workplace. Last year we were accredited with the Hearing Accredited Workplace programme. We're continuing on the great work in this space to continue our efforts in embedding policies, practices, activities and supports for employees with hearing impairments. We provide hearing tests, promote sign language week and offering eLearning modules to build awareness.

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. We implemented Workforce Assurance standards into our systems and processes this year.

We are committed to a diverse workforce. We have a policy to shortlist all eligible Māori and Pacific candidates who meet the minimum requirements for any role. We support Hiring Managers and Recruitment Consultants to conduct recruitment processes in a way that is responsive to those who are neurodivergent or have access needs. We have recently launched a workshop for Culturally Safe Interviewing.

Navigate – Kai Arahi events welcome new employees to Te Toka Tumai. It is an opportunity to connect with our senior leadership teams, learn more about the District and be formally welcomed to the whānau. We support managers through the Onboarding module in the Management Development Programme alongside guides on how to create a great welcoming experience.

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 health tertiary qualification.

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

Diversity and Inclusion

Te āheinga ā-ahurea | Cultural competence
Te Toka Tumai 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. This is achieved through online learning, face to face workshops and partnering with Directorate Leadership Teams. In 2022, we launched two new workshops that delivers learning in these areas. Critical Tiriti Analysis and Tū Ngātahi, standing as one to achieve equity. Both workshops have received great feedback and are well subscribed. We were also a partner organisation in support of Tiriti Based Futures and Anti-Racism Conference 2022.

Te urupare i te mariu | Addressing bias
Workforce capability and awareness of addressing bias is developed through a variety of online learning modules and face-to-face workshops. It is also woven through existing learning modules and HR practices, such as the recruitment and selection workshop and talent management processes.

Hautūtanga ngākau tuwhera | Inclusive leadership
Inclusive leadership is developed at Te Toka Tumai through our broad range of management development programme modules, online learning and Rainbow and Accessibility accreditations, which are a strong symbol of our commitment.

Te whakawhanaungatanga | Building relationships
Whakawhanaungatanga is woven throughout all learning and development opportunities here at Te Toka Tumai. It forms the basis of many modules within the Management Development Programme and is role modelled during all workshops as a practice we encourage of all Managers. 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 Te Toka Tumai is a welcoming employer for those who have access needs.

Ngā tūhononga e kōkiritia ana e ngā kaimahi | Employee-led networks
Te Toka Tumai supports the establishment of employee-led networks across the organisation. This means ensuring all managers enable and encourage employees to attend where possible. There are currently two well-established employee-led networks. The Rainbow Employee Network delivered a successful pronouns campaign and the Kahui Hononga Network meet monthly to connect and hear from various speakers.

Pay Equity

Administration & Clerical Pay Equity

The Pay Equity Settlement has allowed employees carrying out Administration or Clerical work to feel more valued and creates a way forward whereby the undervaluation of this female dominated workforce is corrected. The PSA's claim sets out that this work is predominantly performed by women and that it was currently and historically undervalued due to social, cultural and historical factors, which affected the remuneration.

This settlement recognises the worth of this workforce, the value and importance their roles play resulting in higher salaries and therefore closing the pay gap. It also creates better career pathways for our employees.

Ongoing pay equity claims remain in place for Meras, NZNO and Allied Health.

Employee Development, Promotion and Exit

Te Toka Tumai is committed to providing development opportunities for individuals, teams and services.

Our To Thrive programme supports cleaners, orderlies and sterile sciences kaimahi to grow and develop their careers if they wish to do so. The programme offers financial literacy, leadership development and digital literacy training to enable career pathways. Recently, Hospital Supporter Roles have been created at Te Toka Tumai, which is another great pathway into a health career. We provide targeted leadership development, ongoing management development and coaching programmes. We have a broad range of learning on Ko Awatea LEARN.

- 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.

We engage an external provider to conduct exit interviews to understand the experience of those leaving to inform where improvements can be made in the future.

Flexibility and Work Design

Te Toka Tumai offers flexible rostering practices where possible, demonstrated by our large part-time workforce. Our flexible working policy encourages managers to enable this within their teams where possible. There is a currently a project underway looking in to how we can further improve our rostering practices for nursing and healthcare assistants.

A staff crèche/early learning centre is provided on each of the two major sites.

Remuneration, Recognition and Conditions

Te Toka Tumai 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 for Nursing and Midwifery, and Allied Health Scientific and Technical
- long-service awards and tributes to retiring staff in Te Whetu Marama
- a 'shout out' feature is included on our staff intranet (HIPPO), which allows public peer recognition.
- 'receive one, give one' coffee cards to say thank you during COVID-19
- snacks delivered to Wards for all the hard mahi during our busy periods.

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. We're committed to ensuring we provide safe pathways to report racism. The Speak Up programme is currently being reviewed to explore the suitability of this to include a pathway to report racism, or if another avenue is more appropriate.

Safe and Healthy Environment

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

Our Health, Safety and Wellbeing Governance Committee (HSWGC) oversees worker health, safety and wellbeing. The committee provides assurance that Te Toka Tumai complies with all relevant health and safety-related acts, regulations, codes of practice, safe work instruments, industry standards and district health board policies.

Our programme **Kia Ora tō Wahi Mahi**, a healthy workplace plan for Te Toka Tumai, focuses on activity in these areas: giving employees a voice, improving connections, empowering leaders, enhanced ways of working, comfortable work spaces, and living our values.

As part of this programme, we partner with Directorates to implement their wellbeing plans. We conduct regular Leaders Check-Ins to support managers and encourage regular check ins with their teams. We have an online wellbeing hub ensuring employees know of the benefits available to support their holistic wellbeing. We have onsite fitness classes for employees and free or subsidised gym memberships.

Auckland DHB Board members

Pat Snedden
Board chair

William (Tama) Davis
Deputy Chair

Michelle Atkinson

Michael Quirke

Zoe Brownlie

Peter Davis

Bernie O'Donnell

Fiona Lai

Jo Agnew

Douglas Armstrong, QSO

Ian Ward

Meeting attendance

	Board (13 meetings)	HAC (5 meetings)	FRAC (7 meetings)	CPHAC (3 meetings)	DiSAC (3 meetings)
Board members					
Pat Snedden, Board Chair	13	*	6	*	*
Jo Agnew	12	0	6	0	1
Doug Armstrong	12	0	6	-	-
Michelle Atkinson	13	0	6	0	1
Zoe Brownlie	12	0	5	0	1
Peter Davis	11	0	-	0	-
Tama Davis, Deputy Chair	11	0	3	0	1
Fiona Lai	10	0	5	0	-
Bernie O'Donnell	9	0	-	0	-
Michael Quirke	13	0	5	0	-
Ian Ward	13	-	6	-	-
Independent committee members					
Dame Paula Rebstock, Chair	2	-	6	-	-
Norman Wong, Deputy Chair	1	-	5	-	-
Teuila Percival, Chair	-	0	-	0	-
Heather Came	1	0	-	0	-
Michael Steadman	-	-	-	0	-

In September 2021, the Board made the decision that, due to a further lockdown for COVID-19, only the Board and the Finance, Risk and Assurance Committee would continue meeting as per the published meeting schedule. All business that would normally be conducted by the Hospital Advisory, Community and Public Health Advisory and Disability Support Advisory Committees would be sent straight to Board for consideration, with independent members' attendance being optional. There were an additional three Emergency Board meetings and one Special Board meeting held during this period, bringing the total meetings for Board to 13.

Members not belonging to a committee are denoted with '-'. Ex officio members are denoted with '*'.

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.

Subsidiaries, associates and joint ventures

Auckland DHB has two independent charitable trusts that are consolidated into the DHB Group financial statements, i.e. Auckland DHB Charitable Trust (A+ Trust) and Auckland Health Foundation. The DHB is also a shareholder in a number of Crown Entities: healthAlliance N.Z. Limited (owned by Auckland, Waitematā, Counties Manukau and Northland DHBs, each with a 25% A Class Shareholding); HealthSource New Zealand Limited (owned by Auckland, Waitematā, Counties Manukau and Northland DHBs, each with the following A Class Shareholdings: Auckland DHB 40%; Counties Manukau DHB 25%; Waitematā DHB 25%, Northland DHB 10%); Northern Regional Alliance Limited (owned equally by Auckland, Waitematā and Counties Manukau DHBs).

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 2021/22 year there were no permissions, waivers or modifications given under the clauses of this legislation.

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

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 2021/22 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.

	2020/21		2021/22	
	Final budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,488,802	1,488,802	1,568,189	1,568,189
Supplementary estimates		1,323		53,776
Total appropriation revenue	1,488,802	1,490,125	1,568,189	1,621,965

Asset performance

Introduction

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

Auckland DHB is designated a Tier 1 entity for the purposes of the Investor Confidence Rating (ICR) implemented by Treasury in 2016 in response to the Cabinet Circular C0(15) 5: investment Management and Asset Performance in the State Services, superseded by Cabinet Circular CO (19) 6 in 2019. The Circular gives effect to Cabinet's intention that there is active stewardship of government resources and strong alignment between individual investments and the government's long-term priorities. In line with Cabinet's intentions, Auckland DHB is required to report annually on the performance of its significant asset portfolios, which compromise Property, Clinical Equipment and Information Communication Technology (ICT).

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

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

Auckland DHB's Asset Portfolios

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

Asset portfolio, description and purpose	Capacity
Property Book Value 30 June 2022 - $1.318 billion (2021 - $1.008 billion). Indicative Replacement Cost (excl. land) $3 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, 39 procedure rooms and 100 day bed/chairs; • 173 Emergency Department beds/trolleys and treatment rooms; • 143 mental health beds; • Cancer: 81 chemotherapy beds/chairs, 1 brachytherapy; • Renal: 4 dialysis units; • 12 dental clinics; • 37 community-based properties leased by Auckland DHB. **Key infrastructure:** includes main site incomers for gas and electricity, site HV electrical rings, site steam and hot water networks, site services tunnels and plant rooms, and site water bores. **Key plant:** includes gas boilers, cogeneration plant, central plant chillers and cooling towers, and emergency power generators. **Key building services:** includes domestic hot and cold water and waste water networks, fire protection systems, medical gas reticulation, heating, ventilation and air-conditioning systems, and electrical networks.

Asset portfolio, description and purpose	Capacity
Clinical equipment Book Value 30 June 2022 - $88m (2021 - $82m). Replacement Cost (Indicative) $405m. 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 • 97 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 2022 - $6m (2021 - $5m). Replacement Cost (Indicative) $12m. 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 also has other assets not included above, which are less significant in value and criticality but play an important role in our service delivery, e.g. vehicle fleet of 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 ($671M cost) of a five Tranche 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	2021/22 target	2021/22 actual	2020/21 target	2020/21 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%	98%
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 has been 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 monthly and quarterly, respectively.

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

Asset performance measure and description	Indicator	2021/22 target	2021/22 actual	2020/21 target	2020/21 actual
% of devices compliant with asset age replacement policy >75% of devices are within the DHB asset age replacement policy.	Condition	>75%	91.38%	>75%	86.09%
% 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%	52.35%	>80%	96.28%
% 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%	77.32%	>55%	71%
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%	82.45%	>80%	99.99%
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%	41.11%	>30%	41.93%
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%	59.03%	>30%	59.06%
% 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%	92%	>75%	93%
Number of SLA breaches ('service interruptions') recorded against application asset over a 12-month period An average of <20 unplanned service interruptions.	Condition	<20	3.93	<20	1.3
% staff have accessed clinical/non-clinical system platforms remotely >35% of users have accessed Citrix/remote platform in the last 12 months.	Utilisation	>35%	61.70%	>35%	54.18%

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	2021/22 target	2021/22 actual	2020/21 target	2020/21 actual
LINAC fleet: maintenance hours Number of units needing a sustained increase in maintenance hours.	Condition	0	4	0	4
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%	5%	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	3.3
MRI fleet: total fleet unplanned downtime for the MRI scanner portfolio <25.6 hours (1%) of operable hours are spent on unplanned maintenance.	Utilisation	28 hours	330 hours	28 hours	56hours
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	3
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	1.8	2.5	2.0
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	50 hours	35 hours	67 hours

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Auckland DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

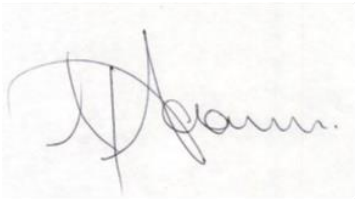
The Board and Management of Te Whatu Ora take responsibility for the preparation of the Auckland District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Auckland DHB group under section 19A of the Public Finance Act.

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Auckland District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:



Naomi Ferguson

Acting Chair

Dated: 6 March 2023

Hon Amy Adams

Board member

Dated: 6 March 2023

Statement of comprehensive revenue and expense for the year ended 30 June 2022

	Notes	Group			Parent		
		Budget 2022 $000	Actual 2022 $000	Actual 2021 $000	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Revenue							
Patient Care Revenue	2i	2,760,066	2,998,124	2,586,953	2,760,066	2,998,124	2,586,953
Interest Revenue		2,625	4,000	2,408	2,255	3,804	2,064
Other Revenue	2ii	86,712	84,690	90,335	81,898	82,626	87,960
Total Revenue		**2,849,403**	**3,086,814**	**2,679,696**	**2,844,219**	**3,084,554**	**2,676,977**
Expenses							
Personnel Costs	3	1,307,405	1,377,003	1,265,566	1,306,850	1,376,705	1,265,012
Depreciation and Amortisation Costs	13, 14	65,874	61,999	59,045	65,874	61,999	59,045
Outsourced Services		162,435	198,011	181,284	162,435	198,011	181,284
Clinical Supplies		322,714	341,490	310,746	322,714	341,490	310,746
Infrastructure and Non-Clinical Expenses		90,139	147,007	97,374	90,137	146,960	97,307
Other District Health Boards		116,867	118,171	104,768	116,867	118,171	104,768
Non-Health Board Provider Expenses		768,473	732,893	660,241	768,473	732,893	660,241
Capital Charge	4	34,793	34,748	33,661	34,793	34,748	33,661
Interest Expense		1,201	882	704	1,201	882	704
Other Expenses	5	52,502	77,466	62,636	49,537	74,778	62,200
Total Expenses		**2,922,403**	**3,089,670**	**2,776,025**	**2,918,881**	**3,086,637**	**2,774,968**
Share of Surplus/(Deficit) of Associates and Joint Ventures	15	-	(741)	100	-	-	-
Surplus/(Deficit)		**(73,000)**	**(3,597)**	**(96,229)**	**(74,662)**	**(2,083)**	**(97,991)**
Other Comprehensive Revenue and Expense							
Items that will not be reclassified to surplus/(deficit)							
Gains/(Losses) On Property Revaluations	13, 20	-	322,026	44,837	-	322,026	44,837
Total Other Comprehensive Revenue and Expense		**-**	**322,026**	**44,837**	**-**	**322,026**	**44,837**
Total Comprehensive Revenue and Expense		**(73,000)**	**318,429**	**(51,392)**	**(74,662)**	**319,943**	**(53,154)**

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 2022

	Notes	Group			Parent		
		Budget 2022 $000	Actual 2022 $000	Actual 2021 $000	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Assets							
Current Assets							
Cash and Cash Equivalents	6	125,928	257,573	202,468	111,290	252,165	190,411
Investments	7	-	-	-	-	-	-
Trust/Special Funds	8	9,297	-	10,707	-	-	-
Restricted Trust Funds	9	1,410	1,429	-	1,410	1,429	-
Receivables	10	121,311	175,786	121,311	118,477	180,071	125,060
Prepayments		5,216	6,857	5,919	5,216	6,857	5,919
Inventories	11	16,275	18,975	16,275	16,275	18,975	16,275
Total Current Assets		**279,437**	**460,620**	**356,680**	**252,668**	**459,497**	**337,665**
Non-Current Assets							
Investments	7	-	-	-	-	-	-
Trust/Special Funds	8	17,577	37,293	17,577	-	-	-
Property, Plant and Equipment	13	1,378,277	1,582,191	1,206,860	1,376,763	1,581,184	1,205,868
Intangible Assets	14	20,753	10,513	10,046	20,753	10,463	10,046
Investments in Joint Ventures and Associates	15	79,676	71,946	79,677	79,058	72,070	79,060
Total Non-Current Assets		**1,496,283**	**1,701,943**	**1,314,160**	**1,476,574**	**1,663,717**	**1,294,974**
Total Assets		**1,775,719**	**2,162,563**	**1,670,840**	**1,729,241**	**2,123,214**	**1,632,639**
Liabilities							
Current Liabilities							
Payables and Deferred Revenue	16	242,602	279,984	242,596	228,894	270,251	235,579
Employee Entitlements	17	635,625	683,432	593,837	635,542	683,432	593,783
Provisions	18	1,661	2,326	3,451	1,661	2,326	3,451
Borrowings	19	2,828	3,860	2,828	2,828	3,860	2,828
Restricted Trust Funds	9	1,410	1,429	1,410	1,410	1,429	1,410
Total Current Liabilities		**884,126**	**971,031**	**844,122**	**870,335**	**961,298**	**837,051**
Non-Current Liabilities							
Employee Entitlements	17	93,268	81,910	93,269	93,268	81,910	93,269
Borrowings	19	20,174	16,791	14,046	20,174	16,791	14,046
Total Non-Current Liabilities		**113,442**	**98,701**	**107,315**	**113,442**	**98,701**	**107,315**
Total Liabilities		**997,568**	**1,069,732**	**951,437**	**983,777**	**1,059,999**	**944,366**
Net Assets		**778,152**	**1,092,831**	**719,403**	**745,465**	**1,063,215**	**688,273**
Equity							
Contributed Capital	20	1,096,134	1,019,383	964,384	1,096,138	1,019,383	964,384
Accumulated Surplus/Deficit	20	(994,043)	(922,203)	(919,379)	(994,661)	(922,182)	(920,099)
Property Revaluation Reserve	20	643,988	966,014	643,988	643,988	966,014	643,988
Trust/Special Funds	20	32,073	29,637	30,410	-	-	-
Total Equity		**778,152**	**1,092,831**	**719,403**	**745,465**	**1,063,215**	**688,273**

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 2022

GROUP	Notes	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Balance as at 1 July		**719,400**	**719,403**	**725,838**
Total Comprehensive Income/(Expense) for the Period		**(73,000)**	**318,429**	**(51,392)**
Owner Transactions				
Capital Contributions from the Crown		131,752	54,999	44,957
Repayment of Capital to the Crown		-	-	-
Balance as at 30 June	20	**778,152**	**1,092,831**	**719,403**

PARENT	Notes	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Balance as at 1 July		**688,373**	**688,273**	**696,470**
Total Comprehensive Income/(Expense) for the Period		**(74,662)**	**319,943**	**(53,154)**
Owner Transactions				
Capital Contributions from the Crown		131,752	54,999	44,957
Repayment of Capital to the Crown		-	-	-
Balance as at 30 June	20	**745,463**	**1,063,215**	**688,273**

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 2022

	Notes	Group Actual			Parent Actual		
		Budget 2022 $000	Actual 2022 $000	Actual 2021 $000	Budget 2022 $000	Actual 2022 $000	Actual 2021 $000
Cash Flows from Operating Activities							
Cash Receipts from MoH and Patients		2,747,895	2,946,704	2,580,830	2,747,895	2,946,704	2,580,830
Other Receipts		98,883	98,486	99,513	93,699	94,418	94,577
Cash Paid to Employees		(1,227,405)	(1,302,347)	(1,170,803)	(1,226,850)	(1,301,850)	(1,170,221)
Cash Paid To Suppliers		(1,514,331)	(1,597,389)	(1,384,403)	(1,511,364)	(1,596,125)	(1,380,854)
GST (Net)		-	3,418	(1,812)	-	3,580	(1,954)
Payments for Capital Charge		(34,793)	(34,748)	(33,661)	(34,793)	(34,748)	(33,661)
Net Cash Inflow From Operating Activities		**70,249**	**114,124**	**89,664**	**68,587**	**111,979**	**88,717**
Cash Flows from Investing Activities							
Interest Received		2,625	3,527	2,408	2,625	3,247	1,945
Proceeds from Sale of Property, Plant and Equipment		-	64	90	-	64	90
Decrease/(Increase) In Investments and Restricted Trust Funds		-	(4,646)	16,358	-	4,363	11,856
Purchase of Property, Plant and Equipment		(259,420)	(112,189)	(87,874)	(259,420)	(112,174)	(87,874)
Purchase of Intangible Assets		(26,672)	(3,668)	(3,147)	(26,672)	(3,618)	(3,147)
Acquisition of Investments		-	-	-	-	-	-
Net Cash (Outflow) From Investing Activities		**(283,467)**	**(116,912)**	**(72,165)**	**(283,467)**	**(108,118)**	**(77,130)**
Cash Flows from Financing Activities							
Interest Paid		(1,201)	(882)	(704)	(1,201)	(882)	(704)
Proceeds from Borrowings/Finance Leases		6,225	7,140	6,358	6,225	7,140	6,358
Repayment of Borrowings/ Finance Leases		(98)	(3,364)	(1,544)	(98)	(3,364)	(1,544)
Proceeds from Capital Contributed/(Repaid)		131,752	54,999	44,957	131,752	54,999	44,957
Net Cash Inflow/(Outflow) from Financing Activities		**136,678**	**57,893**	**49,067**	**136,678**	**57,893**	**49,067**
Net (Decrease)/Increase in Cash and Cash Equivalents		**(76,540)**	**55,105**	**66,566**	**(78,203)**	**61,754**	**60,654**
Cash and Cash Equivalents at Start of the Year		**202,469**	**202,468**	**135,902**	**189,493**	**190,411**	**129,757**
Cash and Cash Equivalents at end of the Year	**6**	**125,928**	**257,573**	**202,468**	**111,290**	**252,165**	**190,411**

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 2022 (continued)

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

	Notes	Group Actual		Parent Actual	
		2022	2021	2022	2021
		$000	$000	$000	$000
Reported Net Surplus/(Deficit) for the Year		**(3,597)**	**(96,229)**	**(2,083)**	**(97,991)**
Add Non-Cash Items:					
Share of Associate and Joint Venture Surplus	15	741	(100)	-	-
Depreciation and Amortisation Expense		62,000	59,044	62,000	59,044
Unrealised Loss/(Gain) on Cash Flow Hedging Instrument		-	-	-	-
Add Items Classified as Investing Activities:					
Net Loss/(Gain) on Disposal of Fixed Assets		952	256	952	256
Net Loss/(Gain) on Disposal of Financial Assets		(37)	(1,893)	(37)	(97)
Net Interest Shown in Investing and Financing Activities		(3,117)	(1,703)	(2,921)	(1,359)
Add Movements in Statement of Financial Position Items:					
(Increase)/Decrease in Debtors and Other Receivables		(51,215)	(9,295)	(51,704)	(9,277)
(Increase)/Decrease in Prepayments		(938)	(1,297)	(938)	(1,297)
(Increase)/Decrease in Inventories		(2,700)	(880)	(2,700)	(880)
Increase/(Decrease) in Creditors and Other Payables		34,924	47,201	32,280	45,730
Increase/(Decrease) in Provision		(1,125)	1,709	(1,125)	1,709
Increase/(Decrease) in Employee Entitlements		78,236	92,851	78,255	92,879
Net Cash Inflow/(Outflow) from Operating Activities		**114,124**	**89,664**	**111,979**	**88,717**

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 2022 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 Hospitals Research and Endowment Fund (previously known as Auckland DHB Charitable Trust) and Auckland Hospital Foundation (previously known as 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, associate and joint ventures 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 and group are for the year ended 30 June 2022, and were approved for issue by the Health New Zealand (Te Whatu Ora) Board on 6 March 2023.

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) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services.

The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred Auckland District Health Board's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Statement of compliance

Except as disclosed in note 27 to the financial statements, the financial statements of the DHB and 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

The disclosure about the amendment to PBE IPSAS 2 is no longer relevant because this is effective for the 30 June 2022 financial statements.

The disclosures below in the 2021 Auckland DHB financial statements for PBE IPSAS 41 Financial Instruments and PBE FRS 48 Service Performance Reporting remain relevant for the 30 June 2022 financial statements. An update has been made to these disclosures about their potential impact.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has assessed that there will be little change as a result of adopting the new standard, as the requirements are similar to those contained in PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

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.

1 Significant accounting policies (continued)

Goods and Services Tax Cont.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Budget figures

The budget figures are derived from the Statement of Performance Expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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.

Software as a Service

In April 2021, the International Financial Reporting Interpretations Committee ("IFRIC") issued an agenda decision on Configuration or Customisation Costs in a Cloud Computing Arrangement (IAS 38). This Interpretation clarifies the accounting treatment in respect of costs of configuring or customising a supplier's application software in a Software as a Service ("SaaS") arrangement. The interpretation has been applied retrospectively. There have been no changes to the comparative information within the financial statements as a result of the retrospective application.

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 2003 – refer to Note 17.

Critical judgements in applying accounting policies

- Classification of leases – refer to Note 19
- Identifying agency relationships – refer to discussion below.

1 Significant accounting policies (continued)

Agency relationships

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.

2 Revenue (continued)

Research revenue

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

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of other services

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

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 is 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	
	2022	2021	2022	2021
	$000	$000	$000	$000
Health and disability services (Crown appropriation revenue)	1,621,965	1,490,125	1,621,965	1,490,125
Other MoH and Government revenue	502,758	308,349	502,758	308,349
PPE and RATS received free of charge ex MOH	25,291	-	25,291	-
ACC contract revenue	34,277	25,791	34,277	25,791
Inter district patient inflows	784,534	733,031	784,534	733,031
Revenue from other district health boards	17,877	17,625	17,877	17,625
Other patient care related revenue	11,422	12,032	11,422	12,032
Total patient care revenue	**2,998,124**	**2,586,953**	**2,998,124**	**2,586,953**

ii Other revenue	Group Actual		Parent Actual	
	2022	2021	2022	2021
	$000	$000	$000	$000
Donations and bequests	14,033	12,585	13,197	12,822
Gain on sale of property, plant and equipment	2	25	2	25
Gain on financial assets	-	1,796	-	-
Rental revenue	7,643	8,243	7,643	8,243
Accommodation revenue	847	864	847	864
Direct charges revenue	29,266	33,271	29,266	33,271
Drug trial revenue	468	493	468	493
Research grants	19,192	17,890	17,944	17,095
Other revenue	13,239	15,168	13,259	15,147
Total other revenue	**84,690**	**90,335**	**82,626**	**87,960**

2 Revenue (continued)

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	2022 $000	2021 $000
Not later than one year	4,692	5,262
Later than one year and not later than five years	4,435	9,126
Later than five years	-	-
Total non-cancellable operating lease commitments as lessor	**9,127**	**14,388**

The DHB and Group lease out a number of buildings under operating leases. 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	
	2022 $000	2021 $000	2022 $000	2021 $000
Salaries and wages	1,257,619	1,132,766	1,257,266	1,132,183
Defined contribution plan employer contributions	42,127	38,159	42,127	38,159
Increase/(decrease) in liability for employee benefits	78,235	92,851	78,290	92,880
Restructuring expense for employee exit costs	(978)	1,790	(978)	1,790
Total personnel costs	**1,377,003**	**1,265,566**	**1,376,705**	**1,265,012**

3 Personnel costs (continued)

Employee remuneration

During the year, the following number of employees of Auckland DHB received remuneration over $100,000 on an annualised basis.

Remuneration range	Actual 2022	Actual 2021	Remuneration range	Actual 2022	Actual 2021
$100,000-$109,999	898	813	$500,000-$509,999	9	2
$110,000-$119,999	757	487	$510,000-$519,999	3	5
$120,000-$129,999	519	303	$520,000-$529,999	6	4
$130,000-$139,999	380	209	$530,000-$539,999	4	2
$140,000-$149,999	252	151	$540,000-$549,999	1	3
$150,000-$159,999	194	120	$550,000-$559,999	2	4
$160,000-$169,999	128	106	$560,000-$569,999	-	3
$170,000-$179,999	126	93	$570,000-$579,999	3	1
$180,000-$189,999	71	68	$580,000-$589,999	1	-
$190,000-$199,999	79	64	$590,000-$599,999	4	-
$200,000-$209,999	60	49	$600,000-$609,999	1	5
$210,000-$219,999	57	61	$610,000-$619,999	-	1
$220,000-$229,999	40	41	$620,000-$629,999	1	-
$230,000-$239,999	42	36	$630,000-$639,999	-	1
$240,000-$249,999	37	52	$640,000-$649,999	1	1
$250,000-$259,999	54	47	$650,000-$659,999	-	1
$260,000-$269,999	40	44	$670,000-$679,999	-	1
$270,000-$279,999	39	41	$680,000-$689,999	1	1
$280,000-$289,999	51	32	$690,000-$699,999	2	1
$290,000-$299,999	46	39	$700,000-$709,999	-	1
$300,000-$309,999	33	30	$710,000-$719,999	-	2
$310,000-$319,999	35	35	$720,000-$729,999	1	-
$320,000-$329,999	31	28	$740,000-$749,999	1	-
$330,000-$339,999	33	18	$800,000-$809,999	2	-
$340,000-$349,999	24	27	$810,000-$819,999	1	1
$350,000-$359,999	24	32	$830,000-$839,999	1	1
$360,000-$369,999	32	24	$880,000-$889,999	1	-
$370,000-$379,999	14	11	$900,000-$909,999	1	-
$380,000-$389,999	15	9	$910,000-$919,999	1	-
$390,000-$399,999	10	25	$930,000-$939,999	1	-
$400,000-$409,999	26	20	$950,000-$959,999	1	-
$410,000-$419,999	12	13	$960,000-$969,999	-	1
$420,000-$429,999	16	9	$970,000-$979,999	2	2
$430,000-$439,999	7	12	$990,000-$999,999	1	-
$440,000-$449,999	13	6	$1,030,000-$1,039,999	1	-
$450,000-$459,999	8	5	$1,040,000-$1,049,999	-	2
$460,000-$469,999	7	9	$1,140,000-$1,149,999	1	-
$470,000-$479,999	4	4	$1,250,000-$1,259,999	1	-
$480,000-$489,999	5	5	$1,430,000-$1,439,999	-	1
$490,000-$499,999	6	7			
			Grand Total	4,281	3,232

Note:

Of these employees, 3,869 (2021: 2,892) are clinical positions for Medical, Nursing and Allied Health staff and 412 (2021: 340) are Management and Support staff.

Of these employees, 149 (2021:104) received compensation and other benefits in relation to cessation totalling $4,077,884 (2021: $2,495,360).

3 Personnel costs (continued)

Board member remuneration

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

	Actual 2022 $000	Actual 2021 $000
Pat Snedden (Chair from 5 Jun 18)	65.27	65.02
Tama Davis (Deputy Chair)	41.26	42.70
Bernie O'Donnell	31.76	33.76
Doug Armstrong	33.51	34.76
Fiona Lai	33.26	33.76
Ian Ward	33.51	33.51
Jo Agnew	33.82	36.45
Michael Quirke	33.26	35.26
Michelle Atkinson	33.76	36.32
Peter Davis	31.76	33.26
Zoe Brownlie	32.01	34.01
Total board member remuneration	403.18	418.80

Co-opted committee members

	Actual 2022 $000	Actual 2021 $000
Norman Wong	15.00	13.00
Dame Paula Rebstock	9.10	9.10
Graeme Bell	6.30	7.94
Fiona Lai	2.25	1.75
Brian Dackers	7.25	5.64
Ian Ward	2.25	1.50
Heather Came	-	1.25
Jennifer Alison	0.25	0.25
Shehara Farik	-	0.25
Fafita Finau	-	0.25
Lovely Mahe	-	0.25
Michael Steedman	-	0.25
Total co-opted committee members	42.40	41.42

Note:

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $42,400 (2021: $41,420).

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 renewed 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 (2021: $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 2022 was 5% (2021:5%).

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	
	2022 $000	2021 $000	2022 $000	2021 $000
Fees to auditor				
- fees to Audit New Zealand for audit of financial statements	383	342	383	342
- prior period under/(over) provision	17	(12)	17	(12)
- fees to Audit New Zealand for audit of financial statements (Auckland Hospitals Research and Endowment Fund and Auckland Hospital Foundation)	40	36	40	36
Fees for other audit services	368	317	368	317
Operating leases	19,539	11,494	19,539	11,494
Impairment of debtors/(provision released)*	254	(839)	254	(839)
Bad debts	2,926	4,175	2,926	4,175
Board members' fees	403	419	403	419
Gains/(Loss) on disposal of property, plant and equipment	954	318	954	318
Foreign currency loss gains/(losses)	(60)	(79)	(58)	(78)
Other financial assets gains/(losses}	1,227	(63)	(64)	(63)
Other expenses	51,415	46,528	50,016	46,091
Total other expenses	**77,466**	**62,636**	**74,778**	**62,200**

* 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	2022 $000	2021 $000
Not later than one year	4,408	4,162
Later than one year and not later than five years	7,439	5,664
Later than five years	1,788	660
Total non-cancellable operating lease commitments as lessee	**13,635**	**10,486**

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

5 Other expenses (continued)

The details of the main property leases are as follows:

- 160 Grafton Road (First and Ground floor) are leased with an expiry date of 31 July 2023 and 31 May 2024 respectively
- Taylor Centre is leased with an expiry date of 31 Oct 2024
- Manaaki Health Clinic is leased with an expiry date of 31 Mar 2026
- Community Mental Health Clinic is leased with an expiry date of 31 Jan 2027
- Aseptic Manufacturing Chemotherapy facility leased with an expiry date of 1 Jun 2031

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	
	2022	2021	2022	2021
	$	$	$	$
Current assets				
Bank balance and cash on hand	92	89	92	89
Bank balance and cash on hand (Trust/Special)	5,408	12,057	-	-
Bank balance and cash on hand (Restricted Trust)	-	1,410	-	1,410
NZ Health Partnerships Limited	252,073	188,912	252,073	188,912
Cash and cash equivalents in the Statement of Cash flows	**257,573**	**202,468**	**252,165**	**190,411**

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 2022, this limit was $162.577m (2021: $150.035m).

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.

8 Trust/special fund assets

Accounting policy

Trust/special fund assets

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

Breakdown of trust/special fund assets and further information

	Group Actual		Parent Actual	
	2022 $000	2021 $000	2022 $000	2021 $000
Current assets				
Cash and cash equivalent				
Term deposits (restricted)	-	10,500	-	-
Investment Bonds (at market)/(restricted)	-	207	-	-
	-	**10,707**	**-**	**-**
Non – current assets				
Investment Bonds (at market)/(restricted)	-	1,104	-	-
Portfolio Investments (restricted)	37,293	16,473	-	-
	37,293	**17,577**	**-**	**-**
Total Trust/special fund	**37,293**	**28,284**	**-**	**-**

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 $37.293m (2021: $17.577m). 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	
	2022 $000	2021 $000	2022 $000	2021 $000
RESTRICTED TRUST FUNDS				
Current assets				
Restricted fund deposit*	1,429	-	1,429	-
	1,429	**-**	**1,429**	**-**
Current liabilities				
Restricted fund deposit	1,429	1,410	1,429	1,410
	1,429	**1,410**	**1,429**	**1,410**

*This was included at Cash on Hand as at 30 June 2021 as the period to maturity was less than 3 months.

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.

Breakdown of receivables and further information

	Group Actual		Parent Actual	
	2022 $000	2021 $000	2022 $000	2021 $000
Receivables from MoH	96,003	61,985	96,003	61,985
Other Receivables	52,485	28,215	50,432	25,499
Other Accrued Income	30,043	33,602	36,381	40,067
Less: Allowance for Credit Losses	(2,745)	(2,491)	(2,745)	(2,491)
Total Receivables	**175,786**	**121,311**	**180,071**	**125,060**

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	Gross	Credit loss allowance	Gross	Credit loss allowance
	2022	2022	2021	2021
Receivable days past due	$000	$000	$000	$000
Not past due	162,842	(64)	112,714	(48)
Past due 0-30 days	2,013	(250)	2,967	(512)
Past due 31-90 days	4,502	(445)	3,085	(301)
Past due 91-360 days	5,520	(1,068)	2,425	(512)
Past due more than 1 year	3,654	(918)	2,611	(1,118)
Total	**178,531**	**(2,745)**	**123,802**	**(2,491)**

PARENT	Gross	Credit loss allowance	Gross	Credit loss allowance
Receivable days past due	2022 $000	2022 $000	2021 $000	2021 $000
Not past due	167,632	(64)	117,673	(48)
Past due 0-30 days	1,880	(250)	2,418	(512)
Past due 31-90 days	4,279	(445)	2,641	(301)
Past due 91-360 days	5,371	(1,068)	2,208	(512)
Past due more than 1 year	3,654	(918)	2,611	(1,118)
Total	**182,816**	**(2,745)**	**127,551**	**(2,491)**

10 Receivables (continued)

Movement in the allowance for credit losses is as follows:

	Group		Parent	
	2022 Actual $000	2021 Actual $000	2022 Actual $000	2021 Actual $000
Balance 1 July	2,491	3,331	2,491	3,331
Additional allowances made/ (released)	254	(840)	254	(840)
Balance at 30 June	**2,745**	**2,491**	**2,745**	**2,491**

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	Actual 2022 $000	Actual 2021 $000
Pharmaceuticals	2,729	2,343
Surgical and Medical Supplies	16,246	13,932
Total Inventories	**18,975**	**16,275**

The amount of inventories recognised as an expense during the year was $294.0m (2021: $289.7m), which is included in the clinical supplies line item of the statement of comprehensive revenue and expense. The free of charge PPE and RATS tests received from MOH amounting to $25.291m have been expended through non clinical supplies so are not to distort the Covid reporting required for funding. The write-down of inventories amounted to $799k (2021: $783k). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2021: $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 (2021: nil).

13 Property, plant and equipment

Accounting policy

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

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

Owned Assets

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

Revaluations

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

Leasehold improvements 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.

13 Property, plant and equipment (continued)

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 TelferYoung from CBRE. The valuation is effective as at 30 June 2022.

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 the Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") which means 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).

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 16.5%.

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 2022 by TelferYoung from CBRE. 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 Rider Levett Bucknall (RLB) 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.

13 Property, plant and equipment (continued)

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 2022 valuation:

- Office market rents range from $255 to $270 per square metre
- Capitalisation rates are market-based rates of return and range from 4.7% to 5.5%.

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 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**
Cost						
Balance at 1 July 2021	397,088	676,750	370,386	5,791	96,597	1,546,612
Additions/ (Transfers)	-	-	-	-	113,120	113,120
Additions from Work in Progress	-	25,558	28,822	109	(54,490)	(1)
Disposals	-	-	(13,851)	-	-	(13,851)
Transfers	-	(1,953)	1,953	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	221,109	-	-	-	221,109
Balance at 30 June 2022	**397,088**	**921,464**	**387,310**	**5,900**	**155,227**	**1,866,989**
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)**
Depreciation and impairment losses						
Balance at 1 July 2021	-	(65,780)	(271,817)	(2,155)	-	(339,752)
Depreciation charge for the year	-	(35,138)	(23,465)	(197)	-	(58,800)
Disposals	-	-	12,836	-	-	12,836
Transfers	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	100,918	-	-	-	100,918
Balance at 30 June 2022	**-**	**-**	**(282,446)**	**(2,352)**	**-**	**(284,798)**
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**
Carrying Amounts						
At 1 July 2021	397,088	610,970	98,569	3,636	96,597	1,206,860
At 30 June 2022	**397,088**	**921,464**	**104,864**	**3,548**	155,227	**1,582,191**

13 Property, plant and equipment (continued)

Breakdown of property, plant and equipment and further information

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

PARENT	Land	Buildings	Plant, equipment and vehicles	Leased Improvements	Work in progress	Total
	$000	$000	$000	$000	$000	$000
Cost						
Balance at 1 July 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	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	44,836	-	-	-	-	44,836
Balance at 30 June 2021	**397,088**	**676,750**	**369,394**	**5,791**	**96,597**	**1,545,620**
Cost						
Balance at 1 July 2021	397,088	676,750	369,394	5,791	96,597	1,545,620
Additions	-	-	-	-	113,105	113,105
Additions from Work in Progress	-	25,558	28,807	109	(54,475)	(1)
Disposals	-	-	(13,851)	-	-	(13,851)
Transfers	-	(1,953)	1,953	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	221,109	-	-	-	221,109
Balance at 30 June 2022	**397,088**	**921,464**	**386,303**	**5,900**	**155,227**	**1,865,982**
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)**
Depreciation and impairment losses						
Balance at 1 July 2021	-	(65,780)	(271,817)	(2,155)	-	(339,752)
Depreciation charge for the year	-	(35,138)	(23,465)	(197)	-	(58,800)
Disposals	-	-	12,836	-	-	12,836
Transfers	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Revaluations	-	100,918	-	-	-	100,918
Balance at 30 June 2022	**-**	**-**	**(282,446)**	**(2,352)**	**-**	**(284,798)**
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**
Carrying Amounts						
At 1 July 2021	**397,088**	**610,970**	**97,577**	**3,636**	**96,597**	**1,205,868**
At 30 June 2022	**397,088**	**921,464**	**103,857**	**3,548**	**155,227**	**1,581,184**

13 Property, plant and equipment (continued)

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.

Capital commitments

GROUP AND PARENT	2022 $000	2021 $000
Capital commitments		
Buildings, fit-out and infrastructure	277,998	25,928
Clinical Equipment, Motor Vehicles and Other	650	1,368
Total capital commitments	**278,648**	**27,296**

Work in progress

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

GROUP AND PARENT	2022 $000	2021 $000
Buildings, fit-out and infrastructure	140,056	70,139
Clinical equipment, motor vehicles and other	15,171	26,458
Non-Current Assets	**155,227**	**96,597**

14 Intangible assets

Accounting policy

Intangible Assets

Computer software acquired, which is not an integral part of a related hardware item, is recognised as an intangible asset. The costs incurred internally in developing computer software are also recognised as intangible assets where the Group has a legal right to use the software and the ability to obtain future economic benefits from that software. Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Cloud based software as a service arrangements are recognised as an intangible asset where the Group has the right to use and the ability to control and obtain future economic benefits. These assets have a finite life and are amortised on a straight-line basis over their estimated useful lives of two to five years.

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.

14 Intangible assets (continued)

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 2 to 5 years (20% - 33%)
- Internally developed software 2 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.

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	FPIM rights Cost $000	Software and development Cost $000	WIP-FPIM rights Cost $000	Total $000
Cost				
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**
Balance at 1 July 2021	8,957	11,324	-	20,281
Additions	-	3,666	-	3,666
Additions to Work in Progress	-	-	-	-
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2022	**8,957**	**14,990**	**-**	**23,947**
Amortisation and 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)**
Amortisation and Impairment Losses				
Balance at 1 July 2021	(1,662)	(8,573)	-	(10,235)
Amortisation charge for the year	(917)	(2,282)	-	(3,199)
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2022	**(2,579)**	**(10,855)**	**-**	**(13,434)**
Carrying Amounts				
At 1 July 2020	5,977	2,216	1,107	9,300
At 30 June 2021	**7,295**	**2,751**	**-**	**10,046**
At 1 July 2021	7,295	2,751	-	10,046
At 30 June 2022	**6,378**	**4,135**	**-**	**10,513**

14 Intangible assets (continued)

PARENT	FPIM rights Cost $000	Software and development Cost $000	WIP-FPIM rights Cost $000	Total $000
Cost				
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**
Balance at 1 July 2021	8,957	11,324	-	20,281
Additions	-	3,616	-	3,616
Additions to Work in Progress	-	-	-	-
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2022	**8,957**	**14,940**	**-**	**23,897**
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)**
Amortisation & Impairment Losses				
Balance at 1 July 2021	(1,662)	(8,573)	-	(10,235)
Amortisation charge for the year	(917)	(2,282)	-	(3,199)
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2022	**(2,579)**	**(10,855)**	**-**	**(13,434)**
Carrying Amounts				
At 1 July 2020	5,977	2,216	1,107	9,300
At 30 June 2021	**7,295**	**2,751**	**-**	**10,046**
At 1 July 2021	7,295	2,751	-	10,046
At 30 June 2022	**6,378**	**4,085**	**-**	**10,463**

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 2022 was $917k (2021: $896k).

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	
		2022	2021
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 associates

Year end 30 June 2022 (unaudited)	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus/(Deficit) $000
healthAlliance N.Z .Limited	233,849	37,253	196,596	177,500	(890)
HealthSource New Zealand Limited	9,972	9,190	782	43,542	71
Northern Regional Alliance Limited	24,904	20,689	4,214	20,751	(549)
Total Investments	**268,725**	**67,132**	**201,592**	**241,793**	**(1,368)**
Year end 30 June 2021	**Assets $000**	**Liabilities $000**	**Equity $000**	**Revenues $000**	**Surplus/(Deficit) $000**
healthAlliance N.Z .Limited	239,647	41,697	197,950	152,357	(80)
HealthSource New Zealand Limited	9,081	8,370	711	42,265	76
Northern Regional Alliance Limited	26,653	21,890	4,764	18,576	1,207
Total Investments	**275,381**	**71,957**	**203,425**	**213,198**	**1,203**

15 Investments in joint venture and associates (continued)

The 2022 financial information is unaudited. The 2021 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	
	2022	2021	2022	2021
	$000	$000	$000	$000
Share of surplus of joint ventures & associates				
Share of post-acquisition surplus/(deficit)	(741)	100	-	-
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)	71,598	78,587	71,598	78,588
Other shares in joint ventures & associates	1	1	1	1
Share of post-acquisition retained surpluses	(124)	618	-	-
Total investments in joint ventures and associates	**71,946**	**79,677**	**72,070**	**79,060**

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 2022 is $71.598m (2021: $78.587m), 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	
	2022 $000	2021 $000	2022 $000	2021 $000
Current				
Payables under exchange transactions				
Creditors	173,058	177,362	173,126	178,752
Income in Advance	14,096	12,261	4,286	4,007
Total payables under exchange transactions	**187,154**	**189,623**	**177,412**	**182,759**
Payables under non-exchange transactions				
GST,PAYE and FBT payable	34,307	34,286	34,316	34,133
Capital charge due to Crown	-	-	-	-
Income in Advance	58,523	18,687	58,523	18,687
Total payables under non exchange transactions	**92,830**	**52,973**	**92,839**	**52,820**
Total payables and deferred revenue	**279,984**	**242,596**	**270,251**	**235,579**

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.

17 Employee entitlements (continued)

Critical accounting estimates and assumptions

Long service leave and retirement gratuities

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

Expected future payments are discounted using 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.

A discount rate of 3.6% (2021: 0.79%) for Long Service Leave and 4.1% (2021: 2.46%) for Retirement Gratuities has been applied. Salary increase rates used were 4.0% p.a. (2021: 3.5% 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 years. 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 $13.6m higher/$10.9m 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 $11.0m 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 (2021: 5 years) before any forfeiture of unused leave will occur. Any staff to 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 2022 (2021: 5% forfeiture covering both cancellation of unutilised leave after 5 years and staff exits).

Breakdown of employee entitlements

	Group Actual		Parent Actual	
	2022 $000	2021 $000	2022 $000	2021 $000
Current portion				
Liability for long service leave	4,037	3,440	4,037	3,437
Liability for sabbatical leave	1,632	750	1,632	750
Liability for retirement gratuities	7,393	7,131	7,393	7,131
Liability for annual leave	540,907	484,129	540,907	484,110
Liability for sick leave	882	845	882	822
Liability for continuing medical leave and expenses	57,122	44,896	57,122	44,896
Salaries and wage accrual	71,459	52,646	71,459	52,637
Total current	**683,432**	**593,837**	**683,432**	**593,783**
Non Current				
Liability for long service leave	5,054	5,034	5,054	5,034
Liability for retirement gratuities	76,856	88,235	76,856	88,235
Liability for continuing medical leave and expenses	-	-	-	-
Total non-current	**81,910**	**93,269**	**81,910**	**93,269**
Total employee entitlements	**765,342**	**687,106**	**765,342**	**687,052**

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 $71.4m (2021: $52.6m) salaries and wages accrual includes $34.44m (2021: $19.8m) back pay provision related to unsettled Multi Employer Collective Agreement (MECA) agreements and $30.2m (2021: $27.6m) which is made up of two major elements: unpaid days of $30.2m (2021: $25.2m) and salaries and wages for June paid in July of $49k (2021: $2.3m).

17 Employee entitlements (continued)

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 on-going 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.

The liability recognised at 30 June 2022 is $347m (2021: $319m). The liability as at 30 June 2022 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 2022 was re-estimated by Ernst & Young based on a significantly larger sample across the various employment groups and the most up to date guidance regarding the extent of the payroll components intended to be covered by the application of the Holidays Act. The liability recorded is the DHB's best estimate at this stage of the Auckland Metro Remediation and rectification programme. However, there remains uncertainty in regards 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 as the programme progresses. 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.

18 Provisions (continued)

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 on-going claims passes to ACC.

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

Breakdown of provisions and further information

	Notes	Group Actual		Parent Actual	
		2022 $000	2021 $000	2022 $000	2021 $000
Current Portion					
ACC Partnership Programme		1,514	1,661	1,514	1,661
Litigation		-	-	-	-
Restructuring		812	1,790	812	1,790
Total Provisions		**2,326**	**3,451**	**2,326**	**3,451**
Movement for each class of provisions are as follows:					
ACC Partnership Programme					
Opening balance		1,661	1,630	1,661	1,630
Additional provisions made during year		895	1,232	895	1,232
Charged against provision for the year		(1,042)	(1,201)	(1,042)	(1,201)
Unused amounts reversed during year		-	-	-	-
Closing balance	(i)	**1,514**	**1,661**	**1,514**	**1,661**
Litigation & Onerous Contracts Provision					
Opening balance		-	112	-	112
Additional provisions made during year		-	-	-	-
Charged against provision for the year		-	(112)	-	(112)
Unused amounts reversed during year		-	-	-	-
Closing balance	(ii)	**-**	**-**	**-**	**-**
Restructuring Provision					
Opening balance		1,790	-	1,790	-
Additional provisions made during year		849	1,790	849	1,790
Charged against provision for the year		(1,790)	-	(1,790)	-
Unused amounts reversed during year		(37)	-	(37)	-
Closing balance	(iii)	**812**	**1,790**	**812**	**1,790**

18 Provisions (continued)

Notes

(i) ACC Partnership Programme

Liability valuation

An external independent Actuary, Simon Ferry of Aon, has calculated the liability as at 30 June 2022. 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 11.1% (2021: 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 11.60% is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are:

- an average assumed rate of inflation of 2.23% p.a. for 30 June 2022 and for the next five years;
- an average discount rate of 2.47% p.a. for 30 June 2022 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 2022; and
- the expected future Average Claim Payment per accident is approximately $3,045 (2021: $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 159% of the DHB Standard Levy is used (i.e. 181% of the risk). The stop loss limit means the DHB will carry the total cost of all claims up to a total of $7.965m ($10.08m 2021) at 181% of standard levy incurred in the cover period from 1 April 2021 to 31 March 2022 (2021-22 ACC Claim Year). Auckland DHB has also contracted a High Cost Claims Cover with an excess of $1,500,000 per event.

(ii) Litigation and onerous contracts

There are no onerous contracts as at 30 June 2022 (2021: 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 2022: nil (2021: nil)

(iii) Restructuring provision

A total provision of $812k has been made, as follows:

$380k - 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;

$432k - The Mental Health Directorate is proposing a significant model of care change (the Core 24/7 MOC) for Liaison Psychiatry for people presenting in mental health crisis to the Emergency Department. This proposed change is that all adult mental health assessments in ED are done by the Liaison Psychiatry service and that it is sufficiently resourced to provide timely and effective interventions 24/7. While in the ED, all necessary mental health care will be carried out by Liaison Psychiatry staff in conjunction with their ED colleagues. This involves a revised structure which may result in a potential redundancy cost of $432k. This provision is being made for the obligation to pay employee redundancy costs.

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.

19 Borrowings Cont.

Leases

Finance leases

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

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

Critical judgements in applying accounting policies

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

Leases classification

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

Breakdown of borrowings and further information

	Group Actual		Parent Actual	
	2022	2021	2022	2021
	$000	$000	$000	$000
Current portion				
Secured loans				
Loan - Energy Efficiency and Conservation Authority	510	97	510	97
Finance Leases (Clinical Equipment)	3,350	2,731	3,350	2,731
Total current portion	**3,860**	**2,828**	**3,860**	**2,828**
Non-current				
Secured loans				
Loan - Energy Efficiency and Conservation Authority	1,500	97	1,500	97
Finance Leases (Clinical Equipment)	15,291	13,949	15,291	13,949
Total non-current portion	**16,791**	**14,046**	**16,791**	**14,046**
Total Borrowings	**20,651**	**16,874**	**20,651**	**16,874**

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 lessees are 2022: $882k (2021: $704k).

19 Borrowings (continued)

Fair Value

The fair value of finance leases is $18.641m (2021: $16.680m). 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	
	2022 $000	2021 $000	2022 $000	2021 $000
Minimum lease payments payable:				
No later than one year	4,146	3,474	4,146	3,474
Later than one year and not later than five years	13,918	11,567	13,918	11,567
Later than five years	3,290	4,444	3,290	4,444
Total minimum lease payments	**21,354**	**19,485**	**21,354**	**19,485**
Future finance charges	(2,713)	(2,805)	(2,713)	(2,805)
Present value of minimum lease payments	**18,641**	**16,680**	**18,641**	**16,680**
Present value of minimum lease payments payable:				
No later than one year	3,350	2,731	3,350	2,731
Later than one year and not later than five years	12,178	9,768	12,178	9,768
Later than five years	3,113	4,181	3,113	4,181
Total present value of minimum lease payments	**18,641**	**16,680**	**18,641**	**16,680**

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.

Reconciliation of movements in liabilities arising from financing activities

	Group Actual	Parent Actual
	2022 $000	2022 $000
Opening Balance 1 July 2021	**16,880**	**16,880**
Cash outflows	(3,117)	(3,117)
New leases	5,078	5,078
Closing Balance 30 June 2022	**18,641**	**18,641**
Made up of:		
Current Liabilities	3,350	3,350
Non Current Liabilities	15,291	15,291
Total Finance Lease Liabilities 30 June 2022	**18,641**	**18,641**

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.

20 Equity (continued)

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.

Breakdown of equity and further information

	Group Actual		Parent Actual	
	2022	2021	2022	2021
	$000	$000	$000	$000
A Contributed Capital				
Opening balance 1 July	964,384	919,427	964,384	919,427
Contributions from/(repayment to) the Crown	54,999	44,957	54,999	44,957
Balance at 30 June	**1,019,383**	**964,384**	**1,019,383**	**964,384**
B Accumulated surplus/(deficit)				
Opening balance 1 July	(919,379)	(821,488)	(920,099)	(822,108)
Surplus/(deficit)	(3,597)	(96,229)	(2,083)	(97,991)
Transfer to trust/special funds	773	(1,662)	-	-
Balance at 30 June	**(922,203)**	**(919,379)**	**(922,182)**	**(920,099)**
C Property revaluation reserves				
Opening balance 1 July	643,988	599,151	643,988	599,151
Net Movement	322,026	44,837	322,026	44,837
Balance at 30 June	**966,014**	**643,988**	**966,014**	**643,988**
D Trust/special funds				
Opening balance 1 July	30,410	28,748	-	-
Transfer from accumulated deficits (Note 6b)	(773)	1,662	-	-
Balance at 30 June	**29,637**	**30,410**	**-**	**-**
Total Equity	**1,092,831**	**719,403**	**1,063,215**	**688,273**
Property revaluation reserves consist of				
Land	381,651	381,652	381,651	381,652
Buildings	584,480	262,336	584,480	262,336
Total property revaluation reserves	**966,131**	**643,988**	**966,131**	**643,988**

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 2022 carried out by TelferYoung from CBRE - see Note 13.

20 Equity Cont.

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 2022, the Scheme had a Funding Basis net past service deficit of $0.6m for the year (2021: surplus $1.3m) which represents 98.3% (2021: 102.2%) funding level of the past service liabilities. This amount is exclusive of Employer Superannuation Contribution Tax. This 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 2022 (2021: 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 (2021: $nil)

Key management personnel compensation

GROUP and PARENT	2022	2021
Board Members		
Remuneration	$403k	$419k
Full-time equivalent members	1.6	1.7
Leadership Team		
Remuneration	$9.452m	$9.187m
Full-time equivalent members	24.3	22
Total key management personnel remuneration	**$9.855m**	**$9.606m**
Total full time equivalent personnel	**25.9**	**23.7**

22 Related party transactions Cont.

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 balance date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

24 Financial Instruments

24a financial instrument categories

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Group Actual		Parent Actual	
	2022 $000	2021 $000	2022 $000	2021 $000
Financial assets measured at amortised cost				
Cash and cash equivalents	257,573	202,468	252,165	190,411
Trust/special funds - bank balances, term deposits	-	10,500	-	-
Receivables	175,786	121,311	180,071	125,060
Patient and restricted trust funds	1,429	-	1,429	-
Total financial assets measured at amortised cost	**434,788**	**334,279**	**433,665**	**315,471**
Financial assets measured at fair value through surplus or deficit				
Investment bonds and portfolio investments	37,293	17,784	-	-
Total financial assets measured at fair value through surplus or deficit	**37,293**	**17,784**	**-**	**-**
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	173,058	177,362	173,126	178,752
Borrowings	20,651	16,874	20,651	16,874
Patient and restricted trust funds	1,429	1,410	1,429	1,410
Total financial liabilities measured at amortised cost	**195,138**	**195,646**	**195,206**	**197,036**

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.

24 Financial Instruments (continued)

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

	Notes		Valuation technique		
		Total	Quoted market price	Observable inputs	Significant non-observable inputs
		$000	$000	$000	$000
GROUP 30 June 2022					
Financial Assets					
Portfolio Investments	8	37,293	37,293	-	-
GROUP 30 June 2021					
Financial Assets					
Portfolio Investments	8	16,473	16,473	-	-
Investment bonds	8	1,311	1,311	-	-

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 which seek 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 2022, 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 (2021: nil).

Sensitivity analysis

As at 30 June 2022, 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 (2021: $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 largest debtor is MoH at 64.7% (2021: 43%). MoH 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	
	2022 $000	2021 $000	2022 $000	2021 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalent, term deposits and investment bonds				
A+	-	-	-	-
AA-	6,929	25,367	1,521	1,499
Total counterparties with credit ratings	**6,929**	**25,367**	**1,521**	**1,499**
COUNTERPARTIES WITHOUT CREDIT RATINGS				
NZHPL -no defaults in the past	252,073	188,912	252,073	188,912
Portfolio Investments-no defaults in the past	37,293	16,473	-	-
Receivables				
Exiting counterparty with no defaults in the past	175,786	121,311	180,071	125,060
Exiting counterparty with defaults in the past	-	-	-	-
Total counterparties without credit ratings	**465,152**	**326,696**	**432,144**	**313,972**

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.

24 Financial Instruments (continued)

Contractual maturity analysis of financial liabilities, excluding derivatives

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

GROUP							
2022	**Carrying amount**	**Contractual cash flow**	**6 months or less**	**6-12 months**	**1-2 years**	**2-5 years**	**More than 5 years**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Borrowings	20,651	23,363	2,327	2,328	4,513	10,906	3,289
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	173,058	173,058	173,058	-	-	-	-
Total	**193,709**	**196,421**	**175,385**	**2,328**	**4,513**	**10,906**	**3,289**

GROUP							
2021	**Carrying amount**	**Contractual cash flow**	**6 months or less**	**6-12 months**	**1-2 years**	**2-5 years**	**More than 5 years**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Borrowings	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**

PARENT							
2022	**Carrying amount**	**Contractual cash flow**	**6 months or less**	**6-12 months**	**1-2 years**	**2-5 years**	**More than 5 years**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Borrowings	20,651	23,363	2,327	2,328	4,513	10,906	3,289
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	173,126	173,126	173,126	-	-	-	-
Total	**193,777**	**196,489**	**175,453**	**2,328**	**4,513**	**10,906**	**3,289**
2021	**Carrying amount**	**Contractual cash flow**	**6 months or less**	**6-12 months**	**1-2 years**	**2-5 years**	**More than 5 years**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Borrowings	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**

25 Patient Trust

Auckland DHB does not administer funds on behalf of patients.

26 Major variances from budget, including the impact of Covid-19 on the DHB

Amended Annual Plan 2022

The 2021-22 SPE published on 30 June 2021 included non-GAAP compliant prospective financial statements – related to the presentation of the Holidays Act impact on the DHB's surplus/(deficit) being disclosed below the line in Other Comprehensive Income. However, these prospective financial statements were amended in the final 2021-22 Annual Plan that was approved by the Minister. The major variances from budget below are against the amended approved prospective financial statements.

Statement of Comprehensive Revenue and Expense

Auckland DHB recorded a deficit of $3.6m which was favourable to the budgeted deficit of $73.0m by $69.4m. The key drivers for the favourable variances include:

- favourable Funder position of $42.4m, mainly driven by less than budget expenditure in Pharmaceuticals ($26m), Aged Residential care ($15m), Budgeted initiatives not progressed ($10M) and Primary Health Organisation ($8m), offset by release of a funding accrual for Undischarged patients ($17m);
- net favourable COVID-19 position of $23.7m in the Provider arm reflecting a surplus from labs COVID-19 funding; and
- net favourable position of $3m across Provider arm services.

COVID-19 Impacts

Healthcare services remained the front line response to the COVID-19 pandemic during 2021-22.

The COVID-19 pandemic 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 the on-going waves, Auckland DHB:

- Implemented the Covid-19 vaccination programme and stood up the additional facilities and staff required
- Support testing stations within general practice and in many locations across the Auckland region
- Postponed 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
- Continued use of tele-health and virtual appointments to ensure continuity of planned care where possible and appropriate
- Re-purposed facilities to be able to manage a potential surge of patients with COVID-19 infection
- Increased COVID-19 laboratory testing and capacity
- Released non-clinical staff and non-acute clinical staff to work in other areas supporting the community effort and regional co-ordination
- Responded to outbreaks in age care, mental health and disability residential care facilities including deploying staff to support
- Continued additional on-call rosters to enable teams to 'split', as well as having dedicated teams for COVID-19 suspect and positive patients.
- Continued additional triage and screening of all patients and visitors, including visitor screening stations and triage tents.
- Continued work from home practices where possible with 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 2021-22 financial year funded by the Ministry. Overall, Covid related revenue impacts for the year amounted to $307.1m offset by $283.4m of Covid-19 related expenditure, leaving a contribution of $23.7m in 2021-22. This includes $25.29m free of charge Covid PPE and RATs received from the Ministry of Health during the year. The fair value of these has been recognised in both revenue and expenses and has been disclosed in the relevant notes to the accounts.

Major revenue variances

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

26 Major variances from budget, including the impact of Covid-19 on the DHB (continued)

Major expenditure variances

- **Personnel costs $70m over budget:** mainly driven by Covid related personnel costs of $54.3m and payment of the Nurse Pay Equity costs.
- **Outsourced services $36m over budget:** $21.7m of this relates to Covid-19 and the balance reflects outsourced staff to cover leave and absences (largely due to sick or isolating staff) with the same for outsourced clinical and other services.
- **Clinical Supplies $19m over budget:** due to recognition of $25.29m for the value of the free of charge PPE and RATs received from MOH, offset by a reduction in costs as a result of deferring planned care during Covid outbreaks ($6m).
- **Infrastructure and non-clinical expenses $57m over budget:** mainly reflecting Covid-19 impacts related to testing and vaccination site security, traffic control, waste removal, electricity, fit out, office equipment, couriers, etc.
- **Other district health boards $1.3m over budget and Non-health board providers $35.6m less 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).
- **Other Expenses $25m over budget:** mainly unbudgeted Covid related costs for: site and vehicle leases, general office, regional IT/IS costs.

Cash and Cash Equivalents over budget

Cash and Cash Equivalents over budget mainly due to the continued impact of Covid impact which has delayed the capital programme and the call on cash. Also, lower than budgeted payments to providers/suppliers and timing of MoH budgeted revenue received.

Receivables over budget

Receivables are impacted by the timing of billings to and receipts from MOH, particularly Covid related receivables.

Trusts/Special Funds under budget

The budget was split between current and non current assets but the majority of funds were on longer term investment at year end. There was an overall decrease in Trust/Special Funds cash and investments of $2.6m.

Property, Plant and Equipment above budget

Property, plant and equipment increase reflects the full revaluation of the DHBs land and buildings that was undertaken effective 30 June 2022.

Intangible Assets under budget

Mainly I.S. projects which have not been able to be completed due to resource shortages during Covid.

Payables and deferred revenue over budget

Payables and deferred revenue over budget is due to planned care funding carried forward towards the volumes not able to be achieved in the current year due to Covid surges. Delays in meeting planned care volumes results in needing to engage external capacity/outsourced services to reduce the wait lists.

Employee benefits over budget

Employee benefits over budget is driven by increase in the Holidays Act non-compliance provision and increases in staff liabilities for annual leave and CME as a result of restrictions on travelling due to Covid.

27 Breach of Statutory Reporting Timeframes

The 2021/22 Annual Report of Auckland District Health Board and group was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021, which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30 June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course

Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Auckland DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[55]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

[55] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[56] (HSU 2021 vs. HSU 2020)

Year[57]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	11.99%	12.84%
2021/2022	79.66%	85.33%
Total	91.65%	98.18%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 92%, compared with 98% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccines doses administered by Auckland DHB

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Auckland DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year

Year[58]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[59]
2020/21	82,904	50,385	0	0	133,289
2021/22	352,272	370,240	289,400	2,731	1,014,643
Total	**435,176**	**420,625**	**289,400**	**2,731**	**1,147,932**

By 30 June 2022, a total of 1,147,932 COVID-19 vaccinations had been administered, of which 88% were administered in 2021/22.

[56] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[57] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[58] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[59] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[60] (1 July 2021 – 30 June 2022)

Age group (years)[61]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[62]
0 to 11	26,695	15,229	-	-	41,924
12 to 15	23,429	22,864	15	-	46,308
16 to 19	21,667	21,816	9,144	-	52,627
20 to 24	33,799	34,355	22,825	8	90,987
25 to 29	38,766	39,990	29,220	15	107,991
30 to 34	36,944	38,236	30,108	36	105,324
35 to 39	30,753	31,871	26,154	32	88,810
40 to 44	26,468	27,681	23,689	49	77,887
45 to 49	25,513	26,775	23,918	58	76,264
50 to 54	23,894	25,608	24,768	137	74,407
55 to 59	20,222	22,627	23,427	211	66,487
60 to 64	16,007	19,020	20,851	261	56,139
65 to 69	9,817	14,466	17,476	413	42,172
70 to 74	7,045	11,125	14,248	480	32,898
75 to 79	4,709	7,675	9,838	453	22,675
80 to 84	3,461	5,689	7,137	321	16,608
85 to 89	1,929	3,153	3,916	151	9,149
90+	1,154	2,060	2,666	106	5,986
Total	**352,272**	**370,240**	**289,400**	**2,731**	**1,014,643**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[63] administered by ethnicity[64] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	113,374	118,661	90,832	315	323,182
European/other	171,569	184,233	157,575	2,219	515,596
Māori	24,452	24,229	14,304	111	63,096
Pacific peoples	39,265	39,435	23,220	77	101,997
Unknown	3,612	3,682	3,469	9	10,772
Total	**352,272**	**370,240**	**289,400**	**2,731**	**1,014,643**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

[60] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[61] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[62] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.
[63] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[64] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

Auckland DHB resident population vaccinated against COVID-19

People vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

People vaccinated by age group during 2021/22[65]

Age group[66] (years)	Partial [67]		Primary course [68]				Booster course	
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	22,890	35%	13,281	20%	-	0%	-	0%
12 to 15	20,503	87%	18,605	79%	-	0%	-	0%
16 to 19	21,334	92%	21,386	92%	4,803	56%	-	0%
20 to 24	31,895	83%	32,572	84%	21,200	61%	-	0%
25 to 29	38,831	75%	40,284	78%	28,756	64%	-	0%
30 to 34	38,695	75%	40,596	78%	30,342	66%	-	0%
35 to 39	32,255	77%	33,764	80%	26,888	70%	-	0%
40 to 44	28,031	79%	29,330	83%	24,262	74%	-	0%
45 to 49	25,268	76%	26,600	80%	23,392	78%	-	0%
50 to 54	25,190	77%	26,782	82%	25,135	82%	131	5%
55 to 59	21,150	70%	23,423	77%	23,480	84%	200	6%
60 to 64	17,210	66%	20,119	77%	21,525	87%	259	7%
65 to 69	11,592	54%	15,911	74%	18,239	89%	388	10%
70 to 74	7,575	45%	11,812	70%	14,796	92%	472	13%
75 to 79	5,232	46%	8,553	74%	10,672	94%	467	17%
80 to 84	3,772	46%	6,187	76%	7,600	96%	336	19%
85 to 89	2,199	48%	3,532	78%	4,292	99%	165	18%
90+	1,359	45%	2,324	77%	2,955	106%	115	19%
Total	354,981	68%	375,061	72%	288,337	76%	2,533	11%

People vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

People vaccinated by ethnicity during 2021/22[69]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received FirstBooster (18+)	Received firstbooster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Asian	105,858	73%	115,223	79%	90,716	74%	253	6%
Māori	22,812	77%	23,476	79%	14,205	61%	103	8%
European/other	162,555	72%	179,317	79%	156,657	82%	2,105	14%
Pacific peoples	36,632	74%	38,720	78%	23,146	60%	65	4%
Unknown	4,234	125%	5,044	149%	3,613	55%	7	3%
Total	332,091	73%	361,780	80%	288,337	76%	2,533	11%

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

[65] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[66] Age groupings in this table reflect age of the persons at end of financial year.
[67] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[68] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).
[69] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

People vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	132,909	91%	131,496	90%	90,718	74%	253	6%
Māori	27,173	91%	26,396	89%	14,205	61%	103	8%
European/other	209,450	93%	207,785	92%	156,660	82%	2,105	14%
Pacific peoples	44,740	90%	43,632	88%	23,146	60%	65	4%
Unknown	7,195	212%	6,912	204%	3,613	55%	7	3%
Total	**421,467**	**93%**	**416,221**	**92%**	**288,342**	**76%**	**2,533**	**11%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)
50+ age determined as at 30-Jun-2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30-Jun-2022.

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our 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 ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[70]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- 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 response.

[70] https://www.stats.govt.nz/methods/population-statistics-user-guide.

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [71]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender.

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2020, 2021 and the Stats NZ PRP for Auckland DHB

As at 31 December 2021, there is an estimated 519,711 health service users in the HSU 2021. This is an increase of 27,612 people from the HSU 2020 (an approximate 6% increase), and 20,611 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[72]

Ethnicity	HSU 2020	HSU 2021	Stats NZ PRP 2021	Difference HSU 2020 – 2021 (Note 1)	Difference HSU – Stats NZ 2021 (Note 1)
Māori	35,190	36,936	41,500	1,746	-4,564
Pacific peoples	58,651	60,660	56,100	2,009	4,560
Asian	150,423	168,256	175,400	17,833	-7,144
European/other	246,288	250,234	226,100	3,946	24,134
Unknown	1,547	3,625	-	2,078	3,625
Total (Note 1)	**492,099**	**519,711**	**499,100**	**27,612**	**20,611**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 519,711. This is 20,611 above the Stats NZ total projected population of 499,100 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

[71] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

[72] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[73] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 deaths by age group and ethnicity

The following outlines the total number of deaths associated to COVID-19 in Auckland DHB by age group and ethnicity at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	1
40 to 49	0
50 to 59	4
60 to 69	12
70 to 79	23
80 to 89	30
90+	16
Total	**86**

Ethnicity	
Asian	8
European/other	50
Māori	6
Pacific peoples	22
Unknown[74]	0
Total	**86**

[73] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

[74] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

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 2022

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 35 to 77, that comprise the statement of financial position as at 30 June 2022, 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 5 to 18, 21 and 22, 28, and 78 to 84.

Opinion

In our opinion:

- the financial statements of the Health Board and Group on pages 35 to 77, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - their financial position as at 30 June 2022; and
        - their financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 5 to 18, 21 and 22, 28, and 78 to 84:
    - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2022, including:
        - for each class of reportable outputs:
            - their standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - their 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 8 March 2023. 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 of Te Whatu Ora – Health New Zealand 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 matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on page 40 outlines that the Health Board and Group have prepared their financial statements on a disestablishment basis because the Health Board and Group was disestablished, and their functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board and Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 17 on page 65 outlines that the Health Board and Group have been investigating issues with the way they calculate holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board and Group have estimated a provision of $347 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Appendix 1 on pages 78 to 83 outlines the information used by the Health Board and Group to report on their Covid-19 vaccine coverage. The Health Board and Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 82 and 83. The information on pages 82 and 83 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 26 on pages 76 and 77 to the financial statements and page 11 of the performance information outline the ongoing 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 of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board and Group is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board and Group were responsible for such internal control as they determined necessary to enable them to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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 of Te Whatu Ora.

- 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 by the Board of Te Whatu Ora.

- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 4, 19 and 20, 23 to 27 and 29 to 34, 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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