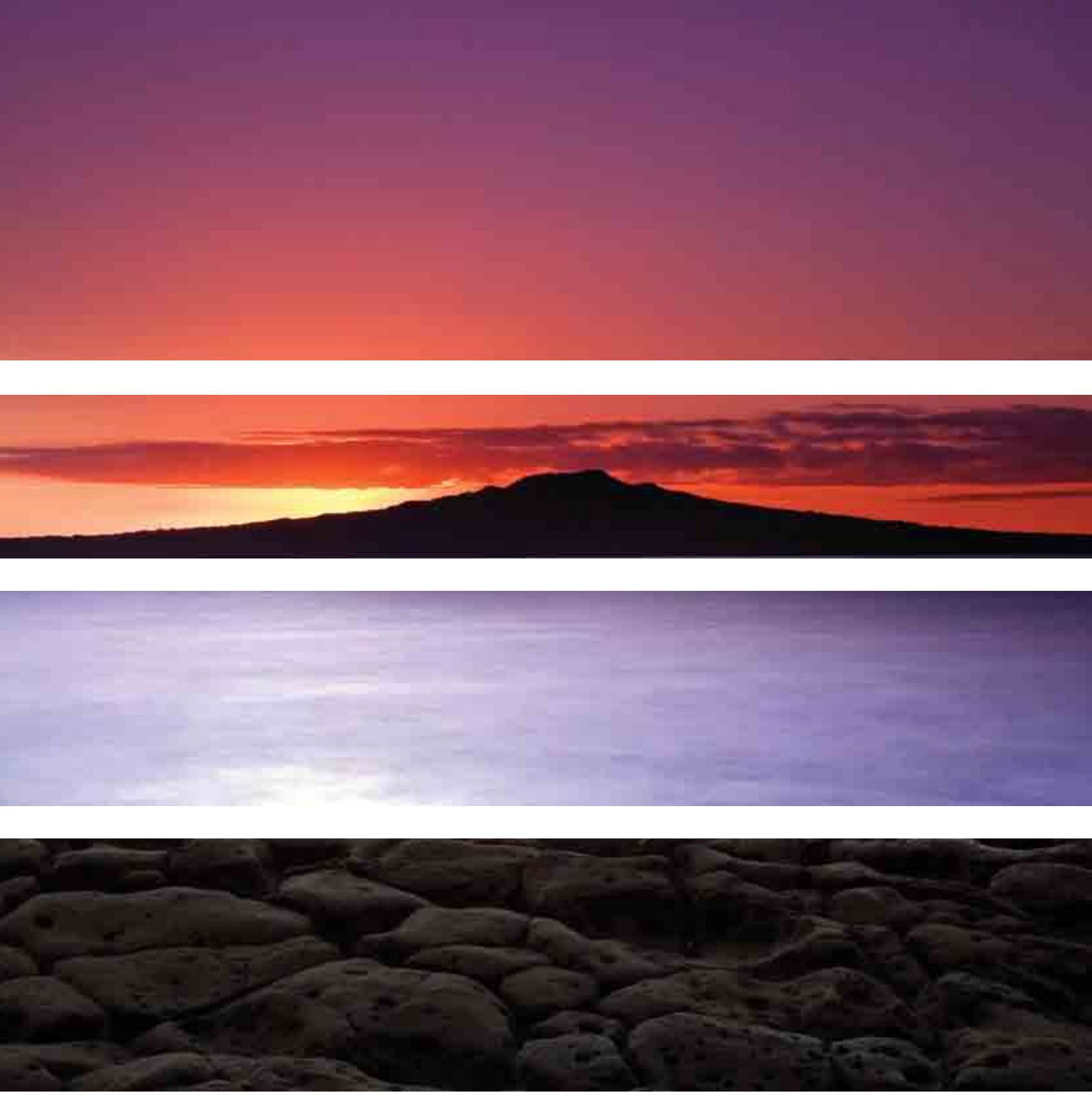

Annual Report 2012/2013

Waitemata District Health Board

Best Care for Everyone

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CHAIR/CEO STATEMENT

It has been another remarkable 12 months for Waitemata District Health Board. Along with further expansion of our facilities and services, we have continued to embed the initiatives and gains that have been made over recent years to improve on the high level of care we provide our communities.

As the organisation delivering public health services to the largest district health board population in New Zealand, we continue to excel in our overall performance. Thanks to the dedication and hard work of the many thousands of people who work for the DHB and in our partner organisations, we end the 2012/13 year having achieved five of the six national health targets. We also came very close to achieving the newest national target of more heart and diabetes checks for our population, with one of our district's two PHOs, ProCare, exceeding the target.

Our DHB's historic problem area, the performance of the emergency departments, has now well and truly been consigned to the past, with our DHB now consistently exceeding the 95% target of all emergency department patients admitted, discharged or transferred in six hours or less. This stellar performance by our two emergency departments, at Waitakere and North Shore, has now been consistently maintained since January 2012.

In many areas, our DHB is now a national leader in health quality, in a range of areas including electronic prescription of medicines, the handling of complaints, transparency and improvements in quality outcomes.

This was noted by Professor Ron Paterson, a leading expert in health quality and safety, in his year-long review of our DHB. We had invited Professor Paterson, a former Health and Disability Commissioner, back to our DHB in late 2011 to conduct a full review of our health quality systems. It marked the first time any DHB in New Zealand had opened itself up to a full and thorough review of its quality services.

The past 12 months has also seen us continue to invest in new facilities that will enable us to serve our communities to the highest possible standard well into the future. Developments completed this year include:

- The $39 million Elective Surgery Centre – a key project in our DHB's aim of providing public elective surgical services faster and more efficiently for our population. Located at the North Shore Hospital site, the ESC is a dedicated facility for elective surgical procedures. It is expected to perform nearly 6,000 operations a year across a range of specialties.
- The final four new school dental clinics in our DHB's three-year, $14.5 million programme to provide modern, comfortable dental facilities for children and families in the Waitemata district. In total, the programme has seen the development of 11 new school dental clinics in the district, as well as the introduction of six dental vans and 15 transportable dental units covering 48 locations.
- A new Advanced Interventional Radiology Suite at North Shore Hospital. The $1.7 million facility means the DHB can now offer minimally invasive treatment options for a wide range of health conditions
- Our DHB's fourth endoscopy suite – and the second one at Waitakere Hospital. The new suite will enable our DHB to carry out more than 2000 additional endoscopy procedures and complements the screening work carried out at the dedicated BowelScreening endoscopy suite at Waitakere. The new $850,000 suite will mean better local access to endoscopy services in the west with reduced wait times. With the new suite, three quarters of all Waitemata DHB elective endoscopy will be undertaken at Waitakere Hospital (excluding the screening done as part of the BowelScreening Pilot).

The year also saw us begin work on a number of exciting new developments, including:

- A new mental health facility on the North Shore Hospital site as part of an expansion of services for the district's growing population. The $25 million, 46-bed development is set for completion in early 2015
- Expansion of our community based renal services in the district. The expansion will take the form of a new 18 station community dialysis facility built in the community. The facility is expected to be completed next year. Our existing facilities will also receive additional work to increase their capacity
- A new MRI suite, which will house a new state of the art MRI scanner, enabling faster, more detailed medical scanning
- A third level of floor space directly above the antenatal unit at North Shore Hospital, providing additional office and meeting space as well as a home for a new chapel to support the spiritual health and wellbeing of patients and their families
- Beginning of planning for a new paediatric and adult emergency department in west Auckland.

We also continue to work closely with our primary care partners to deliver joint services in the community. Central to this aim is facilities such as the Totara Health Services. The Integrated Family Health Centre, located in the heart of New Lynn, is

a key facility for our DHB to provide integrated services such as paediatrics in a highly accessible community location in west Auckland. We have also co-located some key DHB services into Te Whanau O Waipareira's Whanau House. The co-location of services to the Trust's Henderson facility will assist greatly with improving health outcomes for Maori in our district, with the centre ensuring that our communities can access any support that they may require in one, convenient location.

Our national BowelScreening Pilot also marked a full year of screening for New Zealand's second most common cancer. The first screening programme of its kind in New Zealand, the programme has to date picked up 75 cases of bowel cancer.

We also started electronic prescription and administration of medications, rolling out ePrescribing to a number of wards at North Shore and Waitakere Hospitals, as well as the DHB-run Mason Clinic. The move means Waitemata is the most advanced DHB in the country with regards to electronic prescribing.

The work we have been doing is being reflected in health indicators for our district's population. Results released from the 2011/12 New Zealand Health Survey in May this year show people living in the Waitemata district as among the healthiest in the country. The findings show that among the seven larger health districts in the country, Waitemata had the lowest rate of stroke, diagnosed diabetes and medicated high blood pressure. People in our district also enjoy great primary healthcare and after-hours access, with the lowest number of people reporting that they were unable to get an appointment at their usual medical practice within 24 hours over the last 12 months.

This is consistent with data which showed our district's population to be the longest living in the country, with an average life expectancy of 84 years. In fact, if the Waitemata district were to be regarded as a country, we would have the highest life expectancy in the world – well ahead of Japan's 82 years.

The Ministry of Health's annual statistical publication, Cancer: New Registrations and Deaths 2009, has also previously shown that Waitemata residents have the lowest cancer death rates in the country.

Financially, our DHB has continued to live within its means over 2012/13, ending the year with a small surplus which will be re-invested back into our services and facilities.

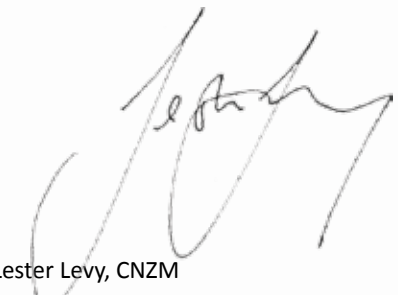
Our bilateral collaboration initiative between Waitemata and Auckland DHBs continues to gain momentum. The move, driven by a focus on patient needs, rather than health district boundary lines, is designed to improve the quality of health service delivery across both our DHBs. Joint Maori and Pacific Health teams have been established, enabling us to provide more seamless service delivery across both districts. A joint Planning, Funding and Outcomes unit supports this aim, enabling our DHB to enhance health outcomes for our population.

Looking to the future, the focus is very much on building upon the investments we have made over recent years so we can embed the significant gains that have been realised to date. Developing new models of care, such as the one operating at the Elective Surgery Centre, will also be crucial to meet the demands of population growth, an ageing population and continuing cost pressures.

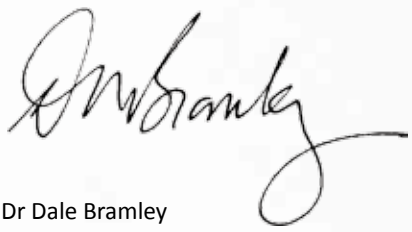
There is still much to do in order to realise our organisation's core purpose of delivering the best care for every single person who uses our services, with services that support a healthy and well population.

But the investments we have made over recent years stand us in good stead as we strive to further improve on the high level of care we provide to our communities.

An organisation is however only as good as its people. We are fortunate to have so many dedicated, talented and hardworking individuals and teams working within our DHB and partner organisations. None of our successes to date would have been possible without them. On behalf of the Board and Executive Leadership Team we wish to thank everyone who has made the 2012/13 year such an outstanding one for Waitemata DHB.



Dr Lester Levy, CNZM
Chairman
Waitemata District Health Board



Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

Maori Te Tiriti - Partnership Statement

Kaua e mahue atu tētahi ki waho

Don't leave anybody out

Given that Māori have poorer health outcomes relative to the rest of the population, the DHBs partnership arrangements with Māori are critical in achieving demonstrable health gain across the district.

The DHB's MoU partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, are committed to assisting the Waitemata DHB to achieve "best care for everyone", but especially so for those within our communities who suffer poorer health outcomes. Of particular importance to us is the assurance that the DHB is doing all it can to improve the health status of the Māori population that we share a joint accountability for - the DHB from a statutory, Crown-agent perspective, and the MoU partners from our obligation of manaakitanga, or to care for and support all those resident within our communities.

We are pleased to note the significant developments in the past year and continued improvement on notable performance indicators as outlined in this annual report. While the DHB is to be congratulated for its contribution to maintaining a higher life expectancy for Māori within the district compared to the national average for Māori, there is still some way to go in reducing the gap between Māori and non-Māori. The poorer health status of Māori will still require us to be vigilant in our focus on improved outcomes, and innovative in our approaches to reducing these inequities.

From the MoU partners' perspectives, in addition to the achievements outlined in this report, other significant accomplishments over the last year include:

- Completing the Māori health collaboration across Waitemata and Auckland DHBs, unifying Māori health hospital and funding and planning services in line with the Ngāti Whātua tribal boundary to ensure consistency of approach to common issues.
- The strengthening of key leadership roles including the joint appointment of a Chief Advisor Tikanga across Waitemata DHB and Auckland DHB to ensure Māori receive care appropriate to their needs and cultural values, and the appointment of a lead Chief Executive for Maori Health, Dr Dale Bramley.
- Further development of a whānau ora centre via Te Whānau o Waipareira Trust's Whānau House including the integration of DHB services within this setting.
- An increased level of Māori engagement in governance, and funding and planning functions, particularly with the DHB's MoU partners.

Once again, we restate the MoU partners' commitment to working in partnership with Waitemata DHB to ensure whānau within the district achieve the best health outcomes, and we look forward to building on the achievements outlined in this annual report in the years ahead.

Our Te Tiriti o Waitangi Partners
Te Runanga o Ngati Whatua

R Naida Glavish JP
Chair, Te Runanga o Ngati Whatua

Te Whānau o Waipareira Trust

John Tamihere
CEO, Te Whānau o Waipareira Trust

VISION AND VALUES

The organisation has recently reviewed its values and promise.
Our wider work programme on culture and values has clearly defined our organisation's purpose as being:

- to relieve suffering of those entrusted into our care
- to promote wellness
- to cure, ameliorate and prevent ill health.

Our focus on Best Care for Everyone means we strive to offer the best care we can to every person and their family receiving our services.

BEING CLEAR WHO WE ARE, WHAT WE DO AND HOW WE DO IT

The organisation, together with its staff, recently reviewed its values, promise and purpose.

These became the anchor for all we do within the organisation.

"best care for everyone

This is our promise to the Waitemata community and the standard for how we work together.

Regardless of whether we work directly with patients/clients, or support the work of the organisation in other ways, each of us makes an essential contribution to ensuring Waitemata DHB delivers the best care for every single patient/client using our services."

"everyone matters

Every single person matters, whether patients/clients, family members or staff members."

"connected

We need to be connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families."

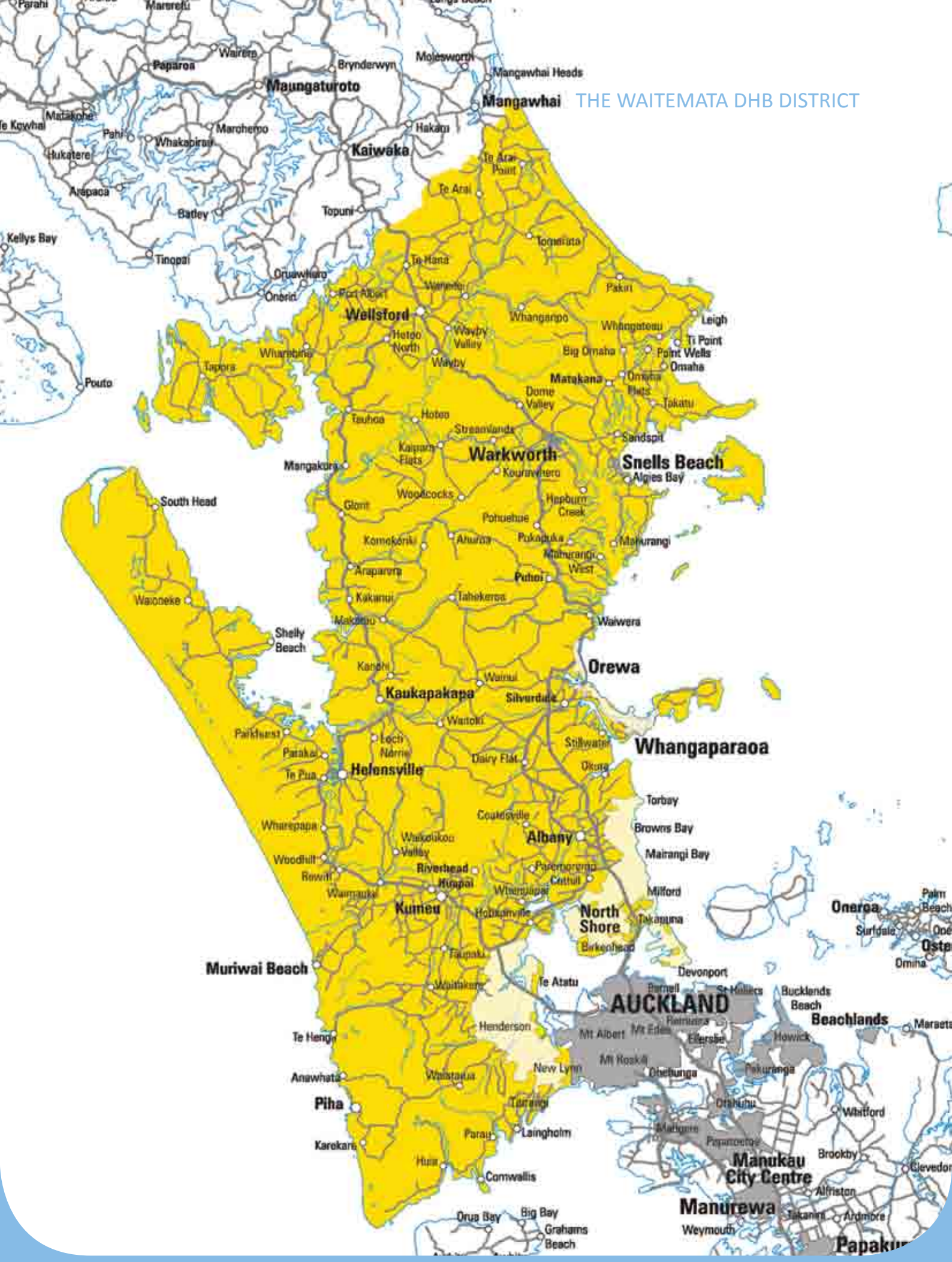
"with compassion

We see our work in health as a vocation and more than a job. We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness."

"better, best, brilliant...

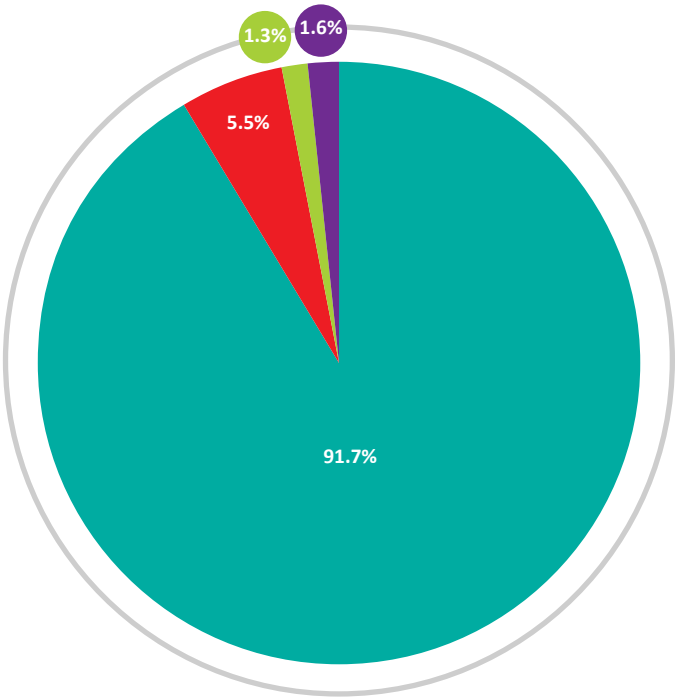
We seek continuous improvement in everything we do. We will become the national leader in health care delivery."

Waitemata
District Health Board
Best Care for Everyone

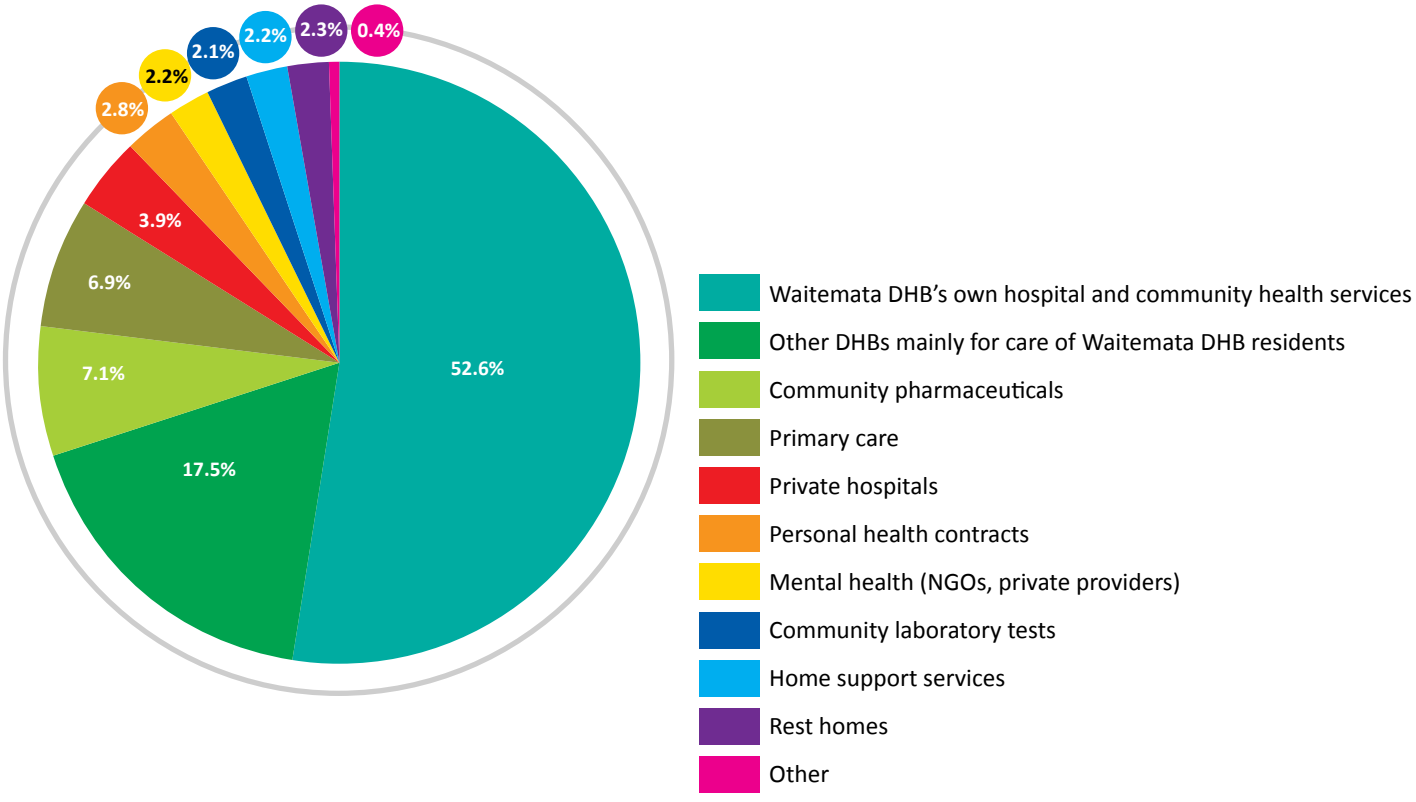

Parahi
Marsefu
Paparoa
Wairere
Brynderwyn
Molesworth
Mangawhai Heads
Maungaturoto
Mangawhai
Matakohe
Te Kowhai
Pahi
Maropiro
Whakapirau
Hukatere
Hakaru
Kaiwaka
Te Arai Point
Te Arai
Arapaca
Batley
Topuni
Kellys Bay
Tinopai
Toomiata
Te Hana
Pakiri
Oruawharo
Oneriri
Port Albert
Wenoto
Wellsford
Whangaripo
Whangateau
Leigh
Hoteo North
Wayby Valley
Ti Point
Point Wells
Omaha
Whamoino
Tapora
Wayby
Big Omaha
Matakana
Omaha Flats
Takatu
Pouto
Dome Valley
Tauhoa
Hoteo
Streamlands
Sandspit
Kaipara Flats
Warkworth
Snells Beach
Algies Bay
Mangakura
Kouriwhero
South Head
Woodcocks
Glorit
Hepburn Creek
Pohuehue
Komokoriki
Ahuroa
Pukapuka
Mahurangi
Mahurangi West
Araparera
Puhoi
Waioneke
Kakanui
Tahekeroa
Makarau
Waiwera
Shelly Beach
Orewa
Kaipara
Kaukapakapa
Wainui
Silverdale
Wantoki
Parkhurst
Loch Norrie
Stillwater
Whangaparaoa
Paraka
Dairy Flat
Te Pua
Helensville
Okura
Torbay
Coatesville
Whirepapa
Albany
Browns Bay
Wakolkoo Valley
Mairangi Bay
Woodhill
Riverhead
Parenporenga
Rewiti
Kinapai
Cuttuli
Waimauku
Whenuapai
Milford
Kumeu
Hobsonville
North Shore
Takapuna
Onerea
Palm Beach
Surfdale
Oste
Omaha
Muriwai Beach
Birkenhead
Devonport
Te Atatu
Waitakere
Burnell
St Heliers
Bucklands Beach
AUCKLAND
Beachlands
Meraets
Henderson
Mt Albert
Mt Eden
Remuera
Ellerslie
Howick
Te Henga
Mt Roskill
New Lynn
Otahuhu
Pakuranga
Anawhata
Waitakere
Oteha
Tamaki
Whitford
Piha
Laingholm
Parau
Karekare
Manukau City Centre
Brookby
Clevedon
Hunu
Cornwallis
Alfriston
Manurewa
Takanini
Ardmore
Orua Bay
Big Bay
Grahams Beach
Weymouth
Papaku

HOW WE ALLOCATE OUR FUNDING

Where did the money come from?



What was it spent on?



DISTRICT SNAPSHOT

Waitemata District Health Board serves the largest DHB population in the country – more than 560,000 people. It is also the second fastest growing of New Zealand's 20 DHBs.

We employ around 6,238 full and part time permanent staff (excluding casual and external agency staff) in more than 30 different locations and manage a budget of more than $1.3 billion a year, serving residents of Rodney, the North Shore and Waitakere.

Waitemata DHB operates North Shore Hospital, on the shores of Lake Pupuke in Takapuna, and Waitakere Hospital in west Auckland.

Locally we provide emergency, medical, surgical, maternity, community health and mental health services. We also provide a range of services for the Auckland region, including child rehabilitation and respite at Takapuna's Wilson Centre, forensic psychiatric services at the Mason Clinic in Point Chevalier, oral health services for children and young people and Community Alcohol and Drug Services from multiple locations.

Our district is a diverse one, made up of 19% Asian (mostly Chinese, Indian and Korean), 10% New Zealand Māori, 7% Pacific peoples with around 64% European and Other ethnicities.

KEY FACTS AND FIGURES – OVER THE PAST YEAR

Where possible, comparative data for other DHBs is presented in order to give a sense of scale of our activities and provide context to our performance (note figures in brackets are for previous year).

- 6,957 babies were born in our hospitals (6,584). This is over 11% of the country's total births. For the same period, there were 7,613 babies born in Auckland DHB facilities – being nearly 12% of the country's total births.

- Waitemata residents made 175,904 (178,187) attendances at an outpatient clinic. This was 31.7% of the population (attendances/population). Comparatively Northland residents made only 54,342 outpatient attendances (34.1% of their population) and Counties Manukau residents made 159,142 attendances (31.3% of their population). Auckland residents made 138,198 outpatient attendances (29.8% of their population).

- There were 119,885 (118,232) attendances at an Emergency department (ED) by Waitemata residents during 2012/13 – 21.6% of the population. 108,279 (104,708) of these attendances were to North Shore or Waitakere hospital Emergency Departments. During the same time period, Northland resident attendances to an ED totalled 43,448 or 27.3% of their population, compared to Counties Manukau residents – 94,702 attendances or 18.6% of their population. Auckland residents made 80,492 ED attendances during the same period, 17.3% of their population.

- 694,464 (566,379) school dental treatments were given to children across the Auckland metro region - 30% for Waitemata DHB children and 34% for Auckland DHB children.

- 72,015 (78,032) vaccinations were given to Waitemata children aged five and under. Over the same period, 63,369 vaccinations were given to Auckland children. 92% of 8 month olds were fully immunised in Waitemata DHB and 90% in Auckland DHB by year end.

- We saw 27,113 (26,594) mental health clients.

- Specialist nurses carried out 5,319 (4,832) home visits.

- 13,155 (13,634) smokers hospitalised in Waitemata DHB facilities were offered advice and help to quit smoking. During the same period 11,683 smokers hospitalised in Auckland DHB facilities were offered this advice.

- We carried out 174,700 (180,573) radiology procedures in our hospitals. Auckland DHB carried out 278,152 during the same period.

- 15,966 (15,891) elective surgeries were performed for Waitemata residents. This was more than 10% of total national elective discharges for the 2012/13 year. During the same period, there were 12,983 elective surgical discharges of Auckland DHB patients – around 8% of the national total.

- There were 13,142 (12,843) acute surgical discharges from our facilities.

- As at March 2013, 108,735 Waitemata women aged 25-69 years underwent a cervical screen in the past 3 years, compared to 106,896 at the same time last year. Comparatively, 100,993 (97,846) Auckland women were screened, 29,569 (29,626) Northland women and 88,068 (86,053) Counties Manukau women.

- There were 12,474 (12,944) mental health home visits.

- There were 72,276 discharges from Waitemata DHB adult inpatient services.

2012/13 HIGHLIGHTS AND ACHIEVEMENTS

Overall	• Achievement of the emergency department, elective surgery, cancer treatment waiting times, immunisation and better help for smokers to quit targets.
2012 July	• Waitemata DHB achieves the national health target for immunisation, making it one of the first large DHBs in the country to reach the target of having 95% of all two-year-olds in the district fully immunised.
August	• Waitemata DHB's Board approves a $3.6 million expansion of renal services in the district – taking the form of a new 18 station community dialysis facility on the North Shore, as well as capacity increases to existing facilities.
October	• The Albany Community Dental Clinic, located at Albany Junior High School, opens. It is the first of four new school dental clinics planned for the DHB's 2012/13 financial year.
November	• Waitemata DHB's BowelScreening Pilot marks a full year of screening for New Zealand's second most common cancer. The programme has picked up 75 cases of bowel cancer to date. • The green light is given for a new mental health facility to be developed on the North Shore Hospital site as part of an expansion of services for the district's growing population. The $25 million, 46-bed development is set for completion in late 2014.
December	• The DHB starts electronic prescription and administration of medications, rolling out its ePrescribing system to an initial two wards at North Shore Hospital. It would later be rolled out to a further 45 beds at Waitakere Hospital as well as 110 beds at the DHB-run Mason Clinic. The move means Waitemata is the first DHB in the upper North Island to start ePrescribing. • The DHB's three-year, $14.5 million programme to provide modern, comfortable dental facilities for children and families in the district is completed with the opening of its final three school dental clinics in Birkenhead, Glen Eden and Westgate. In total, the programme has seen the development of 11 new school dental clinics in the district, as well as the introduction of six dental vans and 15 transportable dental units covering 48 locations.
2013 January	• New Advanced Interventional Radiology Suite opens at North Shore Hospital. The $1.7 million facility means the DHB can now offer minimally invasive treatment options for a wide range of health conditions.
February	• The DHB announces plans to acquire a new state of the art MRI scanner, enabling faster, more detailed medical scanning. The new machine will have a higher magnetic field strength of 3 Tesla (3T), a significant improvement on the existing 1.5T scanner. • Waitemata marks a full year of exceeding the Shorter Stays in Emergency Departments national health target, consigning to its past the historic problem area of long wait times in its emergency departments. Results for the second quarter of 2012/13 released by the Ministry of Health place Waitemata second behind only West Coast DHB – and first among the large DHBs – in its ED health target performance.
March	• The DHB's Intensive Care & High Dependency Units (ICU/HDU) at North Shore Hospital mark more than 400 days without a single case of the often fatal bloodstream infection known as central line associated bacteraemia (CLAB) – making it one of the largest ICU/HDU in New Zealand to achieve this milestone.
May	• The DHB's drive for continuous improvement in patient care has seen it hit a new high in hand hygiene compliance, with the DHB placing joint third among the 20 DHBs nationally. • Results released from the 2011/12 New Zealand Health Survey show people living in the Waitemata district as among the healthiest in the country. The findings show that among the seven larger health districts in the country, Waitemata had the lowest rate of stroke, diagnosed diabetes and medicated high blood pressure. • Waitemata DHB takes possession of the Elective Surgery Centre from its building developers to complete the internal fit out in time to receive the centre's first patient on July 15. The ESC is a key project in the DHB's aim of providing public elective surgical services faster and more efficiently for its population.

‘Luckiest man’ urges others to take the bowel screening test

Takapuna man Bruce Ogilvy calls himself the luckiest man in the country after a free bowel screening test picked up his cancer early, when it could be succesfully treated.

The healthy and active 59-year old took part in Waitemata District Health Board’s bowel screening programme. Bowel cancer is the second most common cancer in New Zealand and the second highest cause of cancer death.

“I had no signs or symptoms of anything wrong at all. But my initial test at home came back positive and a follow-up colonoscopy showed cancer. I had surgery and chemotherapy and now I feel great. I am so pleased I took part in the bowel screening programme,” says Mr Ogilvy.

Bruce Ogilvy has a simple message for everyone living in the region who is eligible to take part in the pilot.

“Take the test! Just do it! It is the best thing I have ever done – I feel like I have won lotto,” he says.

Bruce Ogilvy is one of 75 people found to have bowel cancer to date as part of the pilot.

The programme’s clinical director, surgeon Mike Hulme-Moir, says cancers are being found in people who had no signs or symptoms to suggest there could be a problem with their bowel.

“More than 60 percent of the cancers detected during the first year of the pilot are early stage bowel cancers, which is a higher percentage than is seen in a normal clinical setting where people have symptoms.”

Mr Hulme-Moir says the good news is that earlier stage cancers can be treated more successfully, and the outcomes for patients are generally very good.

The Ministry of Health has just released data from the first year of the pilot, from January to December 2012 showing:

- Bowel cancer was found in 60 people (75 people to date)
- 54,450 people were invited to take part in the pilot
- More than 29,000 returned a sample that was tested in the laboratory
- More than 1,400 people had a colonoscopy at the pilot’s dedicated endoscopy unit at Waitakere Hospital.

The $24 million pilot is being run in the Waitemata DHB area until 2015. People aged 50 to 74 years who live in the DHB area are eligible to take part.

OUTPUT CLASSES AND PERFORMANCE FRAMEWORK

The Statement of Service Performance (SSP) presents a snapshot of the services provided for our population, across the continuum of care. The SSP is grouped into four output classes (refer table below). The four Output Classes assist DHBs to convey their performance story in relation to the health services provided to their population recognising the funding received, Government priorities, national decision-making and Board priorities. Each output class section includes measures which help to evaluate the DHB's performance over time. These include the Minister of Health's six Health Targets.

Output Class	Description
Prevention services	Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
Early detection and management	Services provided in the community by general practitioners, pharmacists, district nurses, Plunket and many others. These services are preventative and treatment services focused on individuals and smaller groups of individuals.
Intensive assessment and treatment	Specialist services delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are at the complex end of treatment services and focused on individuals.
Rehabilitation and support services	Rehabilitation and support services are delivered to people with long-term disabilities; people with mental health conditions and people who have age-related disabilities. These services encompass home-based support services; residential care support services; day services and palliative care services.

The DHB's planning and funding role is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services (North Shore and Waitakere Hospitals), services delivered by other hospitals and contracting services from other specialist providers. Some services are funded and contracted directly by the Ministry of Health. Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Therefore some of the measures chosen in each section reflect and seek to illustrate the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We also have a particular focus on continuing to improve health outcomes and reduce health inequalities for Māori. Therefore, a range of measures have been identified throughout the Statement of Service Performance that monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Waitemata DHB Māori Health Plan 2012/13.

Waitemata DHB's performance has improved considerably in the last few years, particularly with regard to the national health targets. In general we set stretch targets to drive the organisation to improve our performance. Assessment of our 2012/13 performance is based on the same grading system used in for the past two years. This allows for recognition of those measures where we have significantly increased our performance, but have not quite met the target set in the Statement of Intent. The criteria used to allocate these grades is as follows:

Criteria	Rating
> 20% away from target	Not achieved
9-20% away from target	Partly achieved
0.01-9% away from target	Substantially achieved
On target or better	Achieved

Where a measure is made up of multiple components, each with its own target, an average has been applied to determine performance.

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

The following diagram presents the overall framework - illustrating the relationship between national and Board priorities, impacts sought and measures used to assess performance which are included in the SSP.

Government Policy:	Better, sooner, more convenient health services:	Service Integration	Regional Collaboration	Value for Money
Regional Vision:	"To improve health outcomes and reduce disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means."			
Northern Region Goals	Population Health *Adding to and increasing the productive life of people in the northern region*	Patient Experience *Aiming for zero patient harm and performance improvement*	Cost/Productivity *The region's health resources are efficiently and sustainably managed to meet present and future health needs*	
Joint ADHB & WDHB Goals	Improved population health Achieve the health targets / Improve service integration	Improve patient safety and experience	Improved financial performance and productivity	

Priority Populations and Services

Child Health	Youth Health	Māori Health	Pacific Health	Mental Health	Asian and 'new New Zealander' Health	Renal and Respiratory Services

National Priorities	Emergency Departments	Access to Elective Surgery	Cancer Services	Immunisation	Tobacco	CVD/ Diabetes	Primary Care Development & Delivery	Child & Youth Mental Health	Health of Older People	Cardiac Services	Whānau Ora	Living within our Means

Impacts	☑ **Improve life expectancy** ☑ Fewer admissions for falls of older people ☑ Prevention of illness and fewer acute episodes ☑ Prompt recovery from acute mental illness ☑ Prompt diagnosis of acute and chronic conditions ☑ Restoration or maintenance of functional independence ☑ Good access to effective pharmaceutical treatments ☑ Effective and prompt resolution of medical and surgical emergencies and acute conditions ☑ Increased survival/reduced mortality from most common cancers ☑ Management and cure of treatable conditions ☑ Improved oral health of children and young people, with a reduction in ethnic inequalities ☑ Improved acute and chronic care of older people ☑ Maximising functional independence and quality of life of older people ☑ Reduced mortality ☑ Healthier children ☑ Improved overall oral health	☑ **Improved patient satisfaction** ☑ Satisfactory waiting times for our services ☑ Improved patient experience ☑ Pain relief and patient reassurance ☑ Prevention of mental illness relapses ☑ Fewer adverse clinical events ☑ Improved engagement of our community – including Māori, Pacific and Asian – with our health services ☑ Improved engagement of clinicians and other health professionals. ☑ Improved quality of life due to surgical intervention ☑ Improved emergency care ☑ Patients less likely to be readmitted ☑ Social integration and improved quality of life ☑ Quality of Life for those dependent on aged residential care ☑ Increased life expectancy ☑ Improved quality of life for patients with life-threatening illness (and their families)	☑ **Achieving a break-even position each year** ☑ Reduced demand on specialist outpatient appointments ☑ Minimising unnecessary use of high cost secondary care ☑ Lower per capita out of pocket and total expenditure on pharmaceuticals ☑ Prevention of illness ☑ More services delivered in primary care and community based settings ☑ Prudent financial management
Key Impact and Output Performance Measures Note: O = output I = impact	O % of hospitalised smokers and those seen by primary care offered advice and help to quit I Smoking prevalence amongst hospitalised smokers O % of 8 month olds fully immunised O Proportion of women aged 45-69 who had a breast screen in the past 12 months, reducing inequalities O % of eligible population invited to screen for bowel cancer O Mental health services access rates O Proportion of babies fully and exclusively breastfed at 6 weeks, 3 month s and 6 months I Proportion of eligible people who have had a cardiovascular risk assessment in last 5 years, reducing inequalities for Maori I Proportion of people who have good diabetes management at their annual review (focus on Maori) I Average number of decayed, missing or filled teeth in year 8 children I Proportion of children who are caries free at 5 years O Deliver 15,853 elective surgical discharges O Elective services standardised intervention rates for our population I Total QALYs gained from the five Ministry of Health selected procedures O % of Auckland population who can access free under 6's after hours care O % reduction in aged care facility clients presenting to ED O Standardised acute admission rates from residential care	O Patients waiting longer than six months for their first specialist assessment (FSA) O Patients given a commitment to treatment but not treated within six months. I % of respondents who rate the care and treatment they receive as 'very good' or 'excellent' O % of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours. O Hospital readmission rates - focusing on Maori and Pacific O Everyone needing radiation or chemotherapy treatment will have this within four weeks O % complaints responded to within 14 days O % improvement in hand hygiene compliance I Lower the incidence of central line associated bacteraemia I % reduction in incidence of inpatient catheter associated urinary tract infections I % reduction in falls resulting in major harm	O Achieve financial break-even result O Regional achievement of national health targets O Business transformation $12M savings realized O Average fee paid for after-hours GP visits for patients under the age of 6

Output Class

Prevention
- ❖ Health Protection
- ❖ Health Promotion
- ❖ Health Policy/Legislation Advocacy and Advice
- ❖ Population Based Screening

Early Detection and Management
- ❖ Community referred Testing & Diagnostics
- ❖ Oral Health
- ❖ Primary Health Care
- ❖ Pharmacy

Intensive Assessment and Treatment
- ❖ Acute Services
- ❖ Maternity
- ❖ Elective (Inpatient/Outpatient)
- ❖ Assessment, Treatment and Rehabilitation (Inpatient)
- ❖ Mental Health

Rehabilitation and Support
- ❖ Home Based Support
- ❖ Palliative Care
- ❖ Residential Care
- ❖ Mental Health

Cost of Service Statement – for year ending 30 June 2013

New Output Class Names (effective from 1 July 2011)	Intensive Assessment and Treatment		Rehabilitation and Support		Early Detection and Management		Prevention Services		**Total**	
Output Class Names	Hospital Services		Support Services		Primary and Community Services		Public Health Services		**Total**	
In $'000s	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**
Total Revenue	**833,498**	**816,562**	**191,771**	**198,019**	**370,617**	**369,370**	**25,798**	**32,891**	**1,421,684**	**1,416,842**
Expenditure										
Personnel	404,289	400,394	29,555	28,876	55,180	54,767	9,174	9,105	**498,198**	**493,142**
Outsourced Services	43,466	32,937	5,995	4,142	5,954	4,495	990	747	**56,405**	**42,321**
Clinical Supplies	69,710	68,487	4,446	5,668	10,403	9,641	1,729	1,602	**86,288**	**85,398**
Infrastructure and Non-clinical supplies	85,286	84,985	5,910	4,885	10,793	11,432	1,794	1,901	**103,783**	**103,203**
Payment to providers	231,901	227,759	144,328	154,448	282,841	289,035	11,944	19,536	**671,014**	**690,778**
Total Expenditure	**834,652**	**814,562**	**190,234**	**198,019**	**365,171**	**369,370**	**25,631**	**32,891**	**1,415,688**	**1,414,842**
Net Surplus/ (Deficit)	**(1,154)**	**2,000**	**1,537**	**0**	**5,446**	**0**	**167**	**0**	**5,996**	**2,000**

OUTCOME AND IMPACT MEASURES

In our 2012/13 Statement of Intent we used the three goals of the Northern Regional Health Plan; population health, patient experience and cost/productivity as the basis for our priority setting. These are aligned with the World Health Organisation policy guidance [1] for health system performance measurement and improvement. For each of these three outcome areas we have identified high level measures for which progress is not generally seen within one year, but for which we expect to see an improvement over 3-5 years based on the annual priorities and activities implemented. These are our main measures as defined by the Crown Entities Act. Beneath these sit our impact measures. Measurement of impacts helps us determine if we are making progress towards our longer term outcomes over time.

Improved Population Health

One of the key DHB objectives under the New Zealand Public Health and Disability Act is to improve, promote and protect the health of the population the DHB serves. In our approach to improving population health we consider two aspects, improving the overall health gain for our community thereby improving health and reducing disability, as well as reducing inequalities.

For 2012/13 we focused on achieving the health targets and improving service integration as key areas which contribute to the achievement of this outcome.

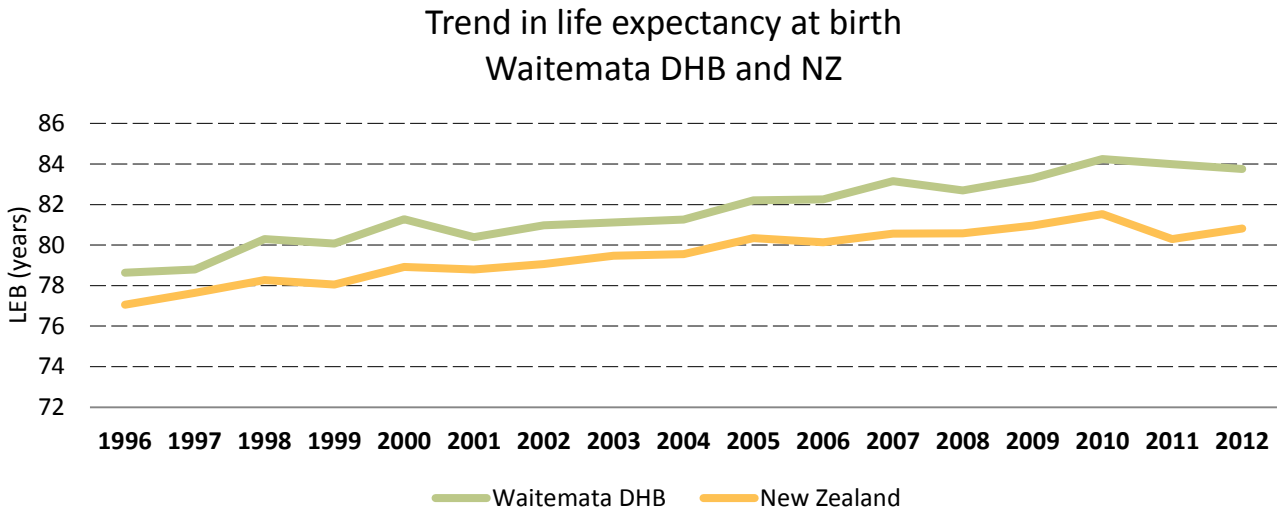
Main Outcome measures:

- **Increased life expectancy**
- **Average annual increase in life expectancy at birth**

Why are these measures our focus? What's the current status?

Internationally recognised, we monitor life expectancy increases as a measure of our population health status. For New Zealand as a whole the trend has been 2.7 years per decade over the last 16 years, Waitemata has seen an impressive trend of 3.3 years per decade.

Overall we continue to have the highest life expectancy in the country at around 84 years – almost three years higher than New Zealand as a whole. If the Waitemata district was a country we would have the highest life expectancy in the world (ahead of Japan, Switzerland and San Marino who all had life expectancies at birth of 83 years in 2011 [2]).



[1] *Murray CJ, Frenk J. A framework for assessing the performance of health systems. Bulletin of the World Health Organization, 2000, 78(6):717-31*

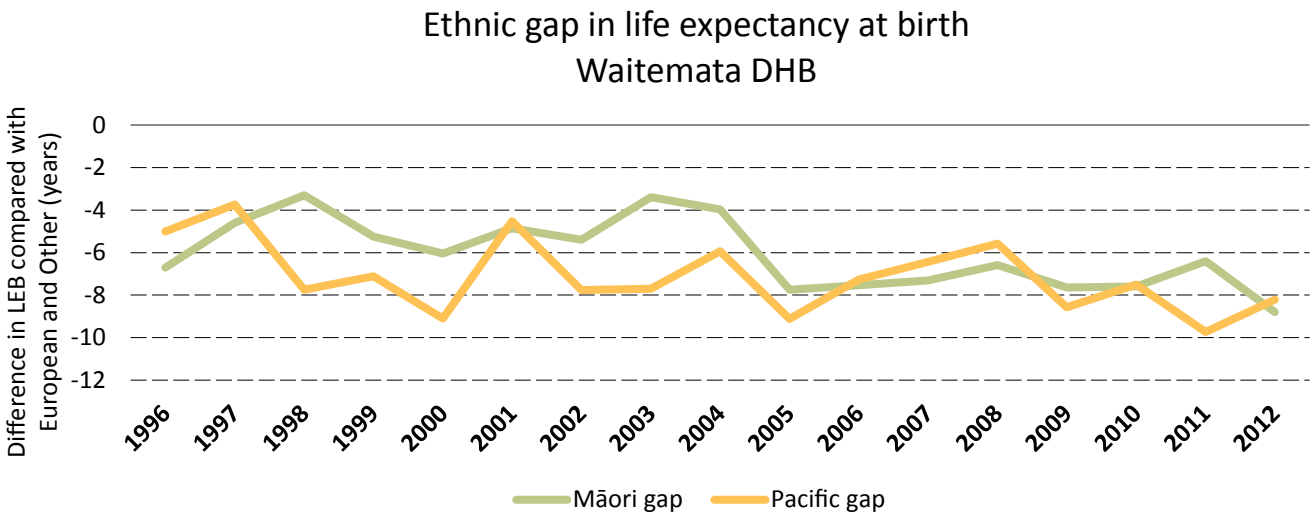
[2] *Global Health Observatory (http://apps.who.int/gho/data/node.main.3?lang=en)*

Main Outcome measures:

- **Reduced inequalities (measured by the life expectancy gap)**

Why are these measures our focus? What's the current status?

Maori and Pacific life expectancy at Waitemata DHB is 76 years. Maori life expectancy is amongst the highest in New Zealand. However a gap still exists and is increasing, given the very high life expectancy of our non-Maori population.

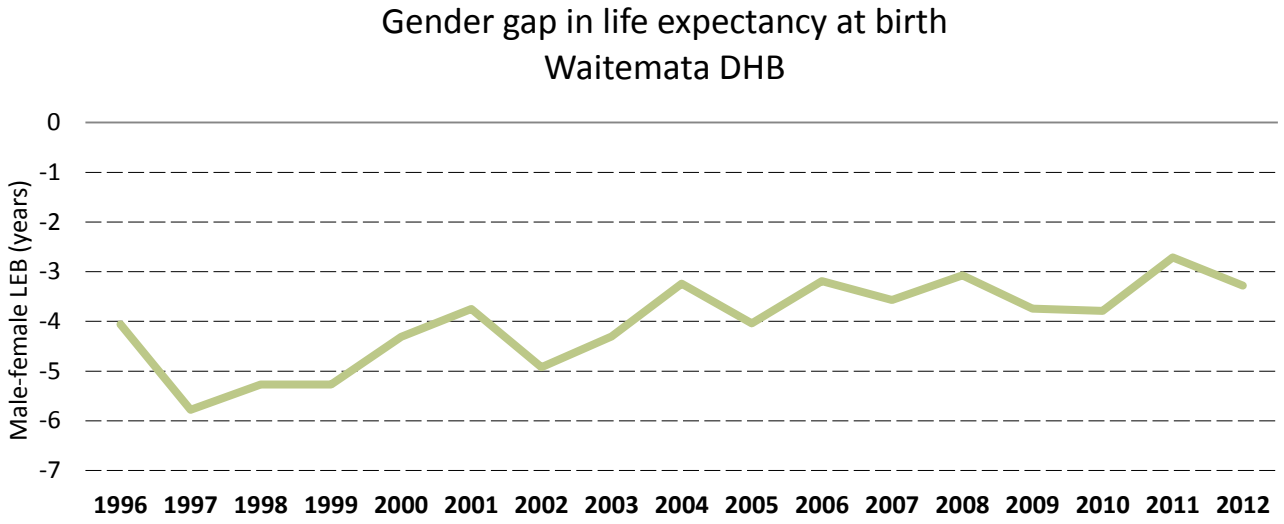


Main Outcome measures:

- **Reduced Inequalities (measured by the life expectancy gap)**

Why are these measures our focus? What's the current status?

The life expectancy at birth gap between males and females in the Waitemata district has shown an improving trend over the last 15 years. The gap declined from approximately 5.8 years in 1997 to around 3 years in 2012 for our DHB population. Nationwide, there was an improvement from 5.5 years in 1996 to 3.6 years in 2012. Waitemata DHB has a smaller gap than many other DHBs. The improvement of the male-female gap was attributed to by all ethnic groups including Maori, Pacific and European/Other.



Impact measures:

- **Health Promotion and Health Policy/ Legislation Advocacy and Advice**

Measure	2011/12 Result	2012/13 Result	Direction required for improvement	Improvement
Proportion of controlled purchase operations in which alcohol or tobacco product sales are sold to minors	Alcohol: 6% Tobacco: 4%	1% 2%	↓	✓
Changes in draft legislation/regulation/ policy made in response to submissions	24	36	↑	✓

The year in review: Auckland Regional Public Health Service (ARPHS)

Concern over the effects of alcohol on our communities and particularly on our young people led to changes in the Sale of Liquor Act 1989. The new Act - The Sale and Supply of Alcohol Act 2012 - was passed on 18 December 2012. The new law comes into force at various times during 2013, so changes to current law (The Sale of Liquor Act 1989) are gradual. From 18 June 2013 there were new licensing criteria and changes to objections to licences. There are also changes to applying for a licence or manager's certificate. From 18 December 2013 the remainder of the new law comes into effect. Key changes include:

- increasing the ability of communities to have a say on local alcohol licensing matters
- allowing local-level decision-making for all licence applications
- requiring express consent of a parent or guardian before supplying alcohol to a minor
- requiring anyone who supplies alcohol to under 18-year-olds to do so responsibly
- strengthening the rules around the types of stores eligible to sell alcohol
- introducing maximum default trading hours for licensed premises
- restricting supermarket and grocery store alcohol displays to a single area.

Other areas which have required attention and input from ARPHS this year have been:

- the ongoing pertussis epidemic - whooping cough is common in New Zealand. We have an outbreak of the disease every three to five years. The most recent outbreak began in August 2011 and is still ongoing. Since the outbreak began, more than 8,800 cases of whooping cough have been reported
- public health input into the Auckland Council draft Unitary Plan.

Impact measures:

- **Population based screening**

Measure	2011/12 Result	2012/13 Result	Direction required for improvement	Improvement
Imputed years of life gained among Waitemata domiciled women through breast screening	15.73	22.5	↑	✓

The year in review: BreastScreen Aotearoa

Screening was on target in Rodney and Waitakere for 2012/13, and close to achieved with some lag in the North Shore area. Pacific screening rates continue to exceed the National Screening Unit (NSU) target and rates for Māori have been consistently improving and should reach the NSU target during 2013/14. We have taken the mobile screening unit to more sites in the Waitemata region to try to improve coverage – e.g. Northcote, Glenfield, New Lynn, Beachhaven, Sunnynook and Albany.

During 2012/2013 Medical Radiation Technologist shortages resulted in a lower than anticipated number of screens at the start of the reporting period. However, that situation was resolved. Reporting time for mammograms has remained above the National Screening Unit's target.

Measure	2011/12 Result	2012/13 Result	Direction required for improvement	Improvement
Imputed Quality Adjusted Life Years (QALYs) gained through bowel screening of Waitemata residents	50.36	114.43	↑	✓

The year in review: BowelScreening Pilot

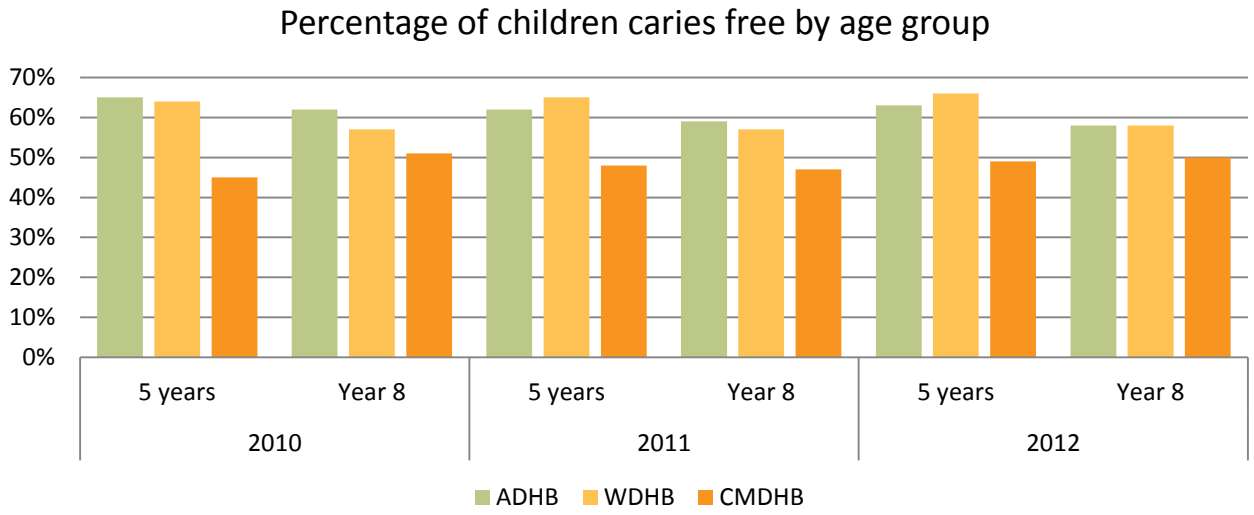
Waitemata DHB is the national screening pilot site for the Bowel Screening Pilot. Information collected in the first 15 months of the Pilot shows positive results. Between January 2012 and March 2013, 72,228 people were invited to take part in the pilot and 39,482 people returned a correctly completed kit that could be tested by the laboratory. This means that the average participation rate over this time was 55 percent. The New Zealand participation rate is already higher than the internationally acceptable minimum participation rate.

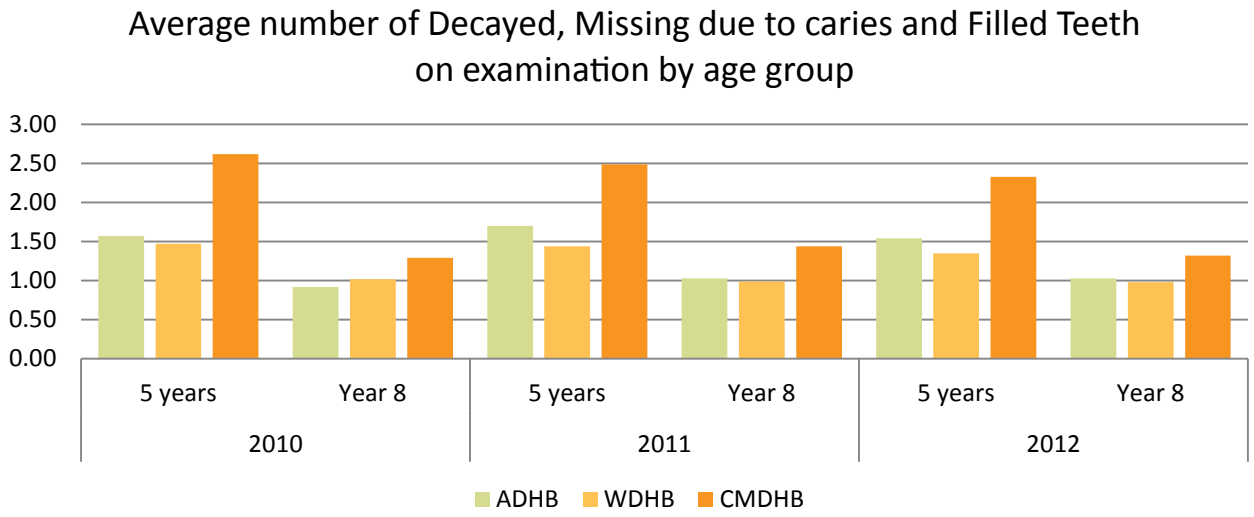
So far, Pacific people are less likely to take part in the programme than other population groups, and efforts to improve this continue. It also shows that for some people, the test kit is proving difficult to complete correctly on the first attempt. Work is underway to improve ease of comprehension of the instructions that go out with the kit.

Impact measures:

- **Oral Health**

Measure	2011	2012	Direction required for improvement	Improvement
Percentage of children caries free and average Decayed , Missing and Filled Teeth of year 8 children by ethnic group	Caries free: 57% DMFT*: 0.99	Caries free: 58% DMFT: 0.98	↑ ↓	✓ ✓
Percentage of children caries free and average decayed , missing and filled Teeth of 5-year-old children by ethnic group	Caries free: 65% DMFT: 1.44	Caries free: 66% DMFT: 1.35	↑ ↓	✓ ✓



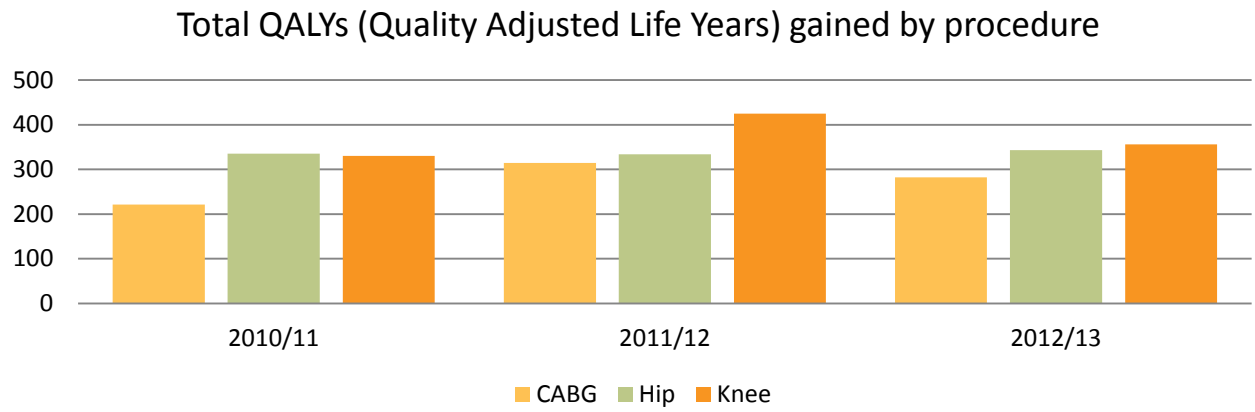


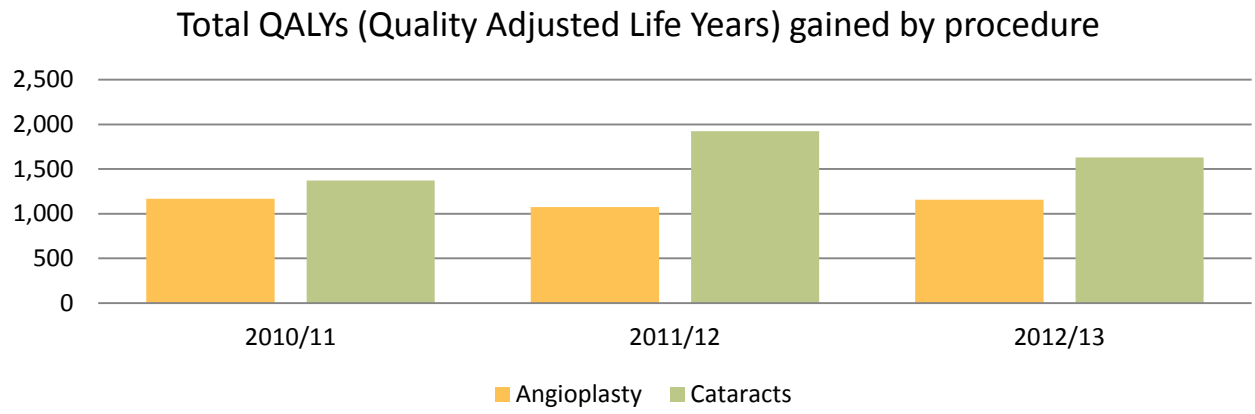
Note: oral health impact measures are only available by calendar year.
* DMFT = decayed, missing, filled teeth

Impact measures:

- **Electives (inpatient/ outpatient)**

Measure	2011/12 Result	2012/13 Result	Direction required for improvement	Improvement
Total QALYs* (Quality Adjusted Life Years) gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows:				
Hip replacement (primary) = 0.85	334	343	↑	✓
Hip replacement (revision) = 0.15	8	11	↑	✓
Knee replacement (primary) = 0.8	425	356	↑	✗
Cataract = 1.1	1,924	1,630	↑	✗
CABG = 1.3	315	282	N/A	
PCI = 1.64	1,073	1,158	↑	✓





* A widely used measure of the impact of medical interventions is the Quality Adjusted Life Year (QALY). The QALYs gained from each of these procedures has been estimated in a number of studies published in the international literature. If we assume that the average number of QALYs gained by our patients are similar to those estimated in these studies, then we can impute the impact of these services in terms of QALYs gained, and monitor this over time.

The year in review: Elective Surgical Services

Located at the North Shore Hospital site, the new Elective Surgical Centre (ESC) opened in July 2013 this year - a dedicated facility for elective surgical procedures. It is expected to perform nearly 6,000 operations a year across a range of specialties. The aim of the ESC is to be the most effective, high quality surgical centre in the public or private sector. We again achieved the 'Improved access to elective surgery' health target, performing 15,966 elective surgeries over the year. Our elective surgical intervention rates are above target for all categories – we are performing the right level of surgery to meet the needs of our population. As well as this, by year end none of our patients were waiting more than 5 months to be seen by a specialist for the first time or for their elective surgical procedure. We have improved productivity and utilisation of theatre resources at North Shore Hospital and redesigned the nursing model of care on the surgical inpatient wards and outpatients. With a focus on quality and safety, hand hygiene results have improved markedly and surgical infection rates declined.

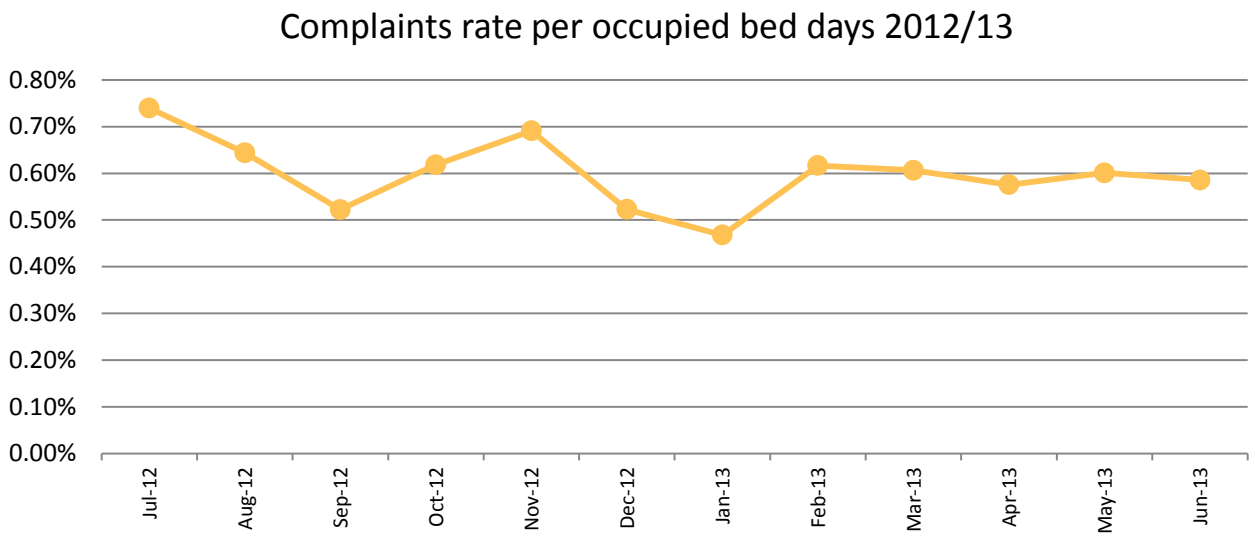
Improved Patient Safety and Experience

Our DHB's values are built around our commitment to offer the 'best care for everyone' – this means we strive to offer the best care we can to every person and their family receiving our services. Thus, the quality of a patient's experience during their contact with the health system is considered a fundamental outcome in its own right. We have also included patient safety in this outcome area as we see the perception of safety from the patient's perspective as part of this 'responsiveness' outcome ie impacting their confidence in the health system, while recognising that patient safety is also attributed to population health gain as it contributes to positive outcomes for patients extending the length and quality of their lives.

During 2012/13 Waitemata DHB commissioned Professor Ron Patterson - the former Health and Disability Commissioner and leading health quality and safety expert – to undertake an extensive review of all of its quality systems and processes. This is the first time such a review has ever been undertaken by a DHB. Professor Ron Paterson's report was released in May 2013. As a result of this report, an action plan has been developed and this is being rolled out over 2013/14.

There is now no Ministry of Health requirement to report on overall patient satisfaction and this survey was therefore discontinued at Waitemata DHB at the end of 2011/12. However, as part of Professor Paterson's recommendations, the DHB has recently implemented a new survey – the Friends and Family Test (Would you recommend this service to friends and family? Why/why not?). This information will be used to help us improve the care we deliver and thus the quality of our patients' experience.

A useful measure of patient concerns is patient complaints. The graph below shows that the rate of complaints per occupied bed days submitted to the DHB over the course of 2012/13 generally declined over the year. The appointment of Quality Assurance Leads (in the Quality Assurance Team) has helped services respond to complex complaints and prevent slippage in the time taken to resolve them. Professor Paterson's assessment found that our complaint process generally works well and that the approach taken at Waitemata is generally consumer-centred and responsive to the issues raised. There is a marked willingness to accept that something has gone wrong from the consumer's perspective and apologise. Key to this has been a clear message from the CEO and Chair that complaints need to be taken seriously and that responding promptly and helpfully to complaints is a priority. Professor Paterson noted that the complaint rate is of interest because a high rate may suggest that a DHB is doing a poor job in resolving complaints made directly to it, or in publicising its own complaint process to complainants. He concluded that there is no evidence of either at Waitemata DHB.



The Health Quality and Safety Commission has recently introduced a set of quality and safety markers (QSMs) for DHBs to help evaluate improvement in the safety and quality of New Zealand's health care driven through the national patient safety campaign 'Open for better care'. Measurement of these markers will determine whether the desired changes in practice and reductions in harm and cost have occurred.

The QSMs are sets of related indicators concentrating on the four areas of harm covered by the campaign:

- healthcare associated infections (hand hygiene and central line associated bacteraemia)
- surgery
- medication
- falls.

The markers chosen are processes that should be undertaken nearly all the time, so the threshold is set at 90 percent in most cases. The markers set the following thresholds for DHBs' use of interventions and practices known to reduce patient harm:

- 70 percent compliance with good hand hygiene practice
- 90 percent compliance with procedures for inserting central line catheters
- 90 percent of older patients are given a falls risk assessment
- All three parts of the WHO surgical safety checklist used in 90 percent of operations.

The tables below show baseline information for each of the markers, as published by the Health Quality and Safety Commission.

Hand hygiene: Are we doing the right things? Percentage of compliant moments of hand hygiene

	2012 Q4	2013 Q1
Waitemata	62	73
Other DHB's	**2012 Q4**	**2013 Q1**
Auckland	70	75
Whanganui	70	74
Tairawhiti	74	73
Northland	77	73
MidCentral	65	72
Counties Manukau	59	70
Wairarapa	71	68
West Coast	66	66
Canterbury	60	65
Hawke's Bay	54	65
Taranaki	65	64
Lakes	62	64
Hutt Valley	47	62
Capital and Coast	60	62
Southern	63	62
Waikato	67	60
Bay of Plenty	43	59
Nelson Marlborough	50	55
South Canterbury	60	54

Green indicates DHB staff were observed to comply with WHO hand hygiene practice at least 70 percent of the time. Grey indicates this occurring 60–70 percent of the time. Deepening shades of red indicate lower percentages. Data are courtesy of Hand Hygiene New Zealand. Further details of the audit can be found on the Hand Hygiene New Zealand website. Note, quarter dates refer to the quarter in which the audit period finished. Thus Q4 2012 ran from July to October 2012 and Q1 2013 from November 2012 to March 2013.

Our DHB has achieved an outstanding result in hand hygiene compliance – improving steadily each quarter and achieving the third place in the country for quarter one of 2012/13. The last audit, conducted in June 2013, showed a result of 74%.

Central Line Associated Bacteraemia (CLAB): Are we doing the right things? Percentage of occasions insertion bundle used, by quarter 2012

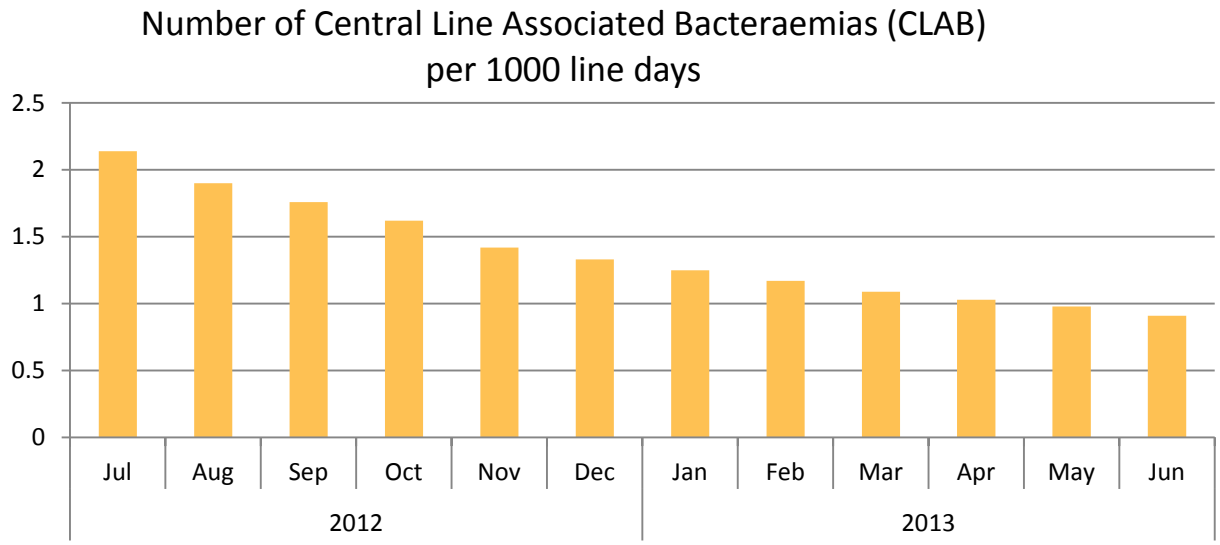
Level	Team	DHB	Q1	Q2	Q3	Q4
2&3	**North Shore**	**Waitemata**	95	95	95	91

Level	Team	DHB	Q1	Q2	Q3	Q4
1	Wanganui	Whanganui		100	91	94
	Gisborne	Tairawhiti	53	100	97	92
	Grey Base	West Coast	100	100	100	91
	Tauranga	Bay of Plenty	100	87	100	91
	Whakatane	Bay of Plenty	75	83	82	89
	Nelson	Nelson Marlborough	65	72	75	87
	Hutt	Hutt Valley	20	57	92	81
2&3	Hawke's Bay	Hawke's Bay	0	26	98	100
	Waikato	Waikato	33	73	83	100
	Wellington	Capital and Coast		100	99	100
	PICU	Auckland	95	89	91	99
	Middlemore	Counties Manukau	93	90	96	98
	Taranaki Base	Taranaki		67	71	94
	North Shore	Waitemata	95	95	95	91
	DCCM	Auckland	95	95	87	91
	Christchurch	Canterbury		85	80	82
	Palmerston North	MidCentral	83	92	78	82
	Whangarei	Northland		59	70	82
	Dunedin	Southern		84	82	72
	CVICU	Auckland	94	85	75	68
	Rotorua	Lakes	8	13	62	10

Green indicates the DHB used the insertion bundle to reduce the risk of CLAB 90 percent of the time in the quarter under review. White indicates this occurred 70–90 percent of the time. Deepening shades of red indicate lower percentages. Data are courtesy of the Target CLAB Zero collaborative and have been aggregated from monthly to quarterly for ease of use. Data apply to insertion of lines in ICUs/high dependency units (HDUs). Data are unavailable for Wairarapa and South Canterbury DHBs. In both cases, insertion of central lines rarely take place in the HDU, hence the lack of data for this measure.

An insertion bundle is a set of five steps to help prevent "catheter-related blood stream infections," harmful bacterial infections that can be introduced through an IV in a patient's vein supplying food, medications, blood or fluid. The steps are simple, common sense tasks: using proper hygiene and sterile contact barriers; properly cleaning the patient's skin; finding the best vein possible for the IV; checking every day for infection; and removing or changing the line only when needed.

We have consistently met this target through the entire reporting period, being one of only two DHBs in the country to achieve this and our rate of CLAB continues to decline (see graph below). The Intensive Care Unit was 605 days CLAB free as at 31 August 2013. This is an excellent result and the target of <1 central line infection per 1,000 line days has now been achieved. Roll-out of CLAB prevention continues.



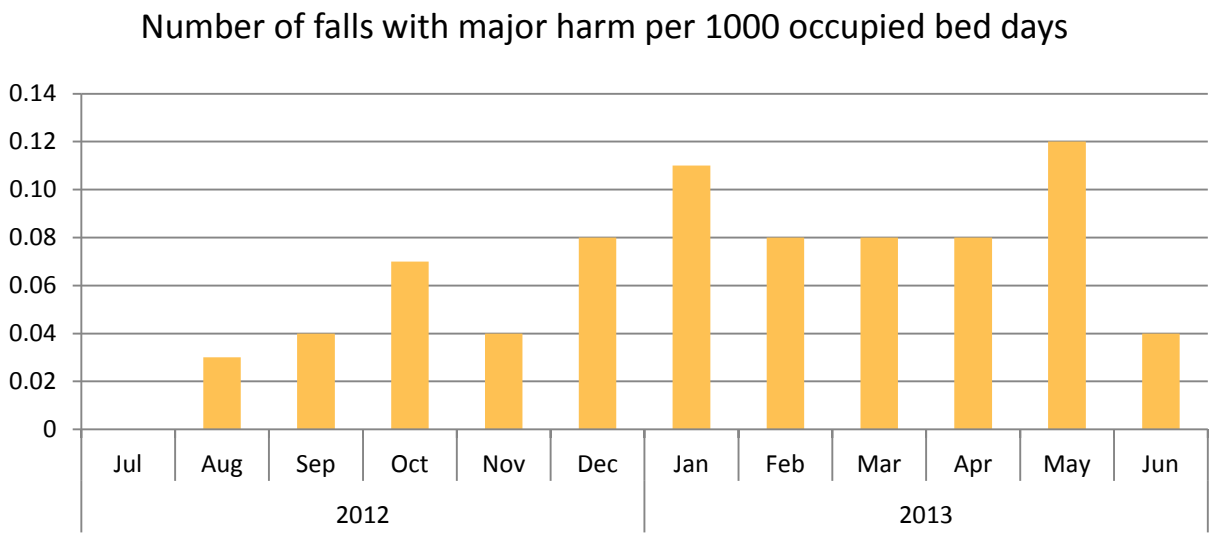
Falls: Are we doing the right things? Percentage of older patients assessed for the risk of falling

Waitemata	64
Other DHB's	
Counties Manukau	98
Canterbury	97
Waikato	96
South Canterbury	91
Taranaki	91
Southern	86
Hawke's Bay	86
Nelson Marlborough	80
Whanganui	79
MidCentral	78
Lakes	77
Northland	73
Auckland	73
Wairarapa	71
Tairawhiti	65
Hutt Valley	63
Capital and Coast	53
West Coast	53
Bay of Plenty	43

This table shows the result of the baseline audit for the risk assessments provided for patients aged 75 and over (or 55 and over if Māori or Pacific peoples). Green indicates 90 percent or more of those audited received a falls risk assessment; grey indicates 75–90 percent received an assessment; progressively deeper red identifies lower proportions.

The need to address our fall rates led to the development of a two phase Falls Prevention quality improvement project that was implemented over the course of 2012/13. Phase I is almost complete – the final component being to place patient information posters above every ward bed. Phase II – 'Zero Falls with Harm' has commenced and aims to reduce the rate of falls with major harm (SAC 1&2 events) in high risk patients (aged 70 and over; 55yrs and over for Maori and Pacific). The Phase II project is currently trialling:

- A new assessment process to be completed in ED & ADU covering falls, delirium, moving and handling, and pressure injuries
- A modified falls assessment tool for use on the wards, which includes an expanded care plan
- A new falls-specific quality board for the pilot wards, including posters, maps, time between falls, falls by time of day
- A new falls incident review process to improve post falls care and identify root causes
- A modified risk identification report to record key information



Perioperative harm: Are we doing the right things? Percentage of operations where all three parts of the surgical checklist are used

Waitemata	80
Other DHB's	
Capital and Coast	97
MidCentral	96
Bay of Plenty	94
Taranaki	92
South Canterbury	91
Nelson Marlborough	90
Counties Manukau	86
West Coast	84
Lakes	81
Whanganui	79
Tairawhiti	78
Wairarapa	73
Northland	70
Auckland	61
Hutt Valley	59
Canterbury	40
Hawke's Bay	34
Waikato	34

The table (page before) shows the result of the baseline audit for use of the surgical safety checklist. Green indicates that all three parts of the checklist were used in 90 percent or more of the cases audited; grey indicates use 75–90 percent of the time; progressively deeper red identifies lower proportions.

*Southern DHB is excluded from this list because it is able to show the position for Southland Hospital (where use is recorded as 100 percent) but not for Dunedin Hospital for use of all three parts of the checklist.

Our Surgical Safety Checklist (SSC) project team have completed a process map of the checklist process from picking up to form completion and identified the inconsistencies and barriers. Following the process mapping the project team are now undertaking a clinical practice audit to identify the part each member of the surgical team plays in completing the SSC. Currently a daily audit is carried out on 10 Charts and compliance is recorded - results indicate an improving trend. The audit has recently been expanded to include venous thromboembolism (VTE) risk assessment.

Impact measures:

- **Improved Patient Safety and Experience**

Measure	July 2012 Result	June 2013 Result	Direction required for improvement	Improvement
Lower the incidence of central line associated bacteraemia (number of central line associated bacteraemia infections per 1000 line days)	2.14	0.91	↓	✓
% reduction in incidence of catheter associated urinary tract infections (per 1,000 catheter days)	Medical: 17	16.8		✓
	Surgical: 7.1	unavailable	↓	unavailable
	Rehab: 15.6 (July 2012 audit)	18.4		✗
% reduction in falls resulting in major harm (number of falls with major harm per 1000 occupied bed days)	0.04 (June 2012)	0.04	↓	~

Improved Financial Sustainability

Waitemata DHB has lived within its means for the past five years. We will continue to ensure we remain a sustainable organisation which manages its resources efficiently and achieves a $1M surplus for 2013/14 and 2014/15 and a breakeven position for 2015/16. Thereby reducing the level of demand for additional funding by the DHB and the financial contribution by the community to the health system either directly through co-payments or indirectly through taxes.

2011/12 Audited $000	2012/13 Audited $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
$5,009	$5,996	$1,000	$1,000	$0

Impact measures:

- **Improved Sustainability**

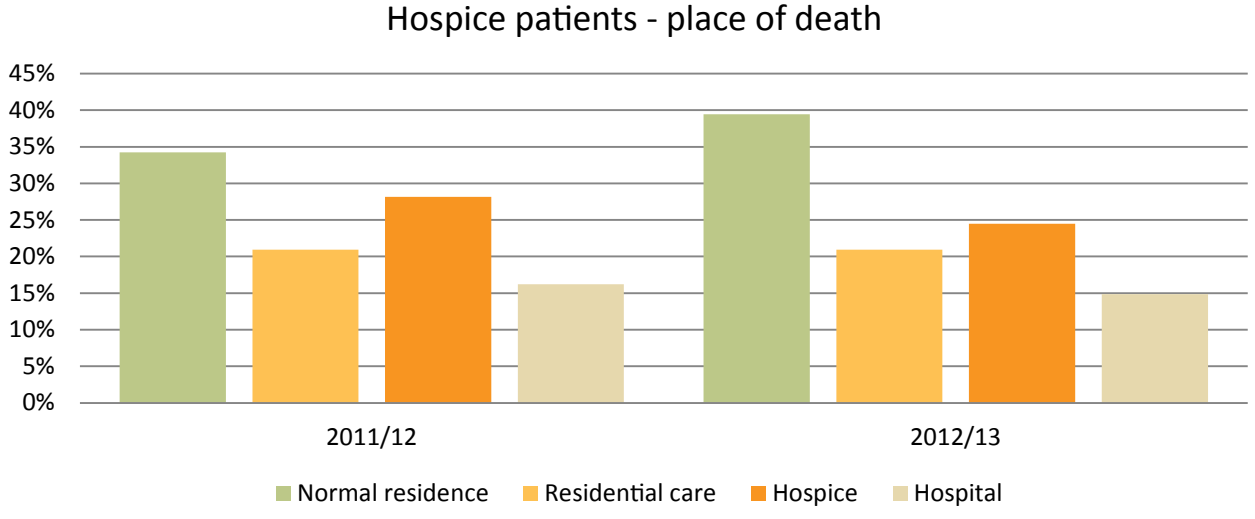
Measure	July 2012 Result	June 2013 Result	Direction required for improvement	Improvement
Proportion of NASC referrals assessed to have high or very high needs who reside in their own home	36%	39.2%	↑	✓
Proportion of deaths from palliative conditions occurring in hospitals versus at home (hospice patients)	34% at normal residence 16% in hospital	39% at normal residence 15% in hospital	↑ at normal residence	✓

The year in review: Palliative Care

We fund community based hospice services to care for people at home. This includes end-of-life care. Admission to a hospice inpatient unit is one option and usually used for pain and symptom control and end-of-life care when the patient is unable to be supported at home. Increasingly patients are being supported to die at their usual residence with a corresponding drop off in deaths in hospital settings.

Service models have been further developed over the past year. Hibiscus Hospice increased the number of outpatient visits provided at their hospice inviting people to come to the hospice for care. Home visits continued to be delivered for patients and/or family. West Auckland Hospice continued to develop their team model with increased collaboration between their nursing and social support teams.

High demand for palliative care inpatient hospice beds has meant that occupancy is sitting above 85%. Only 14% of people needing an urgent bed stay waited more than 48 hours for their admission compared to 18% for the previous year. This information shows that more people are receiving urgent care with their length of stay reflective of the level of care required. The hospices work to get people home as soon as possible to avoid additional stress on the patient and their family.



Output Class measures

The following tables include our output measures from the 2012/13 Statement of Service Performance by Output Class.

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A (not applicable). Output measures are intended to reflect our performance over the year.

Prevention Services

Preventative services are publicly funded services that protect and promote the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. This includes: health promotion to ensure that illness is prevented and inequalities are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases, and population health protection services such as immunisation and screening services.

The year in review: B4 School Checks (B4SC)

Waitemata DHB had not been making progress against B4SC targets for a considerable period of time. A competitive tender process to select a provider for the Waitemata DHB B4 School Check programme was undertaken which resulted in Plunket as the new preferred provider.

The Agreement with Waitemata PHO ended on the 3 May 2013 and the Agreement with Plunket commenced on 1 May 2013.

Service delivery for Plunket was initially focused on children who had completed one component of the Check, were high needs and/or children aged between 4 years 10 months and 5 years.

The vision and hearing team (VHT) have been recalling children who have completed the nurse component of the check, to be seen in clinic as well as continuing to visit preschools aligned to their usual schedule.

The changes have resulted in a more aligned service with a greater number of checks being completed in the first three months of the financial year than in any other year of service delivery of the programme. Joint home visiting of VHT and Plunket has recently commenced and extra clinics were undertaken over the school holidays where 72 children were seen by both VHT and Plunket.

The change in provider has also allowed us to have a greater focus on the quality of the check being provided. A B4SC quality plan has been developed that aligns with the Ministry of Health Well Child/ Tamariki Ora Quality Improvement Framework as well as focusing on Waitemata specific indicators.

Sub-Output Class:

- **Health Protection**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement
Number of outbreaks investigated	1,484	3	225	N/A	
Number of contacts traced in relation to CDC cases	1,166	1,221	771	N/A	
Communicable disease protocols up-to-date	100%	100%	100%	100%	Achieved
Communicable disease protocols adhered to	100%	100%	100%	100%	Achieved
Number of investigations in relation to built environments	42	Unavailable	101	N/A	
Proportion of Hazardous Substances and New Organisms (HSNO) events responded to appropriately	100%	100%	100%	100%	Achieved
Proportion of public health risk management plan (PHRMPs) reports submitted to the water supplier within 20 working days	100%	100%	100%	100%	Achieved
Number of emergency response exercises participated in	5	5	6	N/A	
Number of emergencies responded to	5	3	0	N/A	
Emergency Plan up-to-date	Yes	Yes	Yes	Yes	Achieved
Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border	100%	100%	100%	100%	Achieved

Impact Measure	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
Percentage of outbreaks investigated (note: SoI states 'number', but percentage is more meaningful to measure impact)	45%	100%	↑	✓
Number of environmental hazards detected	12	Not collected by Auckland Regional Public Health Service – 101 public notifications	N/A	N/A

Evaluation reports and inquiries into emergency responses to show adherence to best practice. Full assessment completed based on debrief feedback from major incidents/exercises 2009-2012. Feedback used to advise ongoing work-plan. Debriefs held for major incidents/exercises. This work helps inform and improve practice around emergency response. These were mainly:

- debrief standard operating procedure developed and rolled out
- full report completed with summary assessment of debrief content from 2009-2012
- hepatitis A debrief held
- pertussis debrief held
- debrief report developed for regional Exercise Barrier 2012
- debrief report developed for interagency Auckland Airport Ill Traveller "War Game" 2012
- feedback to regional and national documents/projects (including Auckland Civil Defence plans, Auckland DHB Legionella incident, national CIMS review and DHB OPF 2013/14 draft) based on analysis of national reviews into Christchurch Earthquakes, MV Rena and Pike River incidents.

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Sub-Output Class:

- **Health Promotion**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement
Number of liquor licence applications processed by ARPHS and all problematic premises that receive a compliance check	82%	100%	96% (1,235 applications processed)	100%	Substantially achieved
Alcohol compliance protocols are adhered to when site visits are carried out	97%	100%	97%	100%	Substantially achieved
Proportion of liquor licensing applications processed within 15 days	100%	100%	100%	100%	Achieved
Proportion of tobacco complaints responded to within five (5) days	100%	100%	100%	100%	Achieved

Sub-Output Class:

- **Health Policy/ Legislation Advocacy and Advice**

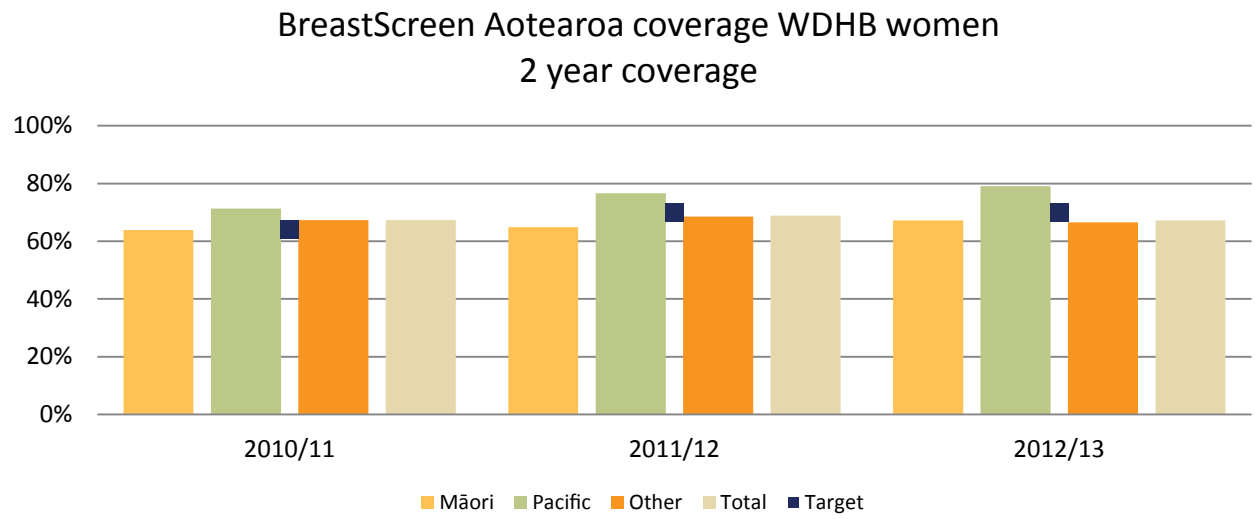
Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement
Numbers of submissions made	12	24	27	N/A	
Submissions policy adhered to	100%	100%	100%	100%	Achieved
Submission documents submitted by deadline	100%	100%	96.3%	100%	Substantially achieved

Sub-Output Class:

- **Population Based Breastscreening**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Breastscreening coverage rates among eligible groups: breast cancer	67.3%	68.9%	67.2%	70%	Substantially achieved	24 months to end of June 2013 Note: coverage is calculated over 2 years.
Proportion of women screened who report that their privacy was respected	97.5%	99%	99%	95%	Achieved	
Proportion of women screened who receive their results within 10 working days	98.3%	96%	97.7%	90-95%	Achieved	

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.



Sub-Output Class:

- **Population Based Bowel Screening Pilot**

Output Measures	Baseline	2012	Target	Achievement	Comments
Proportion of eligible population sent an invitation letter each two year screening cycle	New measure	100%	95%	Achieved	For invitations sent out between January-December 2012. Note: should be measured over two years, so half of population used as denominator for year 1 calculation
Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations (assessed via patient satisfaction survey)	New measure	98%	95%	Achieved	Customer satisfaction survey undertaken annually – completed May 2013. Result relates to those who rated the information given to them to prepare them for their colonoscopy as 'good' or 'very good'. 200 surveys were sent, 138 were returned. 5 people did not answer this question.
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 50 working days	New measure	86.6%	95%	Substantially achieved	

Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various settings. Including general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist and preventative, usually accessible from multiple health providers and from a number of different locations within the DHB. Ensuring good access to early detection and management services for all population groups allows for prompt diagnosis of acute and chronic conditions and management and cure of treatable conditions.

Sub-Output Class:

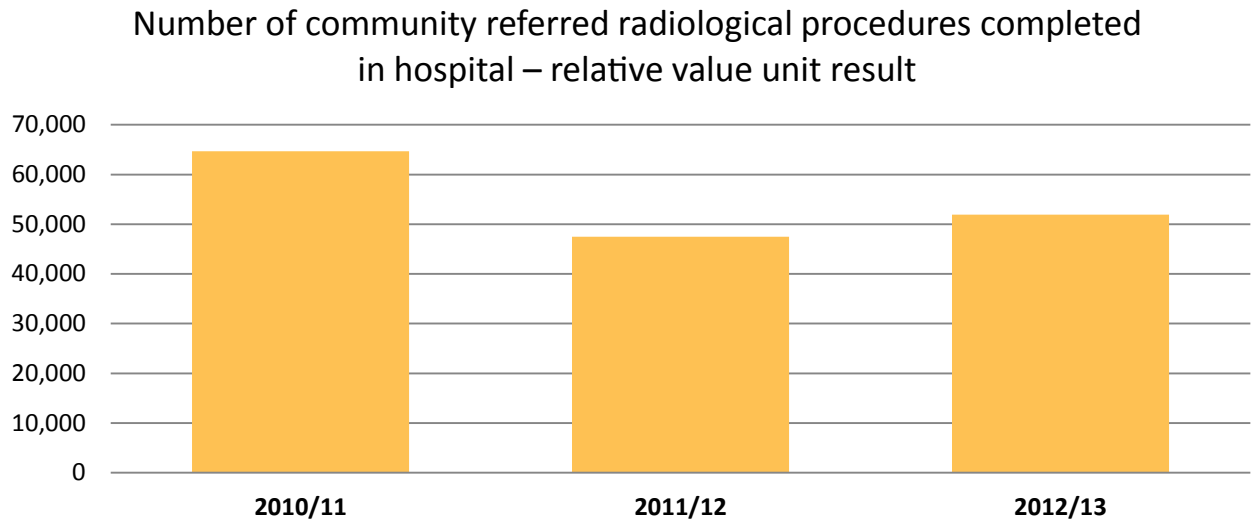
- **Community Referred Testing and Diagnostics**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Number laboratory tests by provider - DML	355,593	352,844	365,174	N/A		12 months rolling average to March 2013 - full 2012/13 year not yet available, some volumes missing from LTA numbers
Number laboratory tests by provider - LTA	2,825,695	3,027,520	3,068,451	N/A		
Number radiological procedures referred by GPs to hospital – relative value unit result	48,839	47,496 ⌘	51,921	N/A		Relates to Purchase Unit Code: CS01001
Complaints as percentage of total no. of laboratory tests	0.002%	0.002%	0.001%	↓	Achieved	
Average waiting time in minutes for a sample of patients attending Waitemata DHB collection centres between 7am and 11am (peak collection time)	9.15 mins	7 mins	7 mins	< 30 mins	Achieved	Sample taken from 29/04/13 – 31/05/13
75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013	57%	66% ⌘	48%	75%	Not achieved	The Ministry of Health has announced an initiative to clear wait list backlogs to support 6 week wait time indicator achievement. Additional funding will be made available this year to either outsource MR and CT scans waiting longer than six weeks or fund overtime in-house sessions. Work also began during the year on a new MRI suite for the DHB, which will house a new state of the art MRI scanner, enabling faster, more detailed medical scanning. The new scanner will improve Waitemata DHB performance against this measure

Impact Measures	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
The percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years	84% (as at 31 March 2012 – no later results were made available from the Ministry of Health)	85%	↑	✓
Proportion of patients attending First Specialist Appointments for back pain who have already had MRI imaging	New measure	unavailable	↑	N/A

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

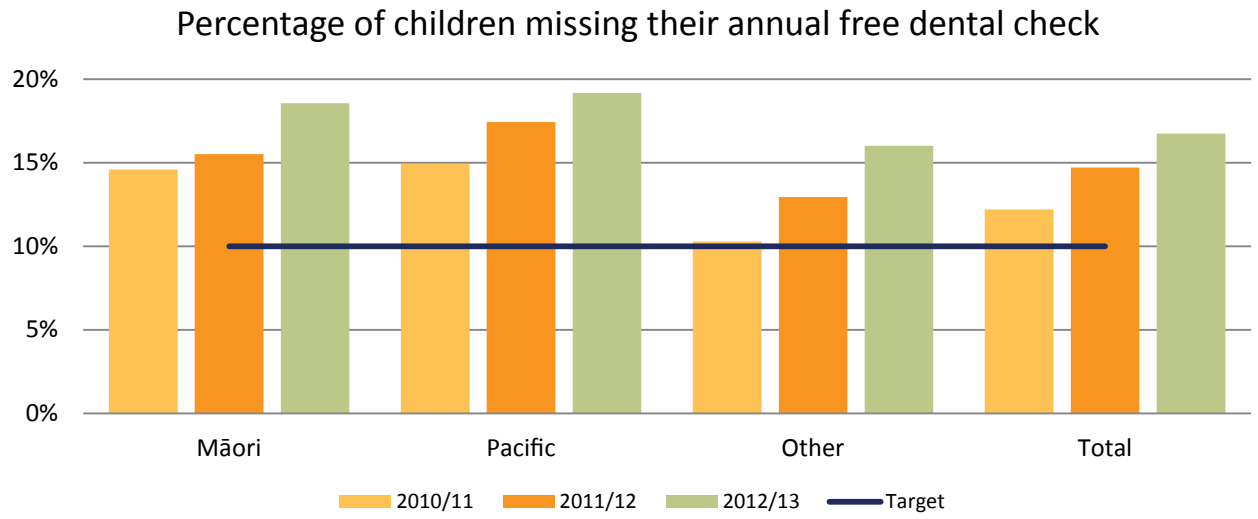

Number of community referred radiological procedures completed in hospital – relative value unit result
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
2010/11
2011/12
2012/13

Sub-Output Class:

- **Oral Health**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Enrolment numbers of children under five by ethnicity:						
Māori	4,525					
Pacific	3,158					
Other	20,413					
Total population	**28,096**	29,250	30,554	28,882	Achieved	
Utilisation rates for adolescents	65.70% (combined ADHB/WDHB result)	61%	64.2%	65%	Substantially achieved	The combined Auckland/ Waitemata result would be 72% against a combined target of about 70%.
Number of visits of preschool, and school children to oral health services (including adolescents)	14,170 (incorrect baseline – figure for preschool only)	113,232	111,016	N/A		
Number of complaints for the financial year	10	15	16	↓	Not achieved	There has been some disruption to services resulting from the roll-out of new dental facilities and models of care in the district which has impacted on arrears rates and complaints. Several strategies to improve performance have been implemented including a stratified recall period which recognises risk, a production plan for chair utilisation and extended opening hours for some clinics.
Arrears rates by ethnicity:						
Māori	16.6%		18.56%		Not achieved	
Pacific	19.9%		19.18%			
Other	12.2%		16.02%			
Total population	13.7%	15%	16.75%	7%		

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.



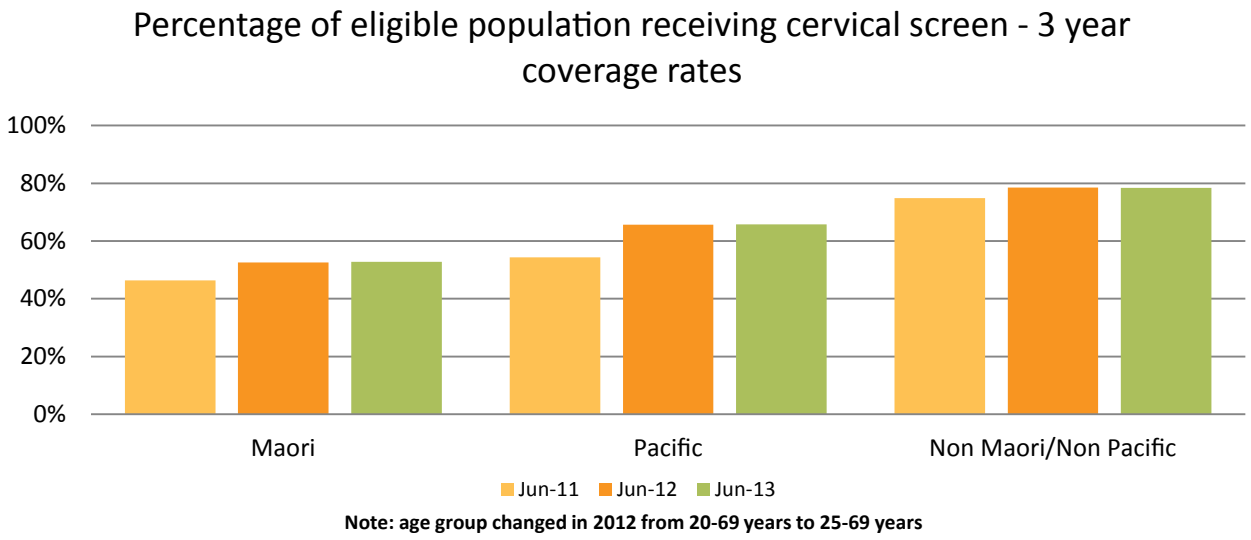
Sub-Output Class:

- **Primary Health Care**

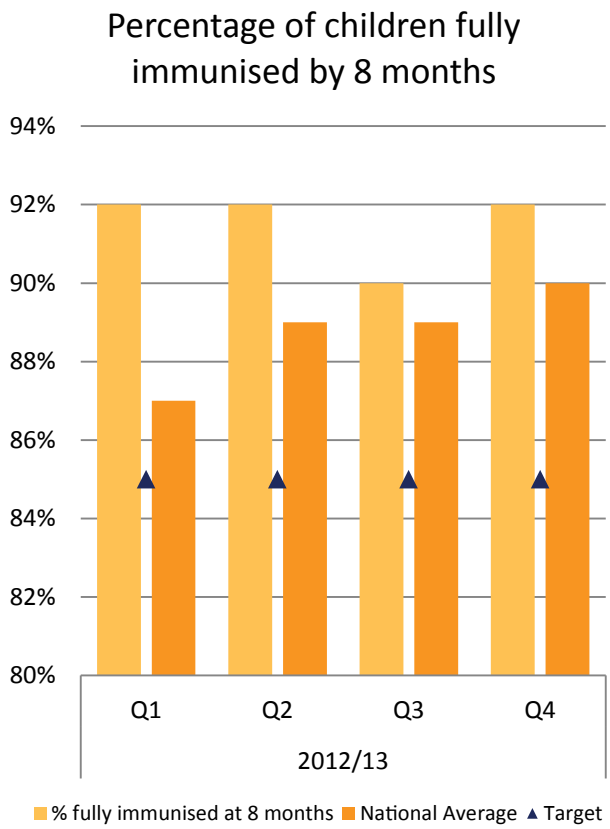
Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Primary care enrolment rates	94%	94%	95%	95%	Achieved	Results measured at Q4 of respective year.
Immunisation health target achievement – 85% of eight month olds fully immunised by July 2013	New measure	unavailable	92%	85%	Achieved	Health Target
Cervical screening coverage for eligible women (25-69 years)	73.9%	73.3%	75.5%	75%	Achieved	All eligible women screened by the programme in the past 36 months as at 30 June 2013.
Percentage of B4 School Checks completed (overall coverage)	31%	91% (Q4 2011/12 result)	68% (Q4 2012/13 result)	80%	Partly achieved	Refer to page 30
Proportion of practices with cornerstone accreditation	54%	57%	58%	↑	Achieved	RNZCGP website for accredited practices
Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	33%	33% (Q4 2011/12 result)	42.6% (Q4 2012/13 result)	90%	Not achieved	Health Target PHO Smoke Free teams have initiated a number of activities to improve performance of this indicator, including phoning smokers to offer advice, staff training and data accuracy investigation
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	54.4%	56%	71.4%	75%	Substantially achieved	Health Target
GMS claims from after-hours providers per 10,000 of population	426/ 10,000	413/ 10,000	441/ 10,000	N/A		Note: result is for 2012 calendar year (data not yet available for 2012/13 year).

Impact Measures	2011/12 Result			2012/13 Result			Direction required for Improvement	Improvement
Standardised acute:	ADHB	WDHB	CMDHB	ADHB	WDHB	CMDHB		
discharge rate	1.02	1.05	0.86	1.09	1.09	1.08	↓	✗
case-weights	1.10	0.97	1.12	1.20	1.03	1.02	↑	✓
trend and benchmarked against other DHBs								

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.



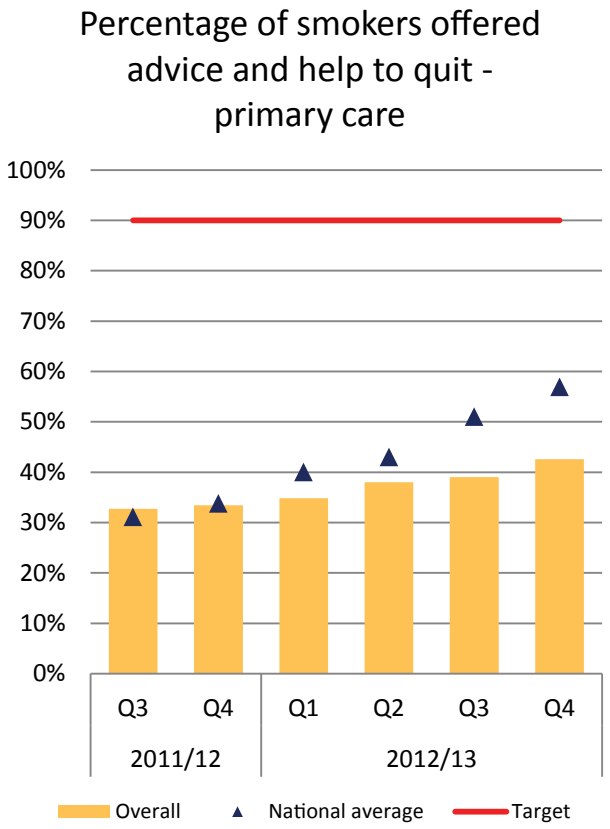
Note: age group changed in 2012 from 20-69 years to 25-69 years



Target: 85% Achieved

Result: 92%

We have consistently exceeded the 8 month immunisation target all year, as well as being above the national average every quarter. Note: the 8 month target is new for 2012/13 – previously the health target measured immunisation coverage for 2 year olds.



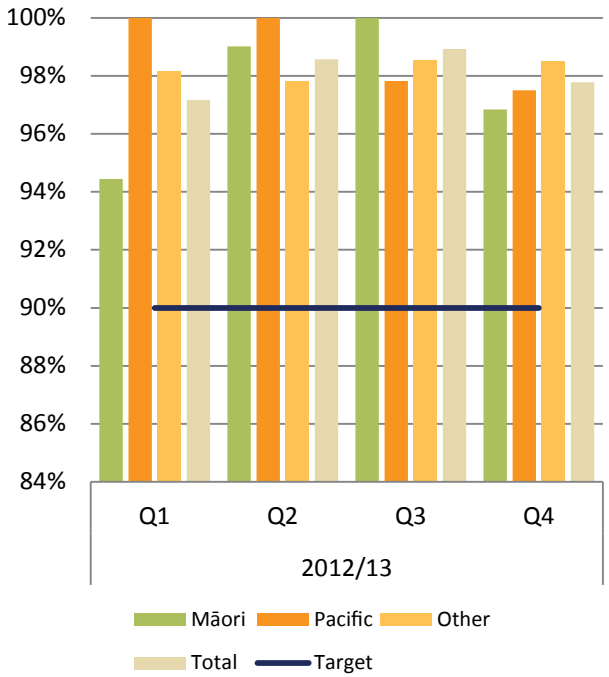
Target: 90% Not achieved

Result: 42.6%

PHO Smoke Free teams have initiated a number of activities to improve performance of this indicator, including phoning smokers to offer advice, staff training and data accuracy investigation.

Note: Waitemata DHB does not have access to practice level data to verify performance. The Ministry of Health provides oversight of data and results.

Percentage of smokers offered advice and help to quit - pregnant women



Note: this indicator was not used until Q3 of 2011/12

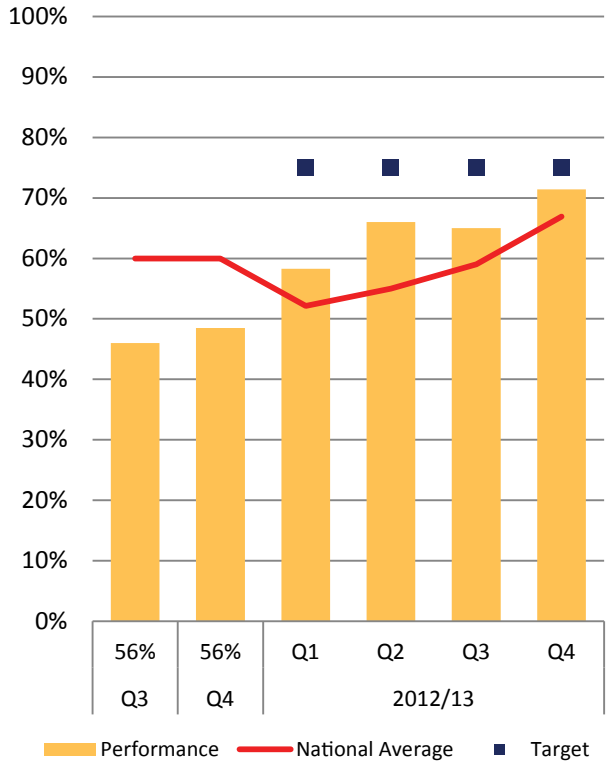
Target: 90% Achieved

Result: 97.78% (Q4)

Results for all ethnic categories are well above target for each quarter of the past financial year – almost all pregnant women in our district who smoke are being given advice and help to quit smoking to improve outcomes for their newborns.

Note: while there is currently no Ministry of Health requirement to report this data, we have set up a system which allows us to do so.

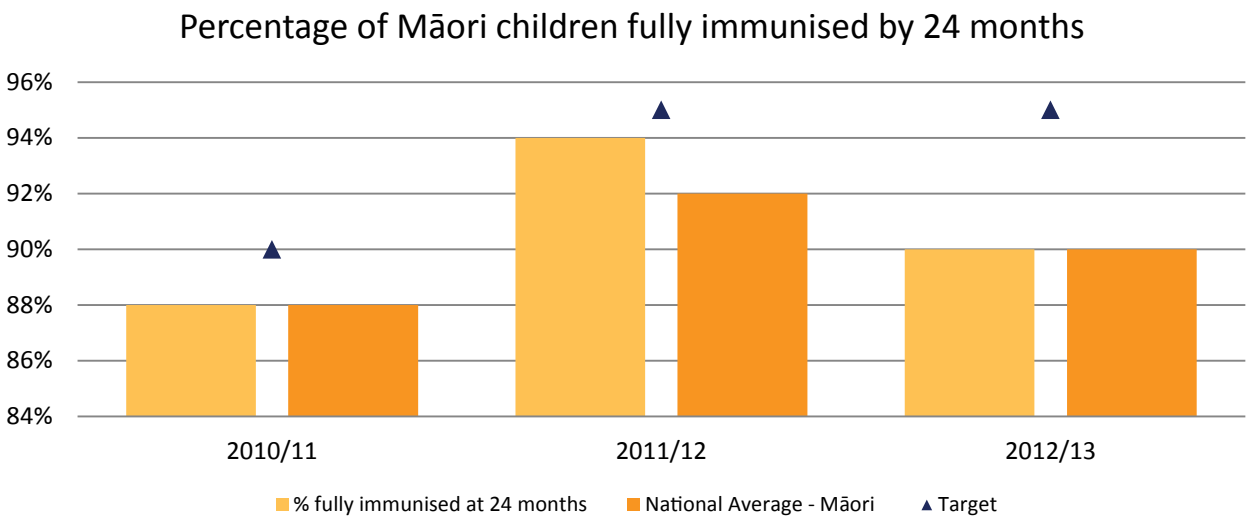
More Heart and Diabetes Checks

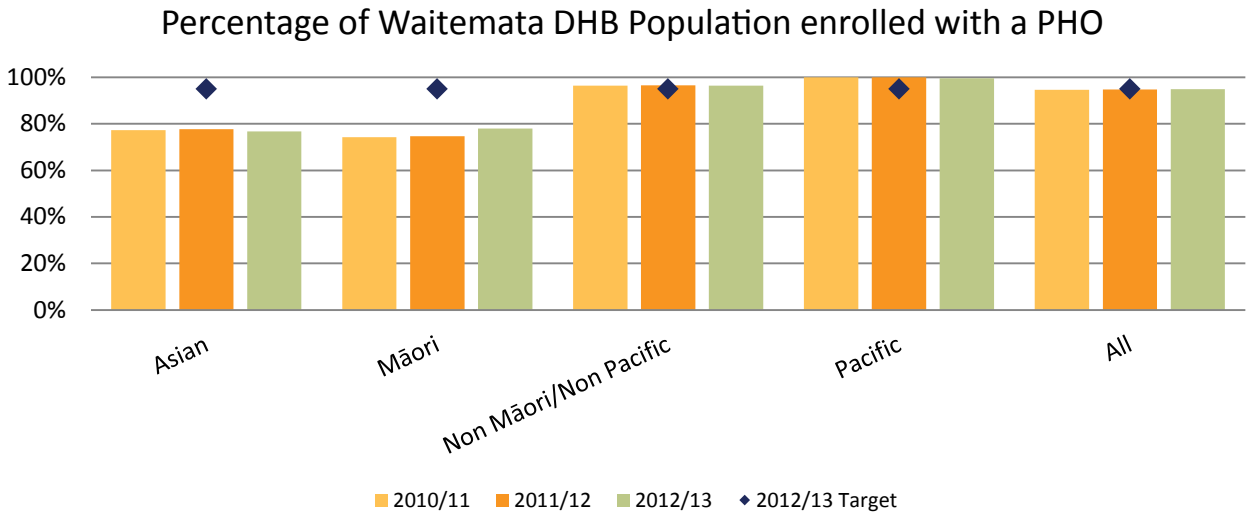


Target: 75% Substantially achieved

Result: 71.4%

A number of strategies and tools have helped to vastly improve the performance against this target over time: PHO Service Agreements ensure general practice have the tools, support and skills to complete assessments. This includes the management and reporting of activity. Weekly reporting and meeting with PHO management to discuss progress now occurs. The DHB is now undertaking inpatient and staff assessments to improve performance. Additional investment was made in quarter four to increase general practice assessments through a range of tools including completion of assessments in practice by agency staff.


Percentage of Māori children fully immunised by 24 months
96%
94%
92%
90%
88%
86%
84%
2010/11
2011/12
2012/13
% fully immunised at 24 months
National Average - Māori
Target


Percentage of Waitemata DHB Population enrolled with a PHO
100%
80%
60%
40%
20%
0%
Asian
Māori
Non Māori/Non Pacific
Pacific
All
2010/11
2011/12
2012/13
2012/13 Target

Sub-Output Class:

- **Pharmacy**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Total value of subsidy provided	$111,263,567	$118,001,495 ⌘	$110,094,642	N/A		Decrease in value of subsidy (from baseline to 2012/13) attributable to a patient co-payment increase in Jan 2013 and reduced drug costs over the period. Value of subsidy is gross reimbursement cost (excl of rebate adjustments).
Number of prescriptions subsidised	6,158,637	6,468,103	6,430,920	N/A		
Number of Medicine Use Reviews (MURs) conducted by community pharmacy	145	175	139	↑	Substantially achieved	There are now less MUR contracts in place, but with little reduction in numbers.
Proportion of prescriptions with a valid NHI number	97%	97%	97.3%	100%	Substantially achieved	
The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	94%	94% ⌘	94%	90%	Achieved	

Impact Measures	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge	81%	Data not yet available	↑	N/A

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

Māori Health Plan indicators

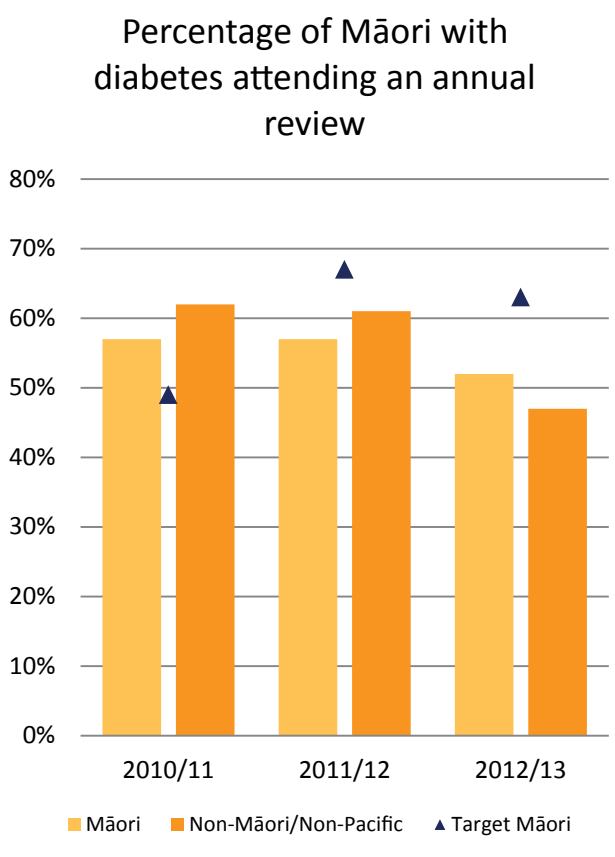
Waitemata has made significant progress in recent years in reducing health inequalities. The DHB has eliminated inequalities in the following areas already:

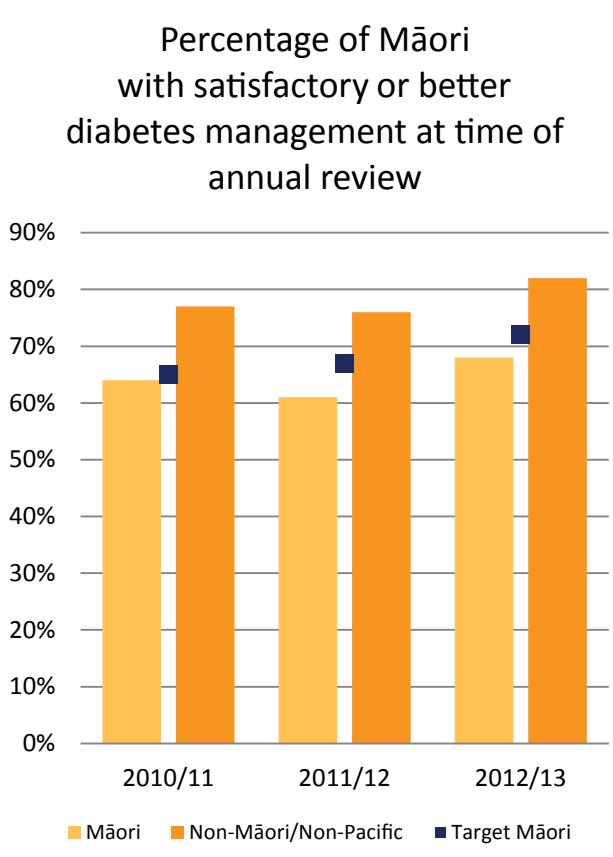
- Percentage of Māori with diabetes attending an annual diabetes review
- Better help for smokers to quit – percentage of those offered advice and help to quit smoking who were:
  - inpatients in hospital
  - seen by their GP in primary care
  - pregnant
- Māori access rates to mental health services
- Mental health relapse prevention planning

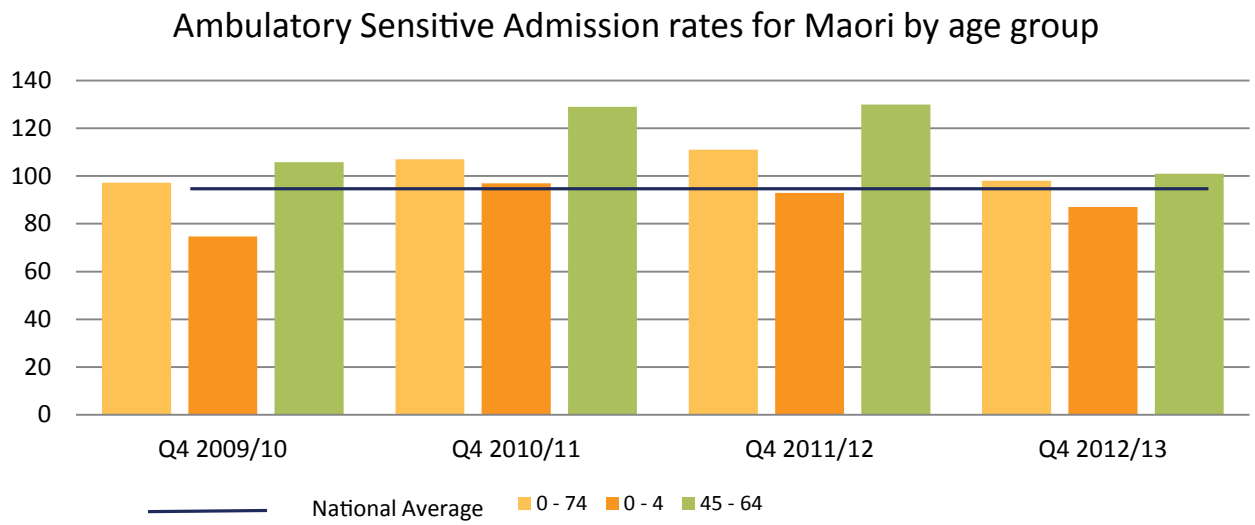
Other areas have recorded a marked improvement, although there is still some way to go to achieve equal performance. These include PHO enrolment rates which continue to improve over time.

There are known issues with misclassification of ethnicity data in all health data sources, including in primary care, which results in an undercount particularly of Māori. Apart from the legislative and consumer rights perspectives, this data quality issue is problematic for the accurate monitoring and reporting of programme performance; the appropriate targeting of individual patients and resource for certain programmes; and for the allocation of funding in primary care. Waitemata DHB and the Ministry of Health funded a pilot Primary Care Ethnicity Data Audit Tool several years ago with Harbour Health PHO. The purpose of the tool is to assess ethnicity data collection, recording and storage at the primary care level. The EDAT was formally evaluated and subsequently further refined by Te Rōpū Rangahau a Eru Pōmare, University of Otago, Wellington and the Ministry of Health. The final EDAT was released in June 2013. We will be taking a northern region lead in the roll out of the tool to PHOs and their practices during 2013/14.

During the year, a cervical ethnicity project was undertaken to evaluate and improve the quality of ethnicity data associated with primary care cervical screening information. The project is nearing completion and the evaluation is underway. So far it has resulted in an approximately 30% increase in women recorded as Māori in the primary care data for both PHOs.







Measured 6 monthly

	Q2 2011/12	Q2 2012/13
0-74	104	104
0-4	90	49
45-64	130	104

Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services tend to be more complex, focused on individuals and are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. Effective and prompt resolution of medical and surgical emergencies and acute conditions prevents, ameliorates and cures ill health and relieves suffering. It also reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life in older adults, thereby improving population health.

The year in review: Maternity Services

Exclusive breastfeeding on discharge rates exceed the target of 75%. This reflects the strong commitment of staff to supporting women in this area.

End of year birth volumes are higher than target with an additional 244 births in 2013. Along with the increase in birth volumes both maternity facilities have seen an increase in complexity of patients.

The DHB has been acknowledged for their support of 'Tapuaki', the Pacific pregnancy and parenting education curriculum. The curriculum was developed to better assist with engagement of Pacific pregnant women, fathers, their families and care providers, and to improve access to and delivery of pregnancy and parenting education.

The Diabetes in Pregnancy (DiP) Service Review was undertaken after the first full year of service. Volumes of referrals are almost double those estimated, with 472 entering the service in one year compared to the estimate of 271 in the business plan. The service plan model of partnership with the primary Lead Maternity Carer (LMC) has proved highly successful with all LMCs remaining in their role and the DiP service providing the secondary service of diabetic care to women. Feedback from the referrers (LMCs) and the consumers was sought and this showed a high level of satisfaction with the service. Review of maternal and neonatal outcomes for women in DiP service aligned well with the general population, reflecting a high level of management of Diabetes in Pregnancy.

The year in review: Assessment, Treatment and Rehabilitation waiting times

The constraints of managing infection control requirements (keeping different multi-resistant strains in separate rooms and not mixing colonised with non-colonised patients) has impacted our performance. These requirements are made more difficult when we have mostly 6-bedded rooms in our north wards. We are working closely with infection control to try to minimise the risk of cross infection since the better we manage this, the easier the processes work. We are going to be looking at our models of care as part of the Richard Bohmer leadership workshops that the DHB are holding. This should highlight improvements that can be made. Harvard Professor of Management Practice, Professor Bohmer is an international expert in the areas of hospital management and quality improvement. Professor Bohmer is meeting with our key clinical and management staff to advance the work on further improving our performance and processes.

The year in review: Mental Health Services

Forensic service bed occupancy is sitting at over 100%. This is due in part to ongoing high demand for service from the prisons and courts. There is a lack of appropriate secure options for the high and complex needs of young forensic clients in the region. Options are being developed to address this need.

Targets for relapse prevention planning for long term clients with serious mental illness are being met or exceeded in every ethnic category. Relapse prevention plans identify early relapse warning signs of clients and identifies what the client can do for themselves and how the service will support the client. Plans are individual and developed with the involvement of clinicians, clients and their families.

Adult services continue to meet national access rate targets however we have not achieved the desired 3% for 0-19 years. While significant improvements in wait times have been noted since the implementation of CAPA (Choice and Partnership Approach) it has not had the desired effect on access rates. Analysis of activity data indicates that while the ratio of referrals to unique clients is increasing (suggesting more referrals are coming through each period) these referrals are not necessarily more new young people. This appears to be an inadvertent by-product of the easy-in/easy-out aspect of CAPA whereby clients are able to access episodic care more readily. Work will need to be undertaken to determine how to continue to support easy access for returning clients while increasing service capacity to enable greater access for new clients.

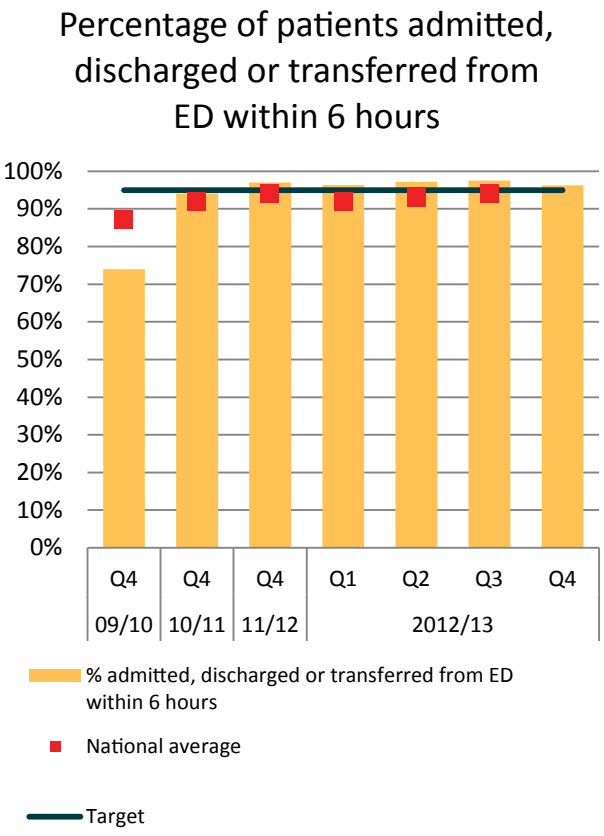
Waiting times for non-urgent mental health and addiction services have improved markedly since last financial year and are well above targets, meeting the national requirement for better access to health services.

Sub-Output Class:

- **Acute Services**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival	92%	97%	96.2%	95%	Achieved	Health Target
Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	Chemo 99% Radiation 100%	100%	100%	100%	Achieved	Health Target
Number of ED attendances	97,770	104,708	108,279	N/A		
Acute WIES total (Provider)	98,750.59	103,201 ⌘	104,420	↓	Substantially achieved	
Readmission rates	10.65%	10.83%	11.20%	10.44%	Substantially achieved	Target was reset during year as baseline data found to be flawed. New baseline became target

Impact Measures	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
Age standardised 30 day survival from acute transmural myocardial infarction	98%	98%	↑	✓



Target: 95% Achieved

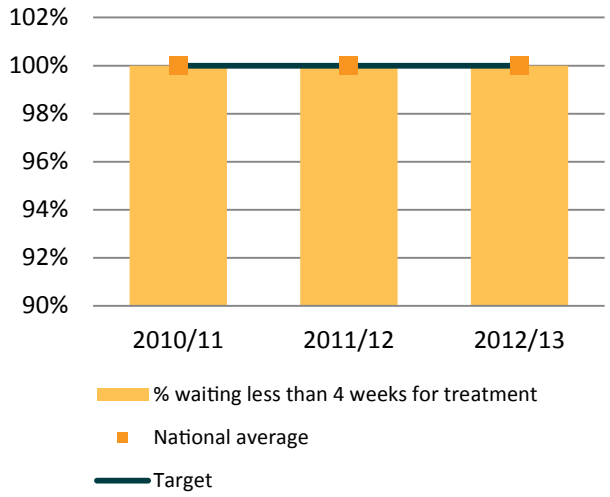
Result: 96%

Our DHB has consistently exceeded the 95% target of all emergency department patients admitted, discharged or transferred in six hours or less, since March 2012. A downwards trend occurring at night was identified, with a number of patients not being seen within the targeted timeframe due to there not being a patient flow coordinator on at night. We have since improved the process with the role and responsibilities of the patient flow co-ordinator being transferred to the charge nurse. This is working well and has addressed the issue.

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

% of Waitemata people receiving radiation oncology treatment within four weeks of first specialist assessment (excluding those waiting by choice or because of co-morbidities)



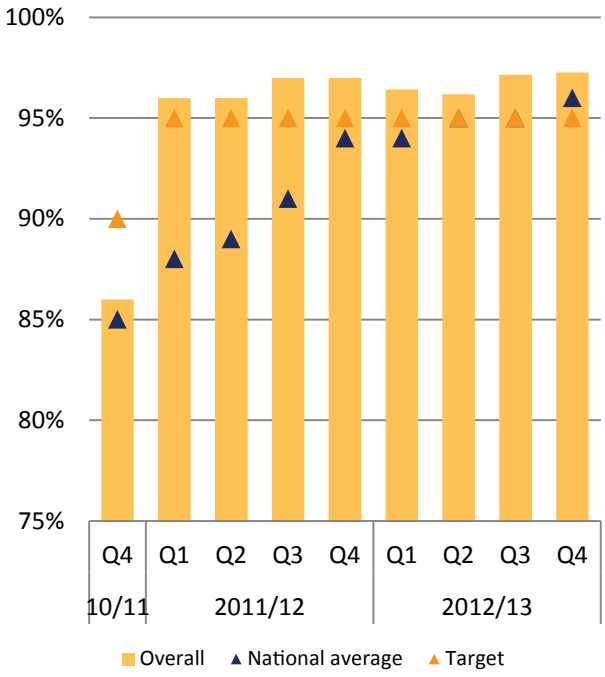
Note: this indicator was not used until Q3 of 2011/12

Target: 100% Achieved

Result: 100%

This target has been met consistently for the past 4 years with little outsourcing of services. Chemotherapy waiting times have been added to this health target for 2012/13. A proportion of these are done at Waitemata DHB – all components of this indicator have complied with the waiting time target of all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

Percentage of hospitalised smokers offered advice and help to quit



Target: 95% Achieved

Result: 97%

Waitemata's performance against the target has remained consistent throughout 2012/13, exceeding 96% every quarter. Refresher training for staff as well as training for new staff and smokefree leads and participation in Smokefree Day have all had a positive impact on performance. Note: data is drawn from Waitemata DHB database.

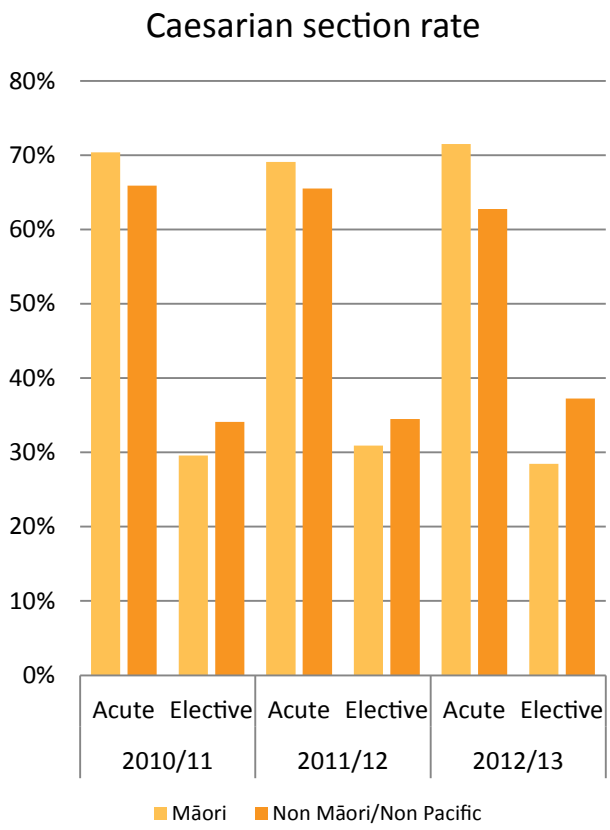
Sub-Output Class:

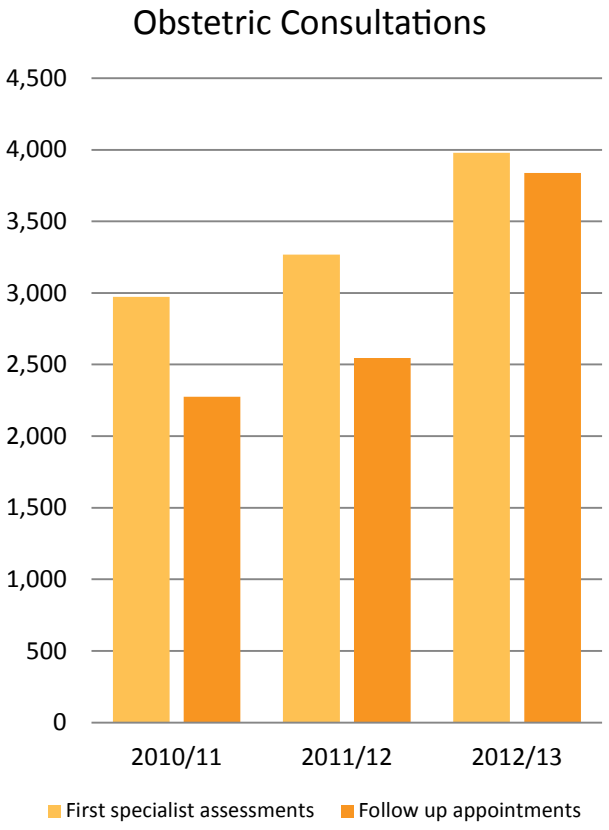
- **Maternity**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Number of births	6,621	6,636	6,957	N/A		
Number of first obstetric consultations	2,757	3,269	3,978	N/A		
Number of subsequent obstetric consults	2,042	2,546	3,838	N/A		
Proportion of all births delivered by caesarean section	26.22%	26.58%	28.8%	N/A	N/A	Most developed countries are experiencing rising caesarean rates; attributed to medico legal concerns, maternal request, obesity, increased complexity and increasing age. We are investigating better utilisation of birthing rooms/ primary birthing facilities and looking at increasing junior doctors' exposure to 'normal' births
Established breastfeeding at discharge excluding NICU admissions	79.1%	78.35%	78.2%	75%	Achieved	
Third/fourth degree tears for all primaparous vaginal births	2.22%	unavailable	3.6%	↓	Not achieved	We are unsure if this result is significant and plan to monitor results over the coming year to identify if there is a continuing pattern.
Percentage of term elective caesarean performed at ≥ 39 weeks	68.84%	unavailable	58.4%	↑	Partly achieved	

Impact Measures	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
APGAR score ≥6 at 5 mins for live term infants	96%	99.5%	↑	✓
Blood loss ≥1500ml during first 24 hours following a vaginal birth	49 women	52 women	↓	✗
Blood loss ≥1500ml during first 24 hours following caesarean birth	42 women (2.4%)	28 women (1.4%)	↓	✓

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.


Caesarian section rate
80%
70%
60%
50%
40%
30%
20%
10%
0%
Acute
Elective
Acute
Elective
Acute
Elective
2010/11
2011/12
2012/13
Māori
Non Māori/Non Pacific


Obstetric Consultations
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2010/11
2011/12
2012/13
First specialist assessments
Follow up appointments

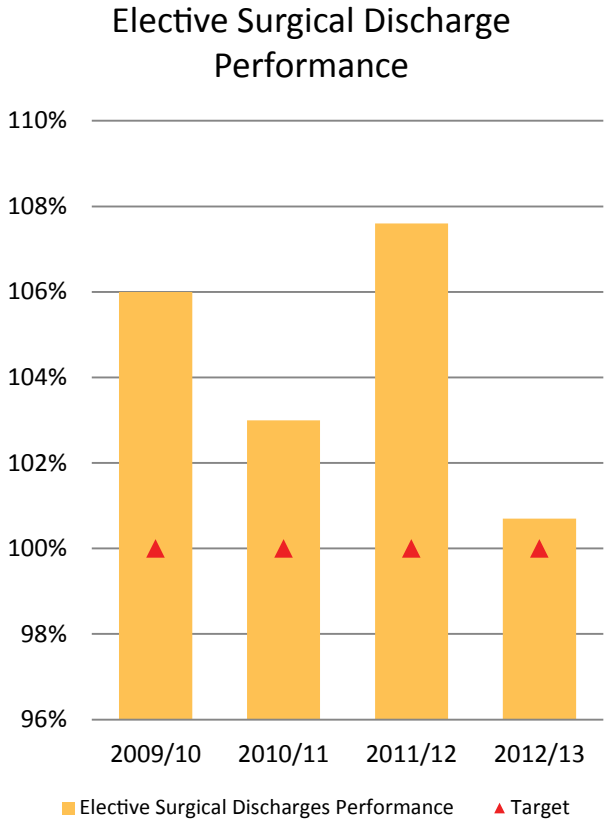
Sub-Output Class:

- **Elective (Inpatient/Outpatient)**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Delivery of health target for elective surgical discharges (Health target)	13,786	15,891	15,966	15,853	Achieved	Health Target
Standardised elective surgical intervention rate (per 10,000 of population):						
Joints	19.08	19.72 ⌘	22.71	21		
Cataracts	27.93	28.96 ⌘	40.25	27		
Cardiac	5.44	6.06 ⌘	7.34	6.2-6.5		Note: results pertain to 2011 and 2012 calendar years respectively
PCR	19.70	20.22 ⌘	18.04	11.9		
Angiography	39.49	40.71 ⌘	43.23	32.3		
Overall	281.11	294.54	328.37		Achieved	
Number of first specialist assessment (FSA) outpatient consultations	38,900	33,612	37,970	N/A		
Surgical infection rates	0.34	unavailable	0.19	↓	Achieved	
Patients waiting longer than six months for their first specialist assessment (FSA)	1.1%	0%	0%	0%	Achieved	As at June 2013
Patients given a commitment to treatment but not treated within six months	3.0%	0%	0%	0%	Achieved	As at June 2013

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

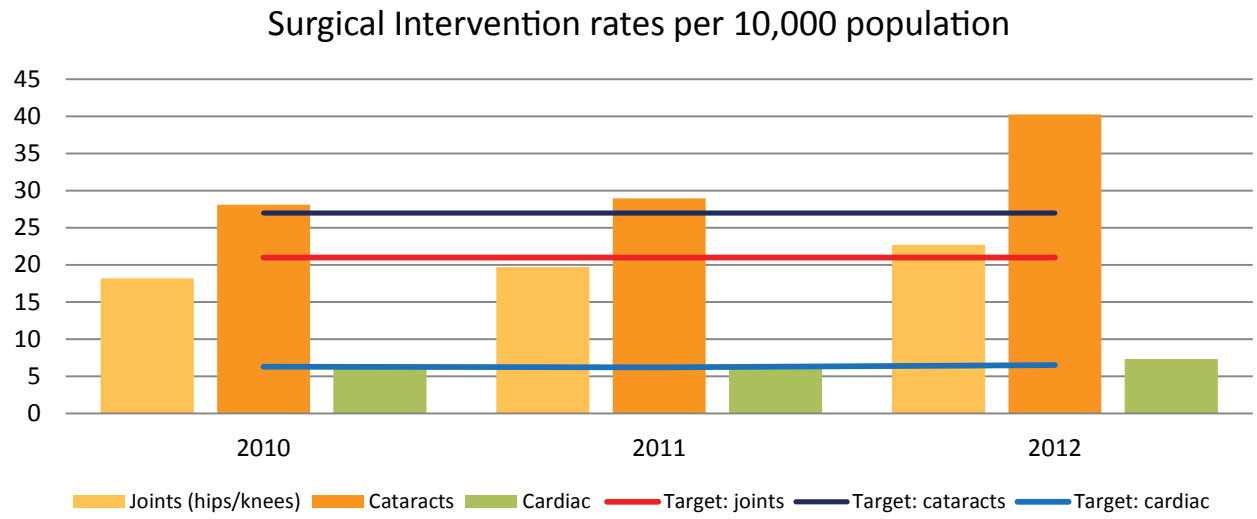
Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.



Target: 100% (15,853 discharges) Achieved

Result: 100.7% (15,966 discharges)

Efficient use of local theatre time and careful management of elective surgery carried out by other DHBs for our population has ensured that our patients have not only received their surgery within acceptable timeframes, but also that elective funds have been effectively applied where most needed. More than 10% of the country's elective surgery during 2012/13 was performed for Waitemata DHB residents. Note that some elective surgery is carried out in other DHBs' facilities for Waitemata residents.



Sub-Output Class:

- **Assessment Treatment and Rehabilitation (Inpatient)**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement
AT&R Bed days	14,020	37,502	37,808	≥ baseline	
Number of AT&R inpatient events	2,003	1,826 ⌘	2,000	N/A	
Average no. of falls per 1,000 occupied bed days	3	1.06	1.16	↓	Substantially achieved
Proportion waiting 4 days or less from waitlist date to admission to AT&R service	65%	unavailable	50.1%	≥ 65%	Not achieved

Impact Measures	2011/12 Result	2012/13 Result	Direction required for Improvement	Improvement
The proportion of patients with an improvement in function between AT&R admission and within 3 days of discharge as measured by the FIM (functional independence measure)	New measure	85.17%	↑	N/A

Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

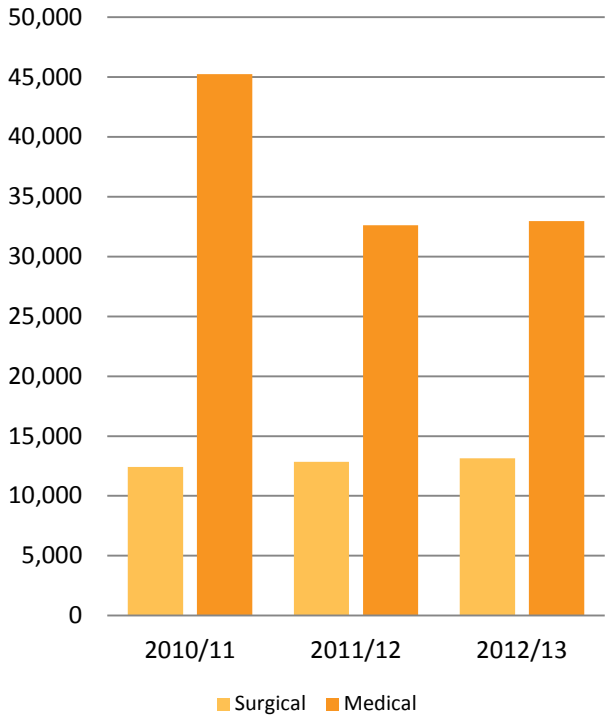
Sub-Output Class:

- **Mental Health**

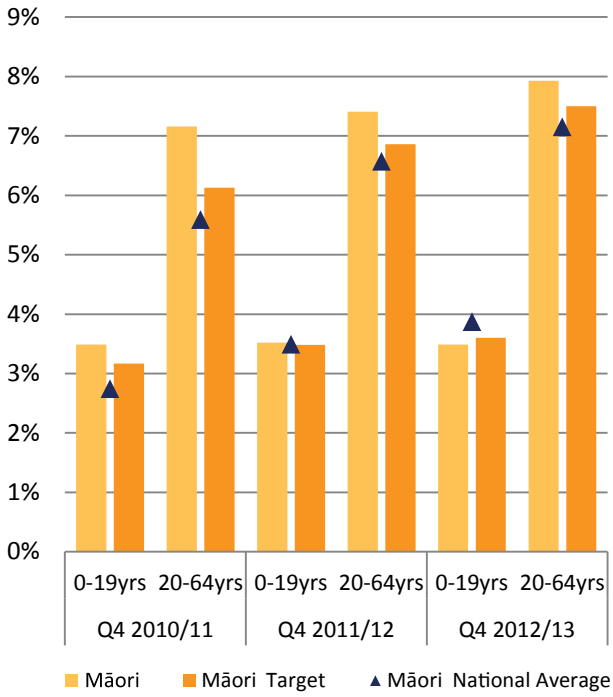
Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year) -						Results = April 2012 - March 2013 (used for Q4 MoH reporting)
Māori 0-19 years	3.60%	3.52%	3.49%	3.60%	Substantially achieved	
Māori 20-64 years	7.51%	7.41%	7.93%	7.50%	Achieved	
Total 0-19 years	2.62%	2.62%	2.62%	3.00%	Partly achieved	
Total 20-64 years	3.43%	3.46%	3.51%	3.50%	Achieved	
Total 65+ years	2.48%	2.42%	2.34%	2.36%	Substantially achieved	
Proportion of long term clients with Relapse Prevention Plan (RPP) in the above population groups -						
Adult Māori	100%	99.5%	99%	95%	Achieved	As at 1 July 2013 (result recorded at a point in time – this is closest available to end of financial year)
Pacific	98.61%	99.38%	98.71%	95%		
Total	97%	97.55%	95.53%	95%		
Child & Youth Māori	93.1%	100%	100%	95%	Achieved	
Pacific	100%	100%	100%	95%		
Total	96%	94.12%	96.1%	95%		
Shorter waits for non-urgent mental health and addiction services:						Results = April 2011 - March 2012 and April 2012 - March 2013 respectively (used for Q4 MoH reporting)
Seen within 3 weeks	78.43%	79.55% ⌘	91.4%	80%	Achieved	
Seen within 8 weeks	85.21%	88.42% ⌘	98.4%	95%		
(wording corrected from SoI)						

Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

Acute medical and surgical discharges



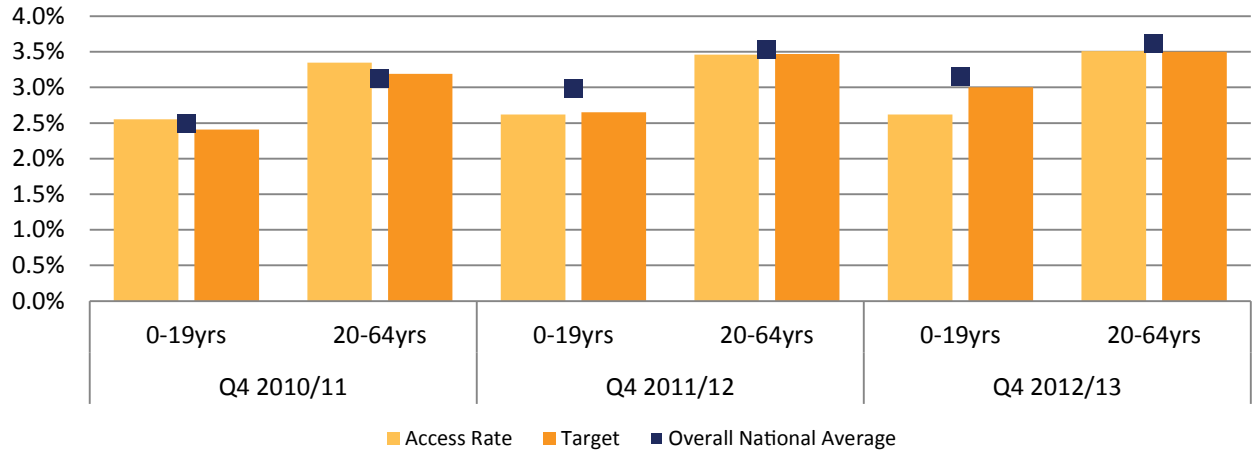
Māori access rates to mental health services by age group



Measured 6 monthly

	Q2 2011/12	Q2 2012/13
0-19 years	3.6%	4.42%
20-64 years	7.5%	10.36%

Access rates to mental health services by age group



Measured 6 monthly

	Q2 2011/12	Q2 2012/13
0-19 years	2.62%	2.56%
20-64 years	3.43%	3.71%

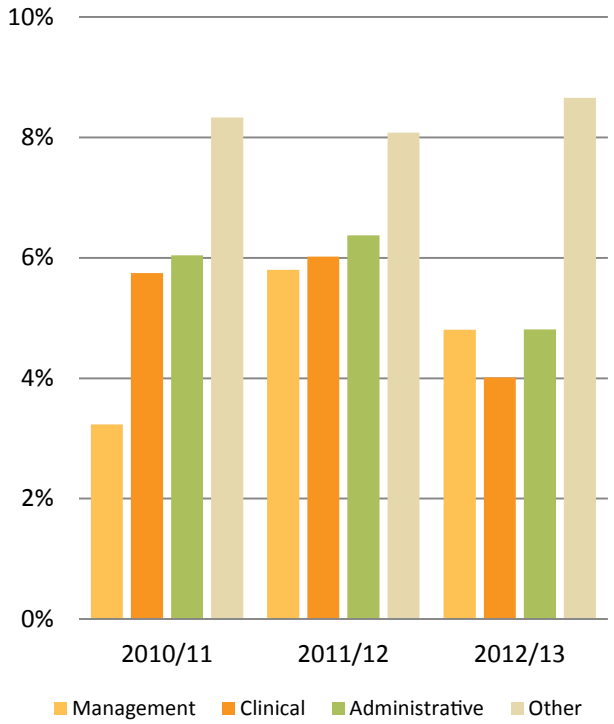
Māori Health Plan indicators

Waitemata and Auckland DHBs have employed extra resource at 0.5 FTE to coordinate all Māori workforce development strategy and activities. The intention is to develop a comprehensive pipeline approach for Māori workforce development within health and across the sectors (including education and appropriate social sector linkages). We are working together with our MOU partner Te Runanga o Ngati Whatua on a regional Māori Workforce Development strategy and subsequent plan. The strategy and plan will increase the Māori workforce within all services across both DHBs and within our providers, until the Māori workforce representation is equitable to the Māori utilisation of services. This will enable routine monitoring of Māori workforce growth.

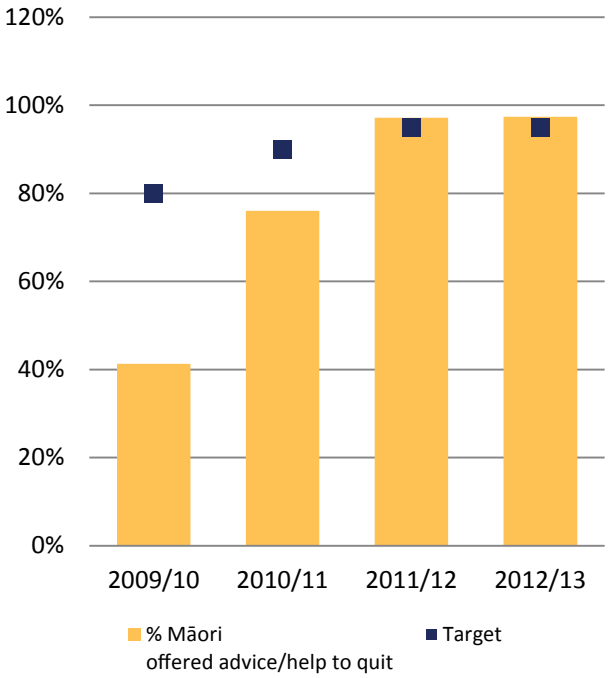
Current activities include:

- Internal DHB liaison with service provider leaders to identify and develop workplace exposure programmes for Māori students
- Work with Māori MOU Liaison partners to identify opportunities to grow the Māori workforce; for example leveraging off DHB streamlined auditing processes with the regulatory bodies
- Develop and review coordinated internal strategies to attract, recruit and retain Māori workforce
- Conduit to Kia Ora Hauora. Kia Ora Hauora is a national Māori workforce development programme funded by the Ministry of Health, delivered through contracts to both Auckland and Waitemata DHBs to:
  - work with careers advisors and subject teachers to promote science subjects as school
  - create opportunities to engage with priority schools that show the link between health and science
  - ensure all students engaged in the programme have access to Waitemata DHB scholarship programme to reduce financial barriers
  - ensure all students engaged in the programme have a focus on career development planning
- Shaping the delivery of Kia Ora Hauora activity in schools to increase the uptake of the workforce development tools each DHB has as its disposal:
  - Rangatahi Programme for Māori and Pacific students (Auckland)
  - Cadetships for Māori and Pacific students (Auckland)
  - Gateway work placements for Māori students (Waitemata)
  - Waitemata DHB Scholarships for Māori and Pacific students (Waitemata)
  - Supporting the Health and Science Academy at Hato Petera College (Waitemata)

Percentage of Waitemata DHB workforce that are Māori



Percentage of hospitalised Māori smokers offered advice/help to quit



The percentage of Māori hospitalised smokers offered advice and help to quit is better than the overall result, exceeding target at 98.7%.

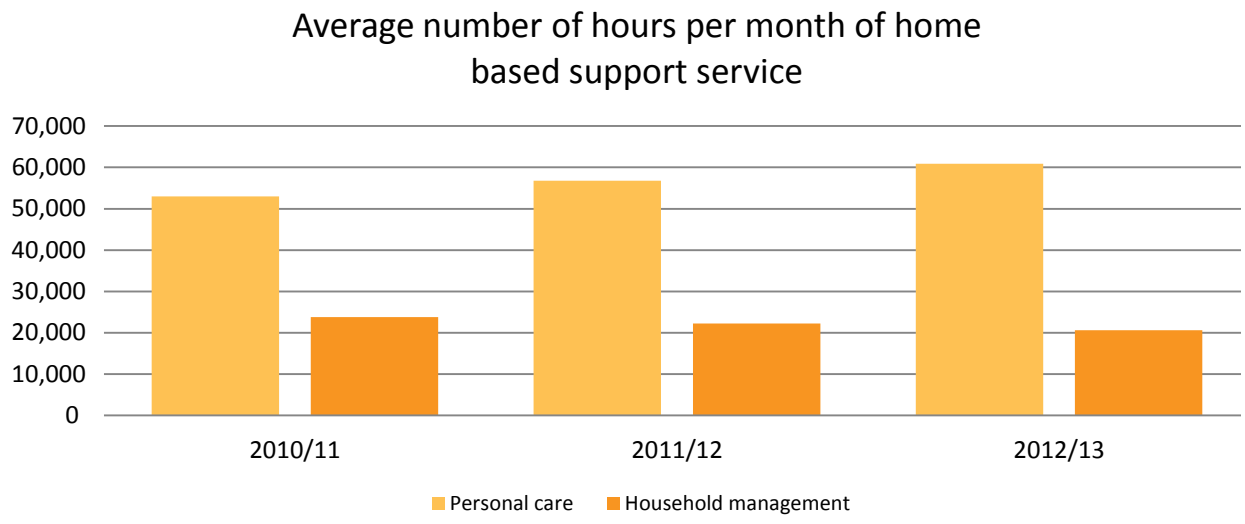
Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals. 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, ameliorating ill health and relieving suffering. There is some evidence that this may also improve length of life.

Sub-Output Class:

- **Home Based Support**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Average number of hours per month of home based support services (HBSS) for:						HBSS have reduced the amount of hours dedicated to household management, as the service focuses primarily on the health (personal care) needs of its clients.
• Personal care	52,958	56,760	60,906	N/A		
• Household management	23,783	22,235	20,601	N/A		
The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Approx. 6%	unavailable	66%	20%	Achieved	Note: results relate to newly referred people, rather than all people. WDHB was a late adopter of the InterRAI assessment tool and the Ministry allowed for this by assessing performance based on new referrals only
Percentage of NASC clients assessed within 6 weeks	95%	91%	89.7%	≥95%	Substantially achieved	



Some output measures are demand driven and it is therefore not possible to set meaningful targets for these measures or assign an 'Achieved' or 'Not Achieved' rating. These are indicated with N/A symbol.

Sub-Output Class:

- **Palliative Care**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement
Number of contacts	21,232	21,418	20,563	↑	Substantially achieved
Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline)	**Admissions** M 9% P 7% **Deaths** M 6% P 4%	**Admissions** M 6% ⌘ P 4% ⌘ **Deaths** M 5% ⌘ P 3% ⌘	**Admissions** M 8% P 5% **Deaths** M 5% P 3%	% admitted should reflect % deaths by ethnicity	Achieved
Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	14%	18%	14%	↓	Achieved

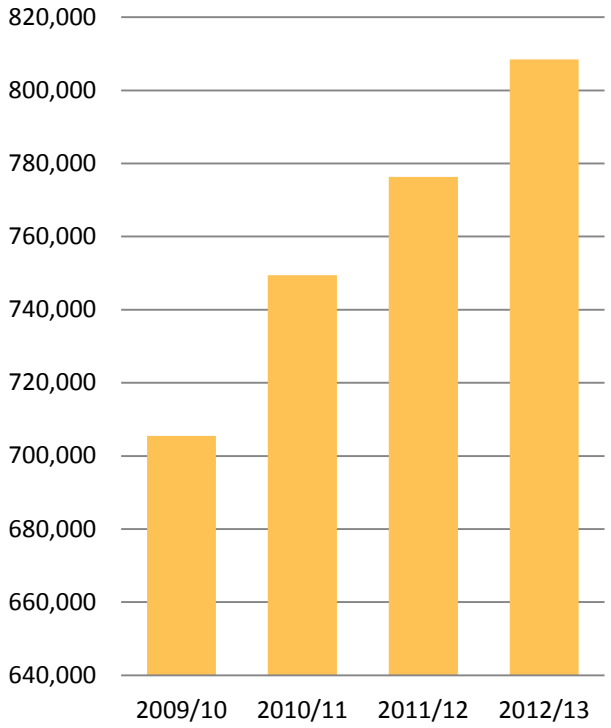
Those measures marked with ⌘ were not previously reported in last year's annual report, baseline or 2011/12 figures provided have therefore not been audited.

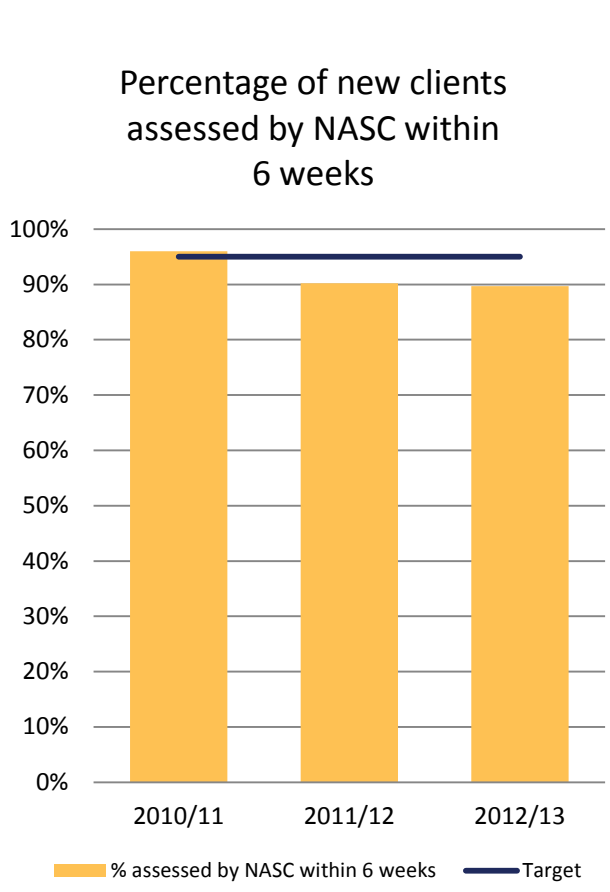
Sub-Output Class:

- **Residential Care**

Output Measures	Baseline	2011/12	2012/13	2012/13 Target	Achievement	Comments
Total number of subsidised aged residential care bed days	751,082	776,293	808,439	≥ baseline		12 months to end of March 2013
Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year	New measure	unavailable	29%	20%	Achieved	
Percentage of NASC clients assessed within 6 weeks	95%	91%	89.7%	≥95%	Substantially achieved	

Impact Measures	2011/12 Result	2012/13 Result	Direction required from improvement	Improvement
Standardised acute admission rates from residential care	1,720/100,000 65+ population	1,829	↓	✗





QUALIFIED AUDIT OPINION REGARDING CERTAIN PERFORMANCE INFORMATION

Audit New Zealand have qualified their audit opinion regarding certain non-financial performance information, as this information relies on the accuracy of data supplied by Primary Care (GP practices). This information is collected by Primary Health Organisations, who then report this information to the Ministry of Health, who in turn publish the results to the public on a quarterly basis. Waitemata DHB includes this information in its reported performance information.

In the 2012/13 audit, Audit New Zealand applied a revised auditing standard to DHBs' service performance reports and has confirmed that, in their opinion, Waitemata DHB's control over much of this information is limited and that at present there are no practical audit procedures to determine the effect of this limited control. Accordingly, Audit New Zealand have qualified their report on the non-financial performance information of our DHB (and as we understand it all other DHBs, on that same basis).

We understand the reasoning behind their audit opinion as the systems and processes for collecting and understanding the data are complex and involve multiple parties and different clinical systems.

However, we consider our Primary Care service performance information to be materially accurate and complete because there are a range of processes that Primary Health Organisations use to monitor primary care data.

FINANCIAL STATEMENTS

WAITEMATA DISTRICT HEALTH BOARD 2012-13

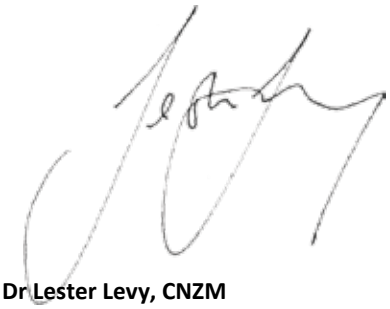
Prepared under New Zealand equivalents to International Financial Reporting Standards.

STATEMENT OF RESPONSIBILITY

The Board is responsible for the preparation of the Waitemata District Health Board and group's financial statements and the statement of service performance, and for the judgements made in them. The Board of the Waitemata District Health Board have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the Board's opinion, these financial statements and statement of service performance fairly reflect the financial position and operations of the Waitemata District Health Board for the year ended 30 June 2013.

Signed on behalf of the Board:



Dr Lester Levy, CNZM
Chairman
31 October 2013

Professor Max Abbott
Deputy Chairman
31 October 2013

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2013

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2013	2012	2013	2013	2012
	Notes	$000	$000	$000	$000	$000
Income						
Patient care revenue	2	1,396,955	1,344,411	1,396,289	1,394,271	1,344,293
Interest Income		5,159	3,820	4,835	2,610	3,486
Other income	3	21,276	26,922	20,560	19,961	26,762
Total income	30	1,423,390	1,375,153	1,421,684	1,416,842	1,374,541
Expenditure						
Personnel costs	4	498,198	477,224	498,198	493,142	477,224
Depreciation and amortisation expense	12,13	21,150	21,322	21,150	25,906	21,322
Outsourced services		56,405	52,654	56,405	42,321	52,654
Clinical supplies		86,288	81,090	86,288	85,398	81,090
Infrastructure and non-clinical expenses		47,040	47,819	47,040	41,034	47,819
Other district health boards		248,298	335,168	248,298	328,251	335,168
Non-health board provider expenses		422,716	320,279	422,716	362,527	320,279
Capital charge	5	13,664	12,406	13,664	14,082	12,406
Interest expense		11,537	11,350	11,537	13,748	11,290
Other expenses	6	11,259	11,021	10,392	8,433	10,280
Total expenditure	30	1,416,555	1,370,333	1,415,688	1,414,842	1,369,532
Share of associate and joint venture surplus / (deficit)	11	0	0	0	0	0
Surplus / (deficit)		**6,835**	**4,820**	**5,996**	**2,000**	**5,009**
Other comprehensive income						
Impairment of land and buildings	18	0	(2,588)	0	0	(2,588)
Revaluation of land and buildings	18	24,176	(540)	24,176	0	(540)
Total other comprehensive income (expense)		24,176	(3,128)	24,176	0	(3,128)
Total comprehensive income / (expense)		**31,011**	**1,692**	**30,172**	**2,000**	**1,881**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2013

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2013	2012	2013	2013	2012
	Notes	$000	$000	$000	$000	$000
Balance at 1 July		172,592	165,709	166,765	169,774	159,693
Comprehensive income / (expense)						
Surplus / (deficit) for the year		6,835	4,820	5,996	2,000	5,009
Other comprehensive income		24,176	(3,128)	24,176	0	(3,128)
Total comprehensive income		**31,011**	**1,692**	**30,172**	**2,000**	**1,881**
Owner transactions						
Capital contributions from the Crown		0	5,191	0	0	5,191
Balance at 30 June	18	**203,603**	**172,592**	**196,937**	**171,774**	**166,765**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2013

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2013	2012	2013	2013	2012
	Notes	$000	$000	$000	$000	$000
Assets						
Current assets						
Cash and cash equivalents	7	105,785	69,473	104,925	51,084	68,677
Debtors and other receivables	8	28,237	33,218	28,535	35,500	33,361
Investments	9	1,343	1,302	0	0	0
Inventories	10	5,338	5,012	5,338	6,000	5,012
Prepayments		404	527	404	500	527
Total current assets		141,107	109,532	139,202	93,084	107,577
Non-current assets						
Investments	9	4,614	3,848	0	0	0
Investments in associates and joint ventures	11	18,179	9,535	18,179	0	9,535
Property, plant and equipment	12	516,801	466,804	516,801	520,003	466,804
Intangible assets	13	3,230	0	3,230	1,167	0
Total non-current assets		542,824	480,187	538,210	521,170	476,339
Total assets		**683,931**	**589,719**	**677,412**	**614,254**	**583,916**
Liabilities						
Current liabilities						
Creditors and other payables	14	131,512	103,094	131,658	79,015	103,118
Borrowings	15A	70,893	100,313	70,893	65,237	100,313
Employee entitlements	16	67,295	71,853	67,295	83,323	71,853
Provisions	17	478	441	478	700	441
Total current liabilities		270,178	275,701	270,324	228,275	275,725
Non-current liabilities						
Borrowings	15A	188,754	120,936	188,754	192,270	120,936
Derivatives	15B	204	0	204	0	0
Employee entitlements	16	21,193	20,490	21,193	21,935	20,490
Total non-current liabilities		210,151	141,426	210,151	214,205	141,426
Total liabilities		**480,329**	**417,127**	**480,475**	**442,480**	**417,151**
Net assets		**203,602**	**172,592**	**196,937**	**171,774**	**166,765**
Equity						
Crown equity	18	103,015	103,015	103,015	102,905	103,015
Accumulated surpluses / (deficits)	18	(57,495)	(63,491)	(57,495)	(61,935)	(63,491)
Revaluation reserves	18	151,417	127,241	151,417	130,369	127,241
Trust funds	18	6,665	5,827	0	435	0
Total equity		**203,602**	**172,592**	**196,937**	**171,774**	**166,765**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2013

		Group		Parent		
		Actual	Actual	Actual	Budget	Actual
		2013	2012	2013	2013	2012
	Notes	$000	$000	$000	$000	$000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,385,527	1,331,796	1,385,527	1,381,855	1,331,796
Other		38,952	41,508	36,392	32,377	40,026
Interest received		4,615	3,465	4,277	2,610	3,119
Payments to suppliers		(846,013)	(850,716)	(844,044)	(867,970)	(848,481)
Payments to employees		(502,018)	(464,699)	(502,018)	(493,142)	(464,699)
Capital charge		(13,398)	(15,182)	(13,398)	(14,082)	(15,182)
Interest payments		(11,537)	(11,197)	(11,537)	(13,748)	(11,197)
Goods and services tax (net)		86	965	86	(3,996)	965
Net cash flow from operating activities	19	56,214	35,940	55,285	23,904	36,347
Cash flows from investing activities						
Receipt from sale of property, plant and equipment		0	0	0	0	0
Receipt from sale or maturity of investments		0	85	0	0	0
Purchase of property, plant and equipment		(53,143)	(58,423)	(53,143)	(61,792)	(58,423)
Purchase of intangible assets		(3,365)	0	(3,365)	(3,000)	0
Acquisition of investments		(1,791)	0	(926)	0	0
Net cash flow from investing activities		(58,299)	(58,338)	(57,434)	(64,792)	(58,423)
Cash flows from financing activities						
Capital contributions from the Crown		0	5,190	0	0	5,190
Proceeds from borrowings		38,480	33,130	38,480	38,555	33,130
Repayment of borrowings		(83)	(83)	(83)	(83)	(83)
Net cash flow from financing activities		38,397	38,237	38,397	38,472	38,237
Net (decrease) / increase in cash and cash equivalents		**36,312**	**15,839**	**36,248**	**(2,416)**	**16,161**
Cash and cash equivalents at the start of the year		69,473	53,634	68,677	53,500	52,516
Cash and cash equivalents at the end of the year	7	**105,785**	**69,473**	**104,925**	**51,084**	**68,677**

Explanations of major variances against budget are provided in note 30.

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1 STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 2013

REPORTING ENTITY

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

The consolidated financial statements of Waitemata DHB for the year ended 30 June 2013 comprise Waitemata DHB and its subsidiaries (together referred to as "Group") and Waitemata DHB's interest in associates and jointly controlled entities. The Waitemata DHB group consists of the parent, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board). Joint ventures are healthAlliance N.Z. Limited (20%), New Zealand Health Innovation Hub Limited Partnership (25%) and Awhina Waitakere Health Campus. The associate company is Northern Regional Alliance Limited (33.3%) formerly called Northern DHB Support Agency Limited (NDSA). Northern Regional Training Hub Limited (a former associate company) merged into Northern Regional Alliance Ltd on 28 February 2013.

The DHB's subsidiary, associates and joint ventures are incorporated and domiciled in New Zealand.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

The DHB has reported in note 29 on the patient trust monies which it administers.

The financial statements for the DHB are for the year ended 30 June 2013, and were approved by the Board on 31 October 2013.

BASIS OF PREPARATION

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

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base
The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, infrastructure assets, dental clinics and bond forward rate agreements.

Functional and presentation currency
The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its subsidiary, associates and joint ventures is New Zealand dollars (NZ$).

Changes in accounting policies
There have been no changes in accounting policies during the financial year.

There have been no revisions to Financial Reporting Standards during the financial year which have had an effect on the DHB's financial statements.

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39.

The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Subsidiaries

Subsidiaries are entities in which Waitemata DHB has the capacity to determine the financing and operating policies and from which it has entitlement to significant ownership benefits. These financial statements include Waitemata DHB and its subsidiaries, the acquisition of which are accounted for using the purchase method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In Waitemata DHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

The DHB does not consolidate its subsidiary Milford Secure Properties Limited as it is dormant and is not material.

Joint ventures

A joint venture is a contractual arrangement whereby two or more parties undertake an economic activity that is subject to joint control.

Waitemata DHB is party to three joint ventures arrangements. One is a jointly controlled operation; Awhina Waitakere Health Campus. The DHB recognises in its financial statements the assets it controls, the revenue that it earns, the liabilities and expenses that it incurs from this joint operation.

The second joint venture is healthAlliance N.Z. Limited, which is a jointly controlled entity. Any contribution of cash or other resources to the joint venture is recognised in the financial statements as an investment in the joint venture entity. The value of the investment in the healthAlliance Joint Venture is reviewed annually for any impairment losses. The investment in healthAlliance joint venture is accounted for using the equity method.

The third joint venture is New Zealand Health Innovation Hub Limited Partnership, which is a jointly controlled entity. The interest in this joint venture is not accounted for as it is not material to Waitemata District Health Board.

Associate

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. The interests in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) are not accounted for as they are not material to Waitemata District Health Board.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Ministry of Health (MoH) revenue

The DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of the DHB meeting its objectives. Revenue from the MoH is recognised as revenue when earned.

ACC contracted revenue

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

Revenue from other DHBs

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

Interest income

Interest income is recognised using the effective interest method.

Rental income

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

Provision of services

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date.

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge

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

Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

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 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 certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. 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 over the lease term as an integral part of the total lease expense.

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

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

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

Debtors and other receivables
Debtors and other receivables are recorded at their face value, less any provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments
Bank deposits
Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories
Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale
Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

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

- land;
- buildings;
- underground infrastructure;
- fixed dental clinics and pads;
- clinical equipment;
- IT equipment; and
- other equipment and motor vehicles.

Land is measured at fair value. Buildings, underground infrastructure, fixed dental clinics and pads are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land, buildings, underground infrastructure, fixed dental clinics and pads 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 land, buildings, underground infrastructure, fixed dental clinics and pads are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset 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 income 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 income.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that 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 at no cost, or for a nominal cost, 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 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 assets have been estimated as follows:

- Buildings (including components) 6 to 60 years (1.67%-16.67%)
- Underground Infrastructure 35 to 43 years (2.33% to 2.86%)
- Fixed dental clinics and pads (including fit out) 19 to 35 years (2.86% to 5.26%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%)

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

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

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

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

- Acquired software 3 to 5 years (20% - 33%)
- Internally developed software 3 to 5 years (20% - 33%)

Indefinite life intangible assets are not amortised.

Impairment of property, plant, and equipment and intangible assets
Property, plant, and equipment and intangible assets are reviewed for indicators of impairment as at each balance date. 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 depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit. For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

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

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Bond forward rate agreements (Bond FRAs)
Bond FRAs are initially recognised at fair value on the date a contract is entered into, and are subsequently re-measured at the fair value at each balance date, with the resulting gain or loss recognised in the surplus or deficit.

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

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

A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation.

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.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

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

Superannuation schemes
Defined contribution schemes
Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Provisions
A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Provisions are not recognised for future operating losses.

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme
The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years up to a specified maximum amount. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

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

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

- Crown equity;
- accumulated surpluses;
- revaluation reserves; and
- trust funds.

Revaluation reserves
These reserves are related to the revaluation of land, buildings, underground infrastructure and fixed dental clinics and pads to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to Three Harbours Health Foundation.

Goods and services tax
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

Cost allocation
The DHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions
In preparing these financial statements, the Board has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land, building, underground infrastructure, fixed dental clinics and pads revaluations
Note 12 provides information about the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads.

Employee entitlements valuations
Note 16 provides information about the estimates and assumptions applied in the measurement of revalued employee entitlements. The most recent valuation of sick, long service and retiring leave were performed by a registered independent valuer, Aon New Zealand and the valuation is effective as at 30 June 2013.

Continuing medical education leave and expenses are calculated based on a discounted valuation of the estimated three years non vesting entitlement under the current collective agreement with Senior Medical Officers. The split between current and non-current employee entitlements is based on projected leave patterns.

Estimating useful lives and residual values of property, plant, and equipment
The useful lives and residual values of property, plant, and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

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

Leases classification
Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Agency relationship
Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sales of goods or the rendering of services. The judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

Some individual DHBs have entered into contracts for services with providers on behalf of themselves (contracting DHB) and other DHBs (recipient DHB). The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. All payments to the service providers under an agency relationship are recognised as costs in the accounts of the recipient DHB.

Comparative Figures
Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year.

2 PATIENT CARE REVENUE

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Health and disability services (MoH contracted revenue)	1,303,938	1,250,715	1,303,938	1,250,715
ACC contract revenue	9,381	9,231	9,381	9,231
Inter district patient inflows	74,425	74,869	74,425	74,869
Revenue from other district health boards	3,861	3,594	3,195	3,476
Other patient sourced revenue	5,350	6,002	5,350	6,002
Total patient care revenue	**1,396,955**	**1,344,411**	**1,396,289**	**1,344,293**

3 OTHER INCOME

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Gain on sale of property, plant and equipment	0	1,059	0	1,059
Clinical Training Agency	8,237	9,093	8,237	9,093
Donations and bequests received	637	513	485	386
Rental income	364	553	364	553
Professional, training and research	3,390	2,570	2,826	2,537
Other income	8,648	13,134	8,648	13,134
Total other income	**21,276**	**26,922**	**20,560**	**26,762**

4 PERSONNEL COSTS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Salaries and wages	494,286	459,849	494,286	459,849
Contributions to defined contribution schemes	7,767	5,851	7,767	5,851
Increase/(decrease) in liability for employee entitlements	(3,855)	11,524	(3,855)	11,524
Total personnel costs	**498,198**	**477,224**	**498,198**	**477,224**

Contributions to defined contribution schemes include KiwiSaver, State Sector Retirement Savings Scheme and the Government Superannuation Fund.

5 CAPITAL CHARGE

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six month actual closing equity balance. The capital charge rate for the year ended 30 June 2013 was 8% (2012: 8%).

6 OTHER EXPENSES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Audit fees for Waitemata DHB financial statement audit	193	181	193	181
Audit fees (for subsidiaries financial statements)	0	9	0	9
Operating lease expense	7,702	7,500	7,702	7,500
Impairment of debtors	1,924	2,167	1,924	2,167
Board members fees Note 23	367	379	367	379
Loss on bond forward rate agreements	204	0	204	0
Koha	2	5	2	5
Other expenses	867	780	0	39
Total other expenses	**11,259**	**11,021**	**10,392**	**10,280**

7 CASH AND CASH EQUIVALENTS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Cash at bank and on hand	14	9	0	0
Call deposits	846	787	0	0
Health Benefits Limited	104,925	68,677	104,925	68,677
Total cash and cash equivalents for the purposes of the statement of cash flows	**105,785**	**69,473**	**104,925**	**68,677**

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value. Cash and cash equivalents include funds of $860k (2012: $796k) donated or bequeathed for a specific purpose. 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 is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Waitemata DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL 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 HBL, which will incur interest at on-call interest rates received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST; for Waitemata DHB that equates to $52.953m. During the year Waitemata DHB terminated an un-used Westpac overdraft facility of $1m and an ANZ cash advance facility of $39m.

8 DEBTORS AND OTHER RECEIVABLES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Ministry of Health	15,973	14,827	15,973	14,827
Other receivables	6,938	8,472	7,236	8,615
Other accrued revenue	7,342	11,563	7,342	11,563
Less: Provision for impairment	(2,016)	(1,644)	(2,016)	(1,644)
Total debtors and other receivables	**28,237**	**33,218**	**28,535**	**33,361**

Fair value
The carrying value of debtors and other receivables approximates their fair value.

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

	Group 2013			Group 2012		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	26,383	0	26,383	28,818	0	28,818
Past due 1-30 days	835	(303)	532	3,483	0	3,483
Past due 31-60 days	458	(241)	217	636	(304)	332
Past due 61-90 days	728	(358)	370	376	(262)	114
Past due > 90 days	1,849	(1,114)	735	1,549	(1,078)	471
Total	**30,253**	**(2,016)**	**28,237**	**35,005**	**(1,644)**	**33,361**

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

The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment. The collective impairment assessment is based on an analysis of past collection history and write-offs. Individually impaired receivables are assessed as impaired due to the significant financial difficulties being experienced by the debtor and management concluding that the likelihood of the overdue amounts being recovered is remote.

Movements in the provision for impairment of receivables are as follows:

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Balance at 1 July	1,644	1,669	1,644	1,669
Additional provisions made	1,924	2,167	1,924	2,167
Receivables written off	(1,552)	(2,192)	(1,552)	(2,192)
Balance at 30 June	**2,016**	**1,644**	**2,016**	**1,644**

9 INVESTMENTS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,343	1,302	0	0
Total current portion	1,343	1,302	0	0
Non-current portion				
Term deposits with maturities greater than 3 months and remaining duration greater than 12 months	4,614	3,848	0	0
Total non-current portion	4,614	3,848	0	0
Total investments	**5,957**	**5,150**	**0**	**0**

The carrying value of the current portion of investments approximates their fair value.

The fair value of term deposits with a remaining duration greater than 12 months is $4.614m (2012: $3.848m). The fair value has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs. There is no impairment provision for investments.

10 INVENTORIES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Pharmaceuticals	583	567	583	567
Surgical and medical supplies	4,755	4,445	4,755	4,445
Total inventories	**5,338**	**5,012**	**5,338**	**5,012**

The write-down of inventories held for distribution amounted to $0 (2012: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2012: $nil). However, some inventories are subject to retention of title clauses.

11 INVESTMENTS IN ASSOCIATES AND JOINT VENTURES

	Interest held 30-Jun-13	Balance date
Investments in joint ventures		
healthAlliance N.Z. Limited	20%	30-Jun
New Zealand Health Innovation Hub Limited Partnership	25%	30-Jun
Investments in associates		
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	33.30%	30-Jun

11 INVESTMENTS IN ASSOCIATES AND JOINT VENTURES (CONTINUED)

Awhina Waitakere Health Campus is a jointly controlled operation between Unitec Institute of Technology and Waitemata DHB per the terms of the joint venture agreement dated March 2011 which expires in 2016. The agreement is renewable for a further term of five years. Each party has provided certain capital inputs and share the operating costs of the Simulation Centre and conference facilities.

Value of investments in associate and joint ventures

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
healthAlliance N.Z. Limited	18,179	9,535	18,179	9,535
New Zealand Health Innovation Hub Limited Partnership	0	0	0	0
Northern Regional Alliance Ltd	0	0	0	0
Total investments	**18,179**	**9,535**	**18,179**	**9,535**

There were no impairment losses in the value of associates and joint ventures assessed for 2013 (2012: $nil). The fair value of investment in healthAlliance N.Z. Limited is the same as the book value $18.179m (2012: $9.535m).

Summary of financial information of joint ventures

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus $000
2013					
healthAlliance N.Z. Limited	85,566	19,280	66,286	99,222	32
New Zealand Health Innovation Hub Limited Partnership	894	526	368	1,749	369
Total	**86,460**	**19,806**	**66,654**	**100,971**	**401**
2012					
healthAlliance N.Z. Limited	61,453	19,629	41,824	90,485	0
New Zealand Health Innovation Hub Limited Partnership	0	0	0	0	0
Total	**61,453**	**19,629**	**41,824**	**90,485**	**0**

11 INVESTMENTS IN ASSOCIATES AND JOINT VENTURES (CONTINUED)

Summary of financial information of associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus $000
2013					
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	14,156	13,353	803	12,184	148
Northern Regional Training Hub *	0	0	0	2,374	(87)
Total	**14,156**	**13,353**	**803**	**14,558**	**61**
2012					
Northern DHB Support Agency	6,059	5,387	672	8,253	38
Northern Regional Training Hub (formerly Auckland Regional RMO Service Limited)	2,414	2,365	49	3,033	47
Total	**8,473**	**7,752**	**721**	**11,286**	**85**

* Northern Regional Training Hub merged into Northern Regional Alliance Ltd on 28 February 2013

Share of surplus / (deficit) of associated entities.

	Actual 2013 $000	Actual 2012 $000
Share of surplus / (deficit) before tax:	20	28
Les: Tax expense	0	0
Share of surplus / (deficit)	**20**	**28**

The Group's share of the surplus / (deficit) in associated entities above has not been accounted for on the grounds of materiality.

12 PROPERTY, PLANT, AND EQUIPMENT

Parent and Group	Land $000	Buildings $000	Underground Infrastructure $000	Fixed Dental Clinics & Pads $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Cost or valuation									
Balance at 1 July 2011	109,419	264,134	0	0	83,592	32,252	6,792	21,789	517,978
Additions from WIP	0	46,143	0	4,512	10,650	1,265	0	(62,570)	0
Revaluation increase/(decrease)	2,481	(18,288)	0	0	0	0	0	0	(15,807)
Additions to WIP	0	0	0	0	0	0	0	56,385	56,385
Disposals	0	0	0	0	0	(128)	(2,787)	0	(2,915)
Balance at 30 June 2012	**111,900**	**291,989**	**0**	**4,512**	**94,242**	**33,389**	**4,005**	**15,604**	**555,641**
Balance at 1 July 2012	111,900	291,989	0	4,512	94,242	33,389	4,005	15,604	555,641
Reclassify Property *	0	9,044	0	0	0	(9,044)	0	0	0
Additions from WIP	0	9,883	0	3,278	4,648	5,228	47	(23,084)	0
Revaluation increase/(decrease)	11,332	(1,812)	14,257	397	0	0	0	0	24,174
Additions to WIP	0	0	0	0	0	0	0	54,546	54,546
Disposals	0	(77)	0	0	(79)	(713)	0	(7,719)	(8,588)
Balance at 30 June 2013	**123,232**	**309,027**	**14,257**	**8,187**	**98,811**	**28,860**	**4,052**	**39,347**	**625,773**

*The property at 124A Shakespeare Rd which is owned by Waitemata DHB was previously incorrectly classified as Other Equipment – lessee's interest in property

12 PROPERTY, PLANT, AND EQUIPMENT (CONTINUED)

Parent and Group	Land $000	Buildings $000	Underground Infrastructure $000	Fixed Dental Clinics & Pads $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Accumulated depreciation and impairment losses									
Balance at 1 July 2011	0	0	0	0	55,163	21,553	6,666	0	83,382
Depreciation expense	0	12,681	0	0	6,305	2,005	156	0	21,147
Impairment losses	0	2,588	0	0	0	0	0	0	2,588
Elimination on disposal/transfer	0	0	0	0	0	(125)	(2,886)	0	(3,011)
Elimination on revaluation	0	(15,269)	0	0	0	0	0	0	(15,269)
Balance at 30 June 2012	**0**	**0**	**0**	**0**	**61,468**	**23,433**	**3,936**	**0**	**88,837**
Balance at 1 July 2012	0	0	0	0	61,468	23,433	3,936	0	88,837
Reclassify Leasehold Property*	0	4,048	0	0	0	(4,048)	0	0	0
Depreciation expense	0	12,432	0	0	6,416	2,120	47	0	21,015
Impairment losses	0	0	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	(90)	0	0	(79)	(711)	0	0	(880)
Elimination on revaluation	0	0	0	0	0	0	0	0	0
Balance at 30 June 2013	**0**	**16,390**	**0**	**0**	**67,805**	**20,794**	**3,983**	**0**	**108,972**
Carrying amounts									
At 1 July 2011	109,419	264,134	0	0	28,429	10,699	126	21,789	434,596
At 30 June and 1 July 2012	111,900	291,989	0	4,512	32,774	9,956	69	15,604	466,804
At 30 June 2013	**123,232**	**292,637**	**14,257**	**8,187**	**31,006**	**8,066**	**69**	**39,347**	**516,801**

*The property at 124A Shakespeare Rd which is owned by Waitemata DHB was previously incorrectly classified as Other Equipment – lessee's interest in property

The net carrying amount of assets held under finance leases is $241k (2012: $323k) for clinical equipment.

IT assets in Work In Progress $403k (2012: $6.049m) will be transferred to healthAlliance N.Z. Limited once completed.

12 PROPERTY, PLANT, AND EQUIPMENT (CONTINUED)

Valuation
The total fair value of land and buildings valued by M E Gamby of Telfer Young as at 30 June 2012 amounted to $408.401m, and with the valuations recorded in the current year for land, underground infrastructure and leased dental sites/improvements and the estimated fair value movement in buildings, the estimated fair value of all assets on a revaluation cycle as at 30 June 2013 is now $453.21m.

Land
Land is valued at fair value using market-based evidence on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

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

The most recent valuation of land was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2012. A desktop valuation was performed as at 30 June 2013 and the land values were adjusted accordingly.

Buildings, Underground Infrastructure, Fixed Dental Clinics and Pads
Specialised hospital buildings, underground infrastructure and fixed dental clinics and pads are valued at fair value using depreciated replacement cost because no reliable market data is available for such assets.

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

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity;
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information;
- The remaining useful life of assets is estimated;
- Straight-line deprecation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

The most recent valuation of buildings and underground infrastructure was performed by a registered independent valuer, M E Gamby of Telfer Young and the valuation is effective as at 30 June 2012. Fixed dental clinics and pads were valued by the same valuer effective as at 30 June 2013.

Impairment
The review and revaluation of buildings resulted in the impairment loss of NIL (2012: $2.588m, 2011: $6.400m). Total combined impairment losses to date of $8.988m consist of:

- $6.605m for a leaky building and $13k seismic upgrade cost at the Mason Clinic;
- $503k seismic upgrade cost at North Shore Hospital;
- $1.867m seismic upgrade cost at Waitakere Hospital.

Condition assessments and remediation plans have been prepared for all buildings. In relation to Mason Clinic, work has been completed for urgent temporary and minor repairs. Unspent capital and operational funds have been reprioritised to cover repair costs, with the full programme of work expected to take two to three years. Litigation advice has been taken and legal action is underway. Decanting space options for housing patients are also being worked through.

Restrictions on title
The DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold. Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981 and, in relation to some land, a right of first refusal in favour of Tamaki Makaurau pursuant to the provisions of a Deed of Settlement with the Crown in relation to Treaty of Waitangi claims.

12 PROPERTY, PLANT, AND EQUIPMENT (CONTINUED)

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

13 INTANGIBLE ASSETS

Movements for each class of intangible assets are as follows:

Parent and Group	HBL–FPSC Work in Progress $000	Acquired software $000	Internally developed software $000	Total $000
Cost				
Balance at 1 July 2011	0	1,118	3,148	4,266
Additions from WIP	0	0	0	0
Additions to WIP	0	0	0	0
Transfer to assets held for sale	0	(1,118)	(3,148)	(4,266)
Balance at 30 June 2012	0	0	0	0
Additions from WIP	0	236	0	236
Additions to WIP	3,129	0	0	3,129
Transfer back from healthAlliance *	0	2,787	0	2,787
Balance at 30 June 2013	3,129	3,023	0	6,152
Accumulated amortisation and impairment losses				
Balance at 1 July 2011	0	0	0	0
Amortisation expense	0	175	0	175
Transfer to assets held for sale	0	(175)	0	(175)
Balance at 30 June 2012	0	0	0	0
Amortisation expense	0	135		135
Transfer back from healthAlliance *	0	2,787	0	2,787
Balance at 30 June 2013	0	2,922	0	2,922
Carrying amounts				
At 1 July 2011	0	1,118	3,148	4,266
At 30 June 2012	0	0	0	0
At 30 June 2013	**3,129**	**101**	**0**	**3,230**

* As at 1 July 2011, all intangible assets were transferred to healthAlliance N.Z. Limited, however this included specialised radiology IT assets and systems which should have been retained by Waitemata DHB. These were transferred back to Waitemata DHB in 2013.

HBL FPSC Work in Progress is the investment in Health Benefits Limited for the Finance Procurement Supply Chain workstream which is currently underway. Waitemata DHB has made investment payments totalling $3.129m (2012: Nil) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) program. The FPSC program is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

13 INTANGIBLE ASSETS (CONTINUED)

HBL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares;

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to the "B" Class share include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of the Waitemata DHB. The five provisions are:

- The service level agreement is renewable indefinitely at the option of the DHBs; and
- The DHBs intend to renew the agreement indefinitely; and
- There is satisfactory evidence that any necessary conditions for renewal will be satisfied; and
- The cost of renewal is not significant compared to the economic benefits of renewal; and
- The fund established through the on-charging of depreciation by HBL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions above means the investment upon capitalisation (at the implementation of the FPSC program) results in the asset being recognised as an indefinite life intangible asset.

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities.

14 CREDITORS AND OTHER PAYABLES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Creditors and accrued expenses	123,928	95,974	124,074	95,998
GST payable	5,854	5,768	5,854	5,768
Capital charge payable	737	471	737	471
Income in advance	993	881	993	881
Total creditors and other payables	**131,512**	**103,094**	**131,658**	**103,118**

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

15A BORROWINGS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Current portion				
Finance leases	83	83	83	83
Crown loans	70,810	100,230	70,810	100,230
Total current portion	**70,893**	**100,313**	**70,893**	**100,313**
Non-current portion				
Finance leases	158	240	158	240
Crown loans	188,596	120,696	188,596	120,696
Total non-current portion	188,754	120,936	188,754	120,936
Total borrowings	**259,647**	**221,249**	**259,647**	**221,249**
Borrowing facility limits				
Crown loan facility limit	262,820	262,820	262,820	262,820
Overdraft facility	0	40,000	0	40,000
Total borrowing facility limits	**262,820**	**302,820**	**262,820**	**302,820**

Crown loans

The Crown loans are secured by a negative pledge.

Without the MOH's prior written consent, the DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted;
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value; or
- provide or accept services other than for proper value and on reasonable commercial terms.

All financial covenants in relation to Crown debt were waived.

The fair value of Crown loans is $267.933m (2012: $237.739m). Fair value has been determined using the contractual cashflows discounted by the Government bond rate plus 15 basis points.

Overdraft facility
At 30 June 2012 the DHB had an overdraft facility with Westpac Bank ($1m) and with ANZ ($39m). These facilities were cancelled during the 2013 financial year following Waitemata DHB entering into a shared commercial banking arrangement with Health Benefits Ltd, Westpac and other DHB's.

Finance leases
Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default. The net carrying amount of assets held under finance lease is disclosed in note 12.

15A BORROWINGS (CONTINUED)

The fair value of finance leases is $241k (2012: $323k). Fair value has been determined using contractual cash flows discounted using a rate based on market borrowing rates at balance date.

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Minimum lease payments payable:				
No later than one year	108	108	108	108
Later than one year and not later than five years	205	313	205	313
Later than five years	0	0	0	0
Total minimum lease payments	313	421	313	421
Future finance charges	(72)	(98)	(72)	(98)
Present value of minimum lease payments	241	323	241	323
Present value of minimum lease payments				
No later than one year	83	83	83	83
Later than one year and not later than five years	158	240	158	240
Later than five years	0	0	0	0
Total present value of minimum lease payments	241	323	241	323

Description of finance leasing arrangements
The DHB has entered into a finance lease for clinical equipment. There are no restrictions placed on the DHB by any of the finance leasing arrangements.

15B BOND FORWARD RATE AGREEMENTS (BOND FRAS)

Waitemata DHB has entered into two derivative financial instruments known as Forward Rate Agreements (FRA's) with Westpac Bank on 2 July 2012. These instruments are used to manage the significant re-pricing risk inherent in the Waitemata DHB loan portfolio in regards to the $83.5m of loans maturing in April 2015. The Bond FRAs have the effect of spreading $50m of repricing risk in 2015 to $25m in 2019 and $25m in 2023.

Each year the fair value of these derivative financial instruments are recognised in the accounts. Fair value is determined by Westpac. An independent valuation was also provided by ETOS. Fair value of the Bond FRA is impacted by the current market bond yield and the term repo rate. The fair value of Waitemata DHB Bond FRAs at 30 June 2013 was a net loss position of $204k (2012 Nil).

16 EMPLOYEE ENTITLEMENTS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Current portion				
Accrued salaries and wages	11,434	18,655	11,434	18,655
Annual leave	45,463	44,300	45,463	44,300
Sick leave	957	1,078	957	1,078
Sabbatical leave	616	300	616	300
Continuing medical education leave & costs	6,538	5,360	6,538	5,360
Long service leave	323	319	323	319
Retirement gratuities	1,964	1,841	1,964	1,841
Total current portion	67,295	71,853	67,295	71,853
Non-current portion				
Continuing medical education leave & costs	4,840	3,926	4,840	3,926
Long service leave	5,117	5,208	5,117	5,208
Retirement gratuities	9,138	8,639	9,138	8,639
Sick leave	2,098	2,717	2,098	2,717
Total non-current portion	21,193	20,490	21,193	20,490
Total employee entitlements	**88,488**	**92,343**	**88,488**	**92,343**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and future likely settlement rates for Waitemata DHB specific employment groups. An inflation factor of 1.0% (2012: 1.0%) was used.

17 PROVISIONS

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Current portion				
ACC Partnership Programme	478	441	478	441
Total current portion	478	441	478	441
Total provisions	**478**	**441**	**478**	**441**

17 PROVISIONS (CONTINUED)

Movements for each class of provision are as follows:

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Balance at 1 July	441	562	441	562
Movement in provisions	37	(121)	37	(121)
Amounts used	0	0	0	0
Balance at 30 June	**478**	**441**	**478**	**441**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2013. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 11% (2012: 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

The risk margin has been determined after consideration of past claims history, costs, and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

Key assumptions:

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

- an average assumed rate of inflation of 2.4% (2012: 3%);
- a weighted average discount factor of 2.7% (2012: 3.5%) has been applied.

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 24 months following the lodgement date. At the end of 24 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.

18 EQUITY

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Crown equity				
Balance at 1 July	103,015	97,824	103,015	97,824
Capital contributions from the Crown	0	5,191	0	5,191
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	103,015	103,015	103,015	103,015
Accumulated surpluses/(deficits)				
Balance at 1 July	(63,491)	(68,500)	(63,491)	(68,500)
Surplus/(deficit) for the year	6,835	4,820	5,996	5,009
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(839)	189	0	0
Balance at 30 June	(57,495)	(63,491)	(57,495)	(63,491)
Revaluation reserves				
Balance at 1 July	127,241	130,369	127,241	130,369
Impairment loss	0	(2,588)	0	(2,588)
Revaluations	24,176	(540)	24,176	(540)
Balance at 30 June	151,417	127,241	151,417	127,241
Revaluation reserves consist of:				
Land	117,748	106,414	117,748	106,414
Buildings	19,015	20,827	19,015	20,827
Infrastructure assets	14,257	0	14,257	0
Dental clinics	397	0	397	0
Total revaluation reserves	151,417	127,241	151,417	127,241
Trust funds				
Balance at 1 July	5,827	6,016	0	0
Movement	838	(189)	0	0
Balance at 30 June	6,665	5,827	0	0
Total equity	**203,602**	**172,592**	**196,937**	**166,765**

Included in the DHB's accumulated surpluses/deficits is nil (2012: $ 12.2m) unspent mental health ring fenced funding representing the excess of funding received over relevant mental health expenses since this funding was established.

19 RECONCILIATION OF NET SURPLUS/(DEFICIT) TO NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Net surplus/(deficit)	6,835	4,820	5,996	5,009
Add/(less) non-cash items				
Loss on Derivatives	204	0	204	0
Depreciation and amortisation expense	21,157	21,322	21,157	21,322
Total non-cash items	21,361	21,322	21,361	21,322
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/ loss on investments	0	1,112	0	1,052
(Gains)/losses on disposal of property, plant and equipment	0	0	0	0
Total items classified as investing or financing activities	0	1,112	0	1,052
Add/(less) movements in statement of financial position items				
Debtors and other receivables	2,537	1,520	2,383	1,372
Inventories	(326)	(51)	(326)	(51)
Creditors and other payables	29,421	(3,937)	29,485	(3,511)
Provisions	241	(121)	241	(121)
Employee entitlements	(3,855)	11,275	(3,855)	11,275
Net movements in working capital items	28,018	8,686	27,928	8,964
Net cash flow from operating activities	**56,214**	**35,940**	**55,285**	**36,347**

20 CAPITAL COMMITMENTS AND OPERATING LEASES

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Capital commitments				
Property, plant and equipment	59,614	38,260	59,614	38,260
Intangible assets	4,129	3,589	4,129	3,589
Total capital commitments	**63,743**	**41,849**	**63,743**	**41,849**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

20 CAPITAL COMMITMENTS AND OPERATING LEASES (CONTINUED)

Non-cancellable operating leases as lessor
The future aggregate receipts to be received under other non-cancellable contractual operating leases are as follows:

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Not later than one year	166	205	166	205
Later than one year and not later than five years	276	652	276	652
Later than five years	0	39	0	39
Total non-cancellable operating leases as lessor	**442**	**896**	**442**	**896**

The majority of these commitments relate to leasing out sites to third parties.

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		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Not later than one year	6,878	6,454	6,878	6,454
Later than one year and not later than five years	15,282	13,275	15,282	13,275
Later than five years	2,052	2,160	2,052	2,160
Total non-cancellable operating leases as lessee	**24,212**	**21,889**	**24,212**	**21,889**

The DHB leases a number of buildings under operating leases, the largest of which are as follows:

- A mental health and administration building on the North Shore is leased with an expiry date of 04 May 2019, with a right of renewal for a further five year period with an annual rent increase of 2%.
- A mental health unit in West Auckland is leased with an expiry date of 29 March 2016, with a right of renewal for a further two periods of five years each, and a review to market rent every three years.

21 CONTINGENCIES

Contingent liabilities
Lawsuits against the DHB
Waitemata DHB and its associates have been notified of seven potential legal claims at 30th June 2013 which creates a contingent liability totalling approximately $306k (2012: six claims approximately $575k).

Unitec Institute of Technology have granted $435k (2012: $435k) towards the refurbishment of Awhina Health Campus which was completed on 02 November 2011. If certain conditions in the joint venture agreement are not fulfilled, Waitemata DHB would need to repay some, or all, of this amount.

Contingent assets
DHB has one unquantified contingent receivable (2012: $nil). Legal proceedings have been issued against the parties involved in the construction of The Mason Clinic under the Weathertight Homes Resolution Services Act 2006. At the date of the approval of these financial statements the case has not been resolved and is due to be presented to the High Court in October 2013 for final resolution. As a result it is not possible to quantify any probable inflow of economic benefit to the Board. The identity of the parties involved in the case cannot be disclosed, as this would prejudice the resolution of the dispute, as this information is not public knowledge.

22 RELATED PARTY TRANSACTIONS

All related party transactions have been entered into on an arm's length basis. The DHB is a wholly-owned entity of the Crown.

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $1.313b (2012: $1.260b) to provide health services in the Waitemata area for the year ended 30 June 2013.

Transactions and balances with other DHBs for the care of patients outside the respective DHB district are as follows:

Parent and Group	Actual 2013 $000	Actual 2012 $000
Transactions with other DHBs		
Services provided to the DHB by other DHBs	315,562	306,230
Payable for services provided to the DHB	449	8,079
Services provided by the DHB to other DHBs	77,623	78,700
Receivable for services provided by the DHB	2,687	3,646

Collectively, but not individually significant, transactions with government-related entities
In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2013 totalled $12.55m (2012: $9.24m). These purchases included the purchase of electricity from Meridian Energy, air travel from Air New Zealand, postal services from New Zealand Post, products from NZ Blood Service and employer contributions to ACC.

Related party transactions with the DHB's subsidiary, associates and joint ventures

	Actual 2013 $000	Actual 2012 $000
Subsidiary – The Three Harbours Health Foundation		
Services provided to the DHB	10	6
Payable for services provided to the DHB	0	0
Services provided by the DHB	1,304	1,242
Receivable for services provided by the DHB	487	403
Associate – Northern Regional Training Hub Ltd (merged with Northern Regional Alliance Ltd on 28 February 2013)		
Services provided to the DHB	2,103	2,370
Payable for services provided to the DHB	0	0
Services provided by the DHB	44	68
Receivable for services provided by the DHB	0	9

22 RELATED PARTY TRANSACTIONS (CONTINUED)

Related party transactions with the DHB's subsidiary, associates and joint ventures

	Actual 2013 $000	Actual 2012 $000
Associate – Northern Regional Alliance Limited (formerly Northern DHB Support Agency Limited)		
Services provided to the DHB	7,496	2,963
Payable for services provided to the DHB	261	233
Services provided by the DHB	1,049	870
Receivable for services provided by the DHB	150	73
Joint Venture – healthAlliance N.Z. Limited		
Services provided to the DHB	24,446	22,394
Payable for services provided to the DHB	0	595
Services provided by the DHB	135	143
Receivable for services provided by the DHB	0	207
Joint Venture – Unitec Institute of Technology re Awhina Waitakere Health Campus		
Services provided to the DHB	0	55
Payable for services provided to the DHB	0	0
Services provided by the DHB	338	505
Receivable for services provided by the DHB	53	57
Joint Venture – New Zealand Health Innovation Hub Limited Partnership		
Services provided to the DHB	200	0
Payable for services provided to the DHB	230	230
Services provided by the DHB	0	0
Receivable for services provided by the DHB	0	0
Investments in Crown Entities – Health Benefits Limited		
FPSC Programme Contribution by DHB - operating	235	364
FPSC Programme Contribution by DHB – capital for B class shares	3,129	0
Interest revenue from HBL treasury services	4,849	366
Interest receivable at year end	925	366
Capital commitment to FPSC programme	1,690	0
Funding provided by DHB	665	661
Shared banking fee	16	4

22 RELATED PARTY TRANSACTIONS (CONTINUED)

Transactions with key management personnel

Key management personnel compensation	Actual 2013 $000	Actual 2012 $000
Salaries and other short-term employee benefits	2,793	2,888
Post-employment benefits	68	68
Other long-term benefits	(3)	10
Termination benefits	38	145
Total key management personnel compensation	**2,896**	**3,111**

Key management personnel include the Chief Executive and the other six members of the management team (2012: seven members).

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2012: $nil).

There were no commitments with related parties, except for the purchase of B class shares in HBL as detailed in note 13 Intangibles which has a commitment of $1.69m (2012: $nil)

22 RELATED PARTY TRANSACTIONS (CONTINUED)

Related party transactions involving Board members

During the year, the DHB transacted with entities in which Waitemata Board members or Senior Management had control or joint control, as set out in the following table. Board members do not participate in decisions directly related to funding of related entities and the terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship.

			Transactions 2012/13 $000				
			Payments	Receipts	Outstanding at 30 June		
Board Member	**Relationship**	**Organisation**	**to**	**from**	**Payable**	**Receivable**	**Nature of Service**
Warren Flaunty	Trustee	West Auckland Hospice	1,765	0	715	0	Palliative assessment care.
	Shareholder 50% (Direct Shareholding and Beneficial Interest)	Westgate Pharmacy Limited	2,590	0	0	0	Provision of community pharmacy services.
Wendy Lai	Partner	Deloitte	25	0	0	0	Consulting services, health and business management.

23 BOARD MEMBER REMUNERATION

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

	Actual 2013 $000	Actual 2012 $000
Dr Lester Levy, CNZM (Chairman)	69	70
Professor Max Abbott (Deputy Chairman)	37	38
Pat Booth, OBE	30	31
Sandra Coney, QSO	30	30
Rob Cooper	26	27
Warren Flaunty, QSM	30	31
Wendy Lai	29	29
Dr James Le Fevre	27	27
Christine Rankin	31	31
Allison Roe, MBE	29	30
Gwen Tepania–Palmer	29	29
Total board member remuneration	**367**	**373**

Co-opted committee members
Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $4k (2012: $5.5k) - Norman Wong (Audit and Finance Committee) $1.5k, Eru Lyndon (CPHAC and MaGAC) $2.5k.

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

No Board members received compensation or other benefits in relation to cessation (2012: $nil).

24 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands were as follows:

Total remuneration paid:

	Actual 2013	Actual 2012		Actual 2013	Actual 2012
$100,000 – 109,999	151	164	$360,000 – 369,999	5	1
$110,000 – 119,999	89	69	$370,000 – 379,999	4	4
$120,000 – 129,999	52	52	$380,000 – 389,999	2	2
$130,000 – 139,999	24	40	$390,000 – 399,999	1	1
$140,000 – 149,999	25	26	$400,000 – 409,999	1	0
$150,000 – 159,999	23	20	$410,000 – 419,999	0	2
$160,000 – 169,999	24	27	$420,000 – 429,999	1	1
$170,000 – 179,999	21	19	$430,000 – 439,999	2	0
$180,000 – 189,999	23	26	$440,000 – 449,999	0	1
$190,000 – 199,999	26	15	$450,000 – 459,999	0	0
$200,000 – 209,999	21	27	$460,000 – 469,999	1	1
$210,000 – 219,999	18	13	$470,000 – 479,999	1	2
$220,000 – 229,999	16	19	$480,000 – 489,999	2	0
$230,000 – 239,999	17	19	$490,000 – 499,999	0	0
$240,000 – 249,999	20	15	$500,000 – 509,999	1	0
$250,000 – 259,999	18	21	$510,000 – 519,999	0	1
$260,000 – 269,999	16	13	$520,000 – 529,999	0	0
$270,000 – 279,999	10	20	$530,000 – 539,999	0	0
$280,000 – 289,999	14	9	$540,000 – 549,999	1	0
$290,000 – 299,999	21	6	$550,000 – 559,999	0	1
$300,000 – 309,999	14	10	$560,000 – 569,999	0	0
$310,000 – 319,999	12	8	$570,000 – 579,999	0	0
$320,000 – 329,999	12	7	$580,000 – 589,999	0	0
$330,000 – 339,999	6	5	$590,000 – 599,999	0	0
$340,000 – 349,999	7	8	$600,000 – 609,999	1	0
$350,000 – 359,999	4	2			
			Grand Total	**707**	**677**

During the year ended 30 June 2013 there were 96 (2012: 71) employees who received compensation and other benefits in relation to cessation totalling $1.485m (2012: $1.892m).

25 EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

26 FINANCIAL INSTRUMENTS

26A FINANCIAL INSTRUMENT CATEGORIES

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
Loans and receivables				
Cash and cash equivalents	105,785	69,473	104,925	68,677
Debtors and other receivables	28,237	33,218	28,535	33,361
Investments	5,957	5,150	0	0
Total loans and receivables	139,979	107,841	133,460	102,038
Financial liabilities measured at amortised cost				
Creditors and other payables (excl income in advance & GST)	124,665	96,445	124,811	96,469
Borrowings – Crown loans	259,406	220,926	259,406	220,926
Finance leases	241	323	241	323
Total financial liabilities measured at amortised cost	384,312	317,694	384,458	317,718
Financial liabilities measured at fair value				
Derivative Financial Instruments - Bond FRA's	204	0	204	0
Total financial liabilities measured at fair value	204	0	204	0

26B FAIR VALUE HIERARCHY

Waitemata DHB has entered into two derivative financial instruments known as Forward Rate Agreements (FRA's) with Westpac Bank on 2 July 2012. These instruments are used to manage the significant re-pricing risk inherent in the Waitemata DHB loan portfolio in regards to the $83.5m of loans maturing in April 2015. The Bond FRAs have the effect of spreading $50m of repricing risk in 2015 to $25m in 2019 and $25m in 2023.

Each year the fair value of these derivative financial instruments are recognised in the accounts. Fair value is determined by Westpac. An independent valuation was also provided by ETOS. Fair value of the Bond FRA is impacted by the current market bond yield and the term repo rate. The fair value of Waitemata DHB Bond FRAs at 30 June 2013 was a net loss position of $204k (2012 Nil).

26C FINANCIAL INSTRUMENT RISKS

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

Market risk

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

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

- Two Bond FRAs were entered into to manage the interest re-pricing risk inherent in the Crown debt of $83.5m maturing in April 2015. If interest rates were to increase significantly then the DHB would have been exposed to higher financing costs at the time of these loans maturing in 2015.

Sensitivity analysis

As at 30 June 2013, if the underlying factors (Current Market Bond Yield and Term Repo Rate) changed by +/- 100 basis points, all other variables held constant, the DHB surplus for the year would have changed as follows:

Bond FRA maturity	Bond	Valuation 30 June 2013 $000	+100bp $000	-100bp $000
13 April 2015	March 2019	29	876	(816)
13 April 2015	April 2023	(233)	1,327	(1,793)
Total (loss) profit on Bond FRAs		**(204)**	**2,203**	**(2,609)**

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits and borrowings from the Crown. Cash flow interest rate risk on fixed rate loans is limited to the maturity date of each fixed rate debt facility. Risk relating to $50m of the fixed rate borrowings is managed by the Bond FRAs as detailed in the previous paragraph. The exposure on the cash deposits and floating rate borrowings is not considered significant and is not actively managed.

Sensitivity analysis

As at 30 June 2013, if floating interest rates had been 100 basis points higher/lower, with all other variables held constant, the surplus for the year would have been $558k lower/higher (2012: $673k) on the floating rate borrowings.

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 Waitemata DHB had no direct exposure to foreign currency risk (2012: nil).

Sensitivity analysis

As at 30 June 2013, if the NZ dollar had weakened/strengthened by 5% against the US dollar with all other variables held constant, the surplus for the year would have seen an insignificant impact.

The DHB has no outstanding foreign denominated payables at balance date (2012: $nil).

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is held as demand funds with Health Benefits Limited who invest with registered banks.

In the normal course of business, exposure to credit risk arises from demand funds with Health Benefits Limited, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The MoH is the largest debtor (approximately 53%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

26C FINANCIAL INSTRUMENT RISKS (CONTINUED)

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

	Group		Parent	
	Actual 2013 $000	Actual 2012 $000	Actual 2013 $000	Actual 2012 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalents and investments				
AA -	1,400	3,819	0	0
A+	340	0	0	0
A	305	784	0	0
BBB+	377	0	0	0
BBB	0	688	0	0
BBB-	208	0	0	0
Total counterparties with credit ratings	2,630	5,291	0	0
COUNTERPARTIES WITHOUT CREDIT RATINGS				
Cash, cash equivalents	104,925	68,677	104,925	68,677
Investments	4,187	655	0	0
Total counterparties without credit ratings	109,112	69,332	104,925	68,677
Total cash, cash equivalents and investments	**111,742**	**74,623**	**104,925**	**68,677**
Debtors and other receivables				
Existing counterparty with no defaults in the past	28,237	33,218	28,535	33,361
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**28,237**	**33,218**	**28,535**	**33,361**

Liquidity risk
Management of liquidity risk
Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining demand funds with, and the availability of funding through, the treasury services agreement with Health Benefits Limited. The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the treasury services agreement with Health Benefits Limited who maintain an overdraft facility. The DHB also receives funding from the MoH in advance of the 4th of each month.

Contractual maturity analysis of financial assets
The table below analyses financial assets into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. Future revenues on floating rate investments are based on the floating rate of the instrument at balance date. The amounts disclosed are the contractual undiscounted cash flows.

26C FINANCIAL INSTRUMENT RISKS (CONTINUED)

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2012						
Cash on hand	68,686	68,686	68,686	0	0	0
On call deposits	787	787	787	0	0	**0**
Debtors and other receivables	33,218	33,218	33,218	0	0	0
Investments	5,150	5,150	1,302	2,968	795	85
Total	**107,841**	**107,841**	**103,993**	**2,968**	**795**	**85**
2013						
Cash on hand	104,939	104,939	104,939	0	0	0
On call deposits	846	846	846	0	0	0
Debtors and other receivables	28,237	28,237	28,237	0	0	0
Investments	5,957	5,957	1,343	3,559	954	101
Total	**139,979**	**139,979**	**135,365**	**3,559**	**954**	**101**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 Year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2012						
Cash on hand	68,677	68,677	68,677	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	33,361	33,361	33,361	0	0	0
Investments	0	0	0	0	0	0
Total	**102,038**	**102,038**	**102,038**	**0**	**0**	**0**
2013						
Cash on hand	104,925	104,925	104,925	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	28,535	28,535	28,535	0	0	0
Investments	0	0	0	0	0	0
Total	**133,460**	**133,460**	**133,460**	**0**	**0**	**0**

26C FINANCIAL INSTRUMENT RISKS (CONTINUED)

Contractual maturity analysis of financial liabilities

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

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2012						
Creditors and other payables	96,445	96,445	96,445	0	0	0
Finance leases	323	323	83	83	157	0
Derivatives – Bond FRAs	0	0	0	0	0	0
Crown loans	220,926	237,739	410	1,640	2,460	233,229
Total	317,694	334,507	96,938	1,723	2,617	233,229
2013						
Creditors and other payables	124,665	124,665	124,665	0	0	0
Finance leases	241	241	83	83	75	0
Derivatives – Bond FRAs	204	204	0	204	0	0
Crown loans	259,406	267,933	71,725	90,221	46,904	59,083
Total	**384,516**	**393,043**	**196,473**	**90,508**	**46,979**	**59,083**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2012						
Creditors and other payables	96,469	96,469	96,469	0	0	0
Finance leases	323	323	83	83	157	0
Derivatives – Bond FRAs	0	0	0	0	0	0
Crown loans	220,926	237,739	410	1,640	2,460	233,229
Total	317,718	334,531	96,962	1,723	2,617	233,229
2013						
Creditors and other payables	124,811	124,811	124,811	0	0	0
Finance leases	241	241	83	83	75	0
Derivatives – Bond FRAs	204	204	0	204	0	0
Crown loans	259,406	267,933	71,725	90,221	46,904	59,083
Total	**384,662**	**393,189**	**196,619**	**90,508**	**46,979**	**59,083**

27 CAPITAL MANAGEMENT

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves, and trust funds. Equity is represented by net assets.

The DHB 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 DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern.

28 THREE HARBOURS HEALTH FOUNDATION

The DHB has consolidated its wholly-owned subsidiary Three Harbours Health Foundation (THHF). The DHB's investment in THHF is accounted for at cost of $0 (2012: $nil).

For the year ended 30 June 2013, THHF had total revenue of $3.010m (2012: $1.854m) and a net surplus of $839k (2012: $156k deficit). THHF had assets of $7.121m (2012: $6.206m) and liabilities of $456k (2012: $379k) as at 30 June 2013.

29 PATIENT TRUST MONIES AND RESTRICTED FUNDS

	Actual 2013 $000	Actual 2012 $000
Balance at 1 July	92	82
Monies received	1,068	750
Payments made	1,080	740
Balance at 30 June	**80**	**92**

The DHB administers funds on behalf of certain patients, which are held in bank accounts that are separate from the DHB's normal banking facilities. Patient fund transactions and balances are not recognised in the DHB's financial statements.

30 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET

The budget figures are those approved by the Board at the beginning of the period in the Statement of Intent.

The budget figures have been prepared in accordance with Generally Accepted Accounting Practice and NZIFRS, and are consistent with the Accounting policies adopted by the Board for the preparation of the financial statements.

Explanations for major variances from the DHB's budgeted figures in the statement of intent are as follows:

The major variances in the Statement of Comprehensive Income are due to

- Total Income for the year (excluding donations) was $4.84m greater than budget due mostly to additional funding received for services from the Crown after the finalisation of the budget. This includes additional funding received for Before School Checks and Vaccines within Community Pharmacy. It also includes PHO funding in excess of budget for Care Plus, Very Low Cost Access, and Under 6's services.
- Expenditure for the year was $846k greater than budget. This includes additional volumes and services purchased by the Crown.

30 EXPLANATION OF MAJOR VARIANCES AGAINST BUDGET (CONTINUED)

The major variances in the Statement of Financial Position are due to

- Improved collection of trade receivables
- Purchase of the B class shares in HBL for the FPSC programme
- Creditors and other payables were higher than planned due to higher than anticipated levels of accrued expense largely from IDF positions and demand driven payments

The major variances in the Statement of Cashflow are attributed to:

- Improved operating cashflow of $31.4m due to
  - Increased receipts from patient care mostly due to the net IDF receivables and payables position being offset in the budget, but separated out for actual results at year end
  - a similarly higher variance in payments to suppliers being due to IDF offsets in the budget
  - increase in outstanding creditors and other payables
- Improved investing cashflow of $7.4m due to capital expenditure being below plan by $8.6m mainly due to the timing of invoicing on major projects

31 COMPLIANCE WITH THE CROWN ENTITIES ACT

Section 139(2) of the Crown Entities Act 2004 requires Waitemata DHB in its Statement of Intent to include two forecast financial statements, the first for the parent and the second for the group. Waitemata DHB did not comply with this requirement in respect of its Statement of Intent for 2012/13 regarding the group forecast financial statements.

Independent Auditor's Report

To the readers of Waitemata District Health Board and group's financial statements and performance information for the year ended 30 June 2013

The Auditor-General is the auditor of Waitemata 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 performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 61 to 105, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, 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 on pages 13 to 59 that comprises the statement of service performance, and which includes outcomes.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 61 to 105:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 13 to 59:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. This is the date at which our opinion is expressed.

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

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control 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.

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

KSMackenzie

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

APPENDICES
WAITEMATA DHB CURRENT BOARD MEMBERS/COMMITTEE MEETINGS: JULY 2012 – JUNE 2013

Board Member	Board 7 Mtgs	HAC 7 Mtgs	Audit and Finance 8 Mtgs	CPHAC 8 Mtgs	DiSAC 4 Mtgs	MHGAC 4 Mtgs
 Dr Lester Levy, CNZM	7	7	6	6*	*	*
 Professor Max Abbott	5	6	8	8	2	x
 Pat Booth, OBE	7	7	x	8	4	x
 Sandra Coney, QSO	6	7	x	7	4	x
 Rob Cooper *Leave of Absence to Feb 2013 due to recovery from illness*	2	2	2	2	x	2
 Warren Flaunty, QSM	5	5	8	7	x	x
 Wendy Lai	6	6	8	*x*	x	2
 Dr James Le Fevre	6	6	x	*x*	x	3
 Christine Rankin	6	7	8	7	x	x
 Allison Roe, MBE	7	7	x	6	x	x
 Gwen Tepania-Palmer	7	7	x	*6*	x	4

Note: Attendance at committee meetings is only shown for members of the committees. Additionally, some Board members attend some meetings of committees of which they are not members.

x = not a member of committee

* = ex-officio member

The next Waitemata DHB Board elections will be held in October 2013.

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 2012/13 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Trusts

Waitemata DHB is associated with the following trusts:

Wilson Home Trust: Waitemata DHB is trustee for the Wilson Home Trust for children with physical disabilities. Waitemata DHB provides rehabilitation and respite services for children with disabilities from facilities at the Wilson Home, which it leases from the trust.

Three Harbours Health Foundation: Waitemata DHB is the appointer of trustees to this charitable trust. Funds from the trust are made available mainly for clinical research, provision of patients' comforts and amenities, staff training and education, and clinical equipment. Associated trusts, North Shore Hospital Foundation and West Auckland Health Services Foundation, operate under the umbrella of the Three Harbours Health Foundation.

Good employer obligations

Waitemata DHB is committed to meeting its legal and ethical obligations to be a good employer. The Good Employer Framework is used to guide the core objectives of the Waitemata DHB Human Resources Strategic Plan.

Waitemata DHB is a member of the EEO Trust and the organisation's Good Employer Policy makes clear that the DHB will provide:

- good and safe working conditions
- an equal employment opportunities programme
- recognition of the employment requirements of women
- recognition of the employment requirements of men
- recognition of the employment requirements of persons with disabilities
- the impartial selection of suitably qualified persons for employment
- recognition of the aims, aspirations and employment requirements of Māori people
- recognition of the aims, aspirations, cultural differences and employment requirements of Pacific Island peoples and peoples from other ethnic or minority groups
- opportunities for the enhancement of the abilities of individual employees.

Waitemata DHB's Good Employer Policy upholds the requirements of the Employment Relations Act 2000, the Race Relations Act 1971, the Human Rights Act 1993, the Health and Safety in Employment Act 1998, the State Sector Act 1998 and the Crown Entities Act 2004.

These commitments are demonstrated and supported by the DHB's Executive Leadership Team and Human Resources at a regional, organisational and service level through various activities, key initiatives and programmes including:

- participation in national Multi Employer Collective Agreements (MECA) which provide national consistency in pay and conditions of employment
- an established employee engagement framework engaging staff from all professional groups and services and providing the opportunity to interact and be involved in the decision making process with the leaders of the organisation

- job-sizing processes which are designed to provide fair and consistent salaries that comply with collective employment agreement requirements and which take account of pay rates for comparable jobs in the private sector
- a staff satisfaction survey to identify and implement ways to improve morale and job satisfaction
- a staff Information intranet site to give guidance on issues such as fraud awareness and our commitment to a smoke free environment
- provision of occupational health and safety services for staff, including the ability to 'self-refer' for any work related health issue for which an employee may wish to receive medical care or advice
- access to an independent and confidential Employee Assistance Programme to which employees may self-refer and have ready access
- information and access to services to support employees facing issues related to family violence outside the workplace
- well publicised and supported bullying and harassment prevention programme which means that staff have a clear process and are provided with support when raising issues of behavioural concern in the workplace
- provision of clinical skill development opportunities to enhance patient safety, with an emphasis on emergency management and 'moving and handling'
- tertiary level accreditation with ACC which means that Waitemata DHB staff can be confident of a safer workplace, and timely in-house management of workplace incidents
- access to a comprehensive range of education and learning opportunities designed to meet professional, clinical and career aspirations and needs
- a dedicated culturally and linguistically diverse learning programme to focus specifically on diversity and inclusion to enhance good working relationships
- commitment to providing flexible working practices where appropriate
- workforce development strategies designed to build a workforce which reflects the diverse nature of the Waitemata DHB population, with an increasing focus on the needs of our current aging workforce
- professional placements and other scholarship and career development opportunities provided by the DHB to recognise the aims, aspirations, cultural differences and employment requirements of our diverse population
- waitemata DHB's disability strategy coordinator role which advises the DHB on ways of removing barriers to employing people with disabilities
- provision of comprehensive recruitment training for managers which includes identification of gender and other bias and how to apply a fair and equitable appointment process
- initiatives to support the aging workforce and employees at all life stages in the workplace
- a focus on continuous improvement through a planned and ongoing review of all EEO and HR policies, processes and practices in operation across the organisation.

Insurance

Waitemata DHB arranged Professional Indemnity, Directors and Officers Liability and Statutory Liability insurance through a collective insurance scheme organised by Health Benefits Limited (HBL). The purpose of taking out this insurance was to ensure that no board member or employee incurred monetary loss as a result of his or her acts or omissions, provided they acted in good faith and in performance of the DHB's functions.

Waitemata District Health Board

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Waitemata
District Health Board

Best Care for Everyone

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