# WAITEMATA DHB
# ANNUAL REPORT 2015/2016

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Waitemata District Health Board

Best Care for Everyone


BODY-PROTECTED
ELECTRICAL AREA
Nurse
Waimata DHB

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# CHAIRMAN/CEO STATEMENT

Waitemata District Health Board is paving the way for a healthier population. This year, a sharpened focus on our organisational promise 'best care for everyone' put the people we serve firmly at the heart of this growth and development.

**Dr Lester Levy, CNZM**
**Chair**

**Dr Dale Bramley**
**Chief Executive Officer**

The future presents new challenges for Waitemata DHB. We are the largest and fastest growing DHB in the country with our population of nearly 600,000 set to increase by 90,000 over the next ten years. Considerable inroads are being made to meet this growth guided by our Board priorities of improving outcomes for our patients and enhancing their experience in our care.

The success of our efforts continues to be reflected in the health of our population. Our population's life expectancy is 83.9 years, more than two years higher than the national figure. While there are improvements to be made, life expectancy for Māori and Pacific people is among the highest in New Zealand at 78.7 years for Māori and 78.9 years for Pacific.

Our DHB has the lowest rate of mortality from cardiovascular disease in New Zealand and the best cancer survival rates. Our infant and cancer mortality rates are also low. Smoking rates within our population are reducing and we are well positioned to be smoke-free by 2025. Our hospitals are very safe with the lowest standardised mortality rate of any DHB and continued excellent performance across a range of Health Quality and Safety Commission measures.

Waitemata DHB has delivered the national bowel screening pilot since 2011. Detecting bowel cancer at an early stage significantly improves the chance of survival. As at February 2016, cancer had been detected in 316 people. The success of the Waitemata pilot has meant Budget 2016 will invest $39.3 million to extend the programme nationwide.

The DHB continues to increase the number of positive interventions to relieve suffering and support our patients to lead active, productive and independent lives. A clear demonstration of this is the 21,994 elective surgeries delivered in the 2015/16 year – 1,300 more than the previous year. Despite significant population growth (our population has grown by 40,000 (7%) in the last 3 years alone), we continue to meet or exceed our surgical intervention rate targets for our population for key elective procedures, while maintaining our waiting time targets.

Alongside our excellent results in improving health outcomes, we continue to live within our means generating a small surplus in the 2015/16 year. This has been achieved by containing costs to affordable levels and providing services more efficiently against a challenging financial backdrop.

During the year a number of significant new projects were completed.

Our first ever purpose-built women's ward 'Hine Ora' opened in November 2015. The $6.2 million development added 15 new beds to the North Shore campus and provides a dedicated 'butterfly room' – a lounge for grieving families to be together should they receive difficult news.

In addition, the new Sky Bridge opened in June 2016 providing an access link between the North Shore hospital and the Elective Surgery Centre. The bridge enables more complex surgeries to be performed at the Elective Surgery Centre by providing direct access between the ESC and the main hospital's High Dependency and Intensive Care unit.

2015/16 saw the final stages of construction of a new emergency department (ED) for Waitakere Hospital. The new ED provides a world-class emergency medicine facility for the people of West Auckland reflecting the DHB's commitment to meet the needs of our growing population. Demand for emergency services at Waitakere hospital is growing with ED attendances increasing 18% since 2012/13. The facility almost doubles the size and layout of the existing department with significantly upgraded clinical and family/whanau facilities to enhance patient care and experience. The increased volume of patients is not impacting on service delivery, with both North Shore and Waitakere emergency departments meeting the ED Health target - 95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours of presentation.

The Leapfrog programme, a hothouse for the DHB's set of strategic innovation projects, continues to improve patient outcomes and experiences through innovation.

This year, e-Vitals, a new system for the digital collection of nursing observations went live resulting in improved safety and more time for our clinicians to focus on patient care. ePrescribing is now fully embedded in the DHB with 950 beds using this technology to enhance medication safety. The DHB is now the most advanced in Australasia with regard to ePrescribing integration into its hospital services.

Ward 7 at North Shore Hospital was the first ward in the country where every patient is provided with a bedside iPad and use of the free DHB-wide wifi to improve their stay in hospital. The devices are part of a pilot to help patients keep connected with their lives outside of the hospital with considerable benefit to their recovery journey and ability to get back to their daily lives.

2016 also saw the launch of the DHB's Institute for Innovation and Improvement – I3. This new institute is focussed on enhancing excellence in clinical care delivery and accelerating gains in health outcomes for our population.

As we look back on another year of significant growth, we thank our healthcare partners and community providers who support the DHB in meeting our promise of best care for everyone. Most significantly we acknowledge our 7000+ staff who work hard to provide high-quality treatment and compassionate care to the people we serve.

Thank you for your support as we grow to meet the future health care needs of our community.

Dr Lester Levy, CNZM
Chair

Dr Dale Bramley
Chief Executive Officer

# MĀORI TE TIRITI - PARTNERSHIP STATEMENT

## Tū Tonu ngā Manaakitanga!

When I look back over the past year, and all of its achievements, the theme that emerges is partnership.

**R Naida Glavish ONZM**
**Chief Advisor Tikanga**

This whakatauākī represents Ngāti Whātua's sacred obligation to manaaki, or care for, all of those within our tribal boundary. It is meant as exaltation and a challenge to hold fast to this obligation.

It is helpful to bear this whakatauākī in mind as we reflect on the achievements of the past year presented in this Annual Report. I am extremely pleased to note that 93% tamariki were fully immunised at 8 months of age, and most tamariki started school having completed their B4 School checks. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities.

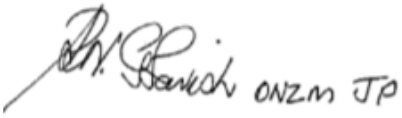
As we acknowledge all of those who have contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indicators in this report show that Māori often suffer disproportionately from health conditions compared to other groups in our communities. One only needs to view life expectancy data to get a sense of how immense the challenge to eliminate health inequities between Māori and non-Māori really is.

When I look back over the past year, and all of its achievements, the theme that emerges is partnership. The combined efforts of hospital based services, primary care providers and community organisations have contributed to a dramatic drop in the number of our whānau smoking. In order to eliminate smoking from our communities completely, every part of the health sector must be mobilised behind our vision for a smokefree Aotearoa.

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

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with Waitemata DHB. This annual report highlights the importance of our partnership, but, more importantly, it provides the basis for our partnership as we look forward to the years ahead.

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




Rangimarie Naida Glavish ONZM
**Co-Chair, Te Rūnanga o Ngāti Whātua**

# ABOUT WAITEMATA DHB

## Who we are and what we do

Waitemata DHB is the Government's funder and provider of health services to the 598,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and fastest growing DHB in the country, expecting an extra 90,000 people by 2025.

We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in twelve of our population live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas.

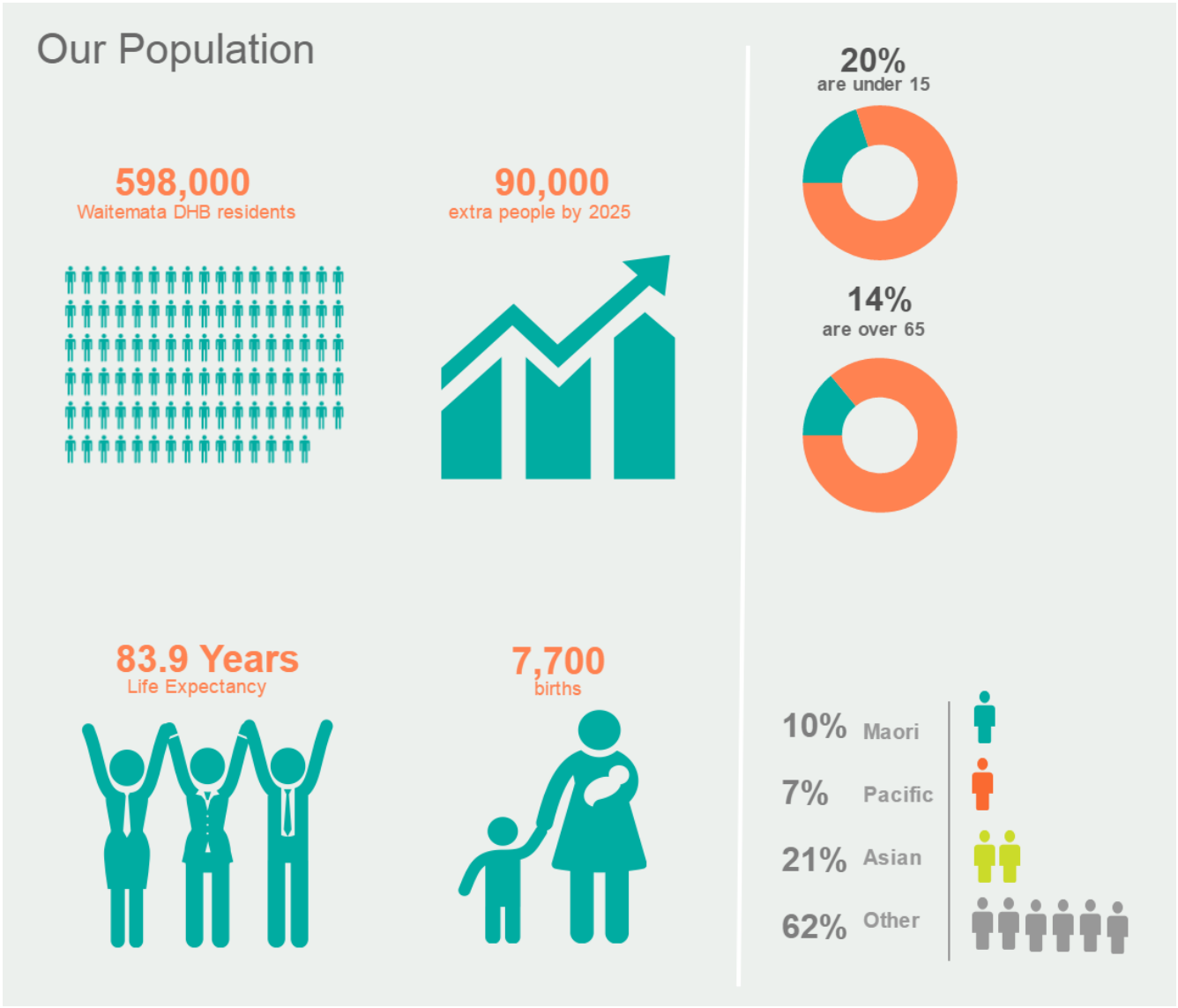
Waitemata DHB provides hospital and community services from 31 sites including North Shore Hospital, Waitakere Hospital and the Mason Clinic.

Around 7,100 people are employed by Waitemata DHB.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs.

We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, e.g. cardiac surgery and radiation oncology services, and have contracts with approximately 600 other community providers.

Our budget in 2015/16 was $1.6 billion.

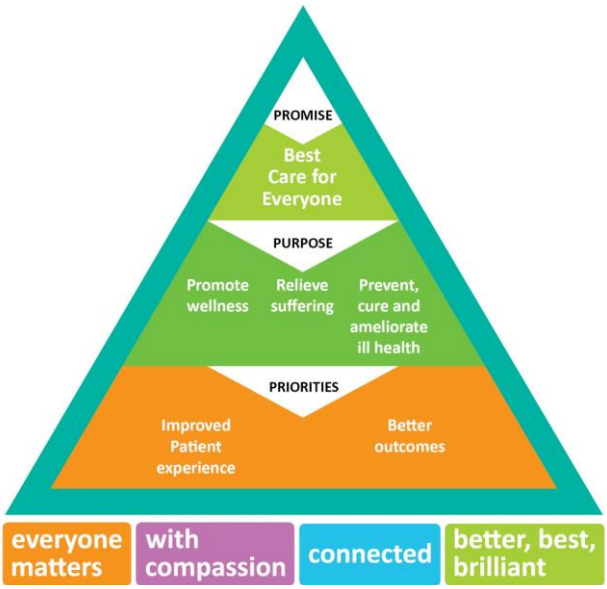


# WHAT ARE WE TRYING TO ACHIEVE?

## Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

- Our **promise** is that we will deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.
- We have two **priorities**:
  - Improved patient experience
  - Better outcomes




The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour and how we measure and continue to improve.

## Strategic Themes

In order to realise our promise of providing '**best care for everyone'** we have identified 7 strategic themes. These provide an overarching framework for the way our services will be planned, developed and delivered in the future. These themes were developed in 2015/16 and implementation will begin in 2016/17.

### Community, family/whānau and patient-centred model of care

**Patients, whānau and our community** are at the centre of our health system. The quality of the patient and whānau experience, and their outcomes, should be the starting point for the way we think, act and invest.

### Emphasis/investment on treatment and keeping people healthy

We are investing in **our people, services and facilities** across the spectrum of care, with increasing investment in preventing ill health.

### Service integration and/or consolidation

We need to **work collaboratively** to ensure that services are delivered by the best provider in the right place.

### Intelligence and insight

The **dynamic use of data, information** and technology will improve clinical decision making and develop our health insights.

### Consistent evidence informed decision making practice

Delivering **safe and high quality care** is an integral part of our culture. Evidence from research, clinical expertise, patients and whānau, and other resources drive our decisions.

### Outward focus and flexible service orientation

We put **patients first** and strive for fundamental standards of care. We must have an **openness to change**, improve and learn and be outward focused and flexible. **Strong clinical leadership** is embedded at all levels of the organisation.

### Operational and financial sustainability

**Operational and financial sustainability** is critical to our ability to deliver on our organisational promise and purpose. We need a longer-term view.

# KEY ACHIEVEMENTS

## National Health Targets

We achieved four of the six National Health Targets in Q4 15/16

Shorter stays in Emergency Departments
**95%**

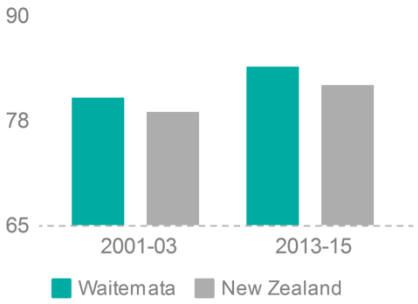
More Heart and Diabetes Checks
**91%**

Better help for Smokers to Quit
**99% Hospitals**
**91% Primary Care**

Improved access to Elective Surgery
**21,994 procedures**

## Life Expectancy

We have the highest life expectancy in the country at 83.9 years with an increase of 3.7 years since 2001




## Financial Performance

We lived within our means for the fifth straight year producing a financial surplus of $2.9m


## Better health outcomes

Health outcomes are improving with our mortality rates from cardiovascular disease and cancer among the lowest in the country and declining

### Cardiovascular disease

Nine out of ten eligible people received their cardiovascular disease risk assessment

### Cancer

We have the highest five year cancer survival ratio in the country with seven out of ten people surviving five or more years after their diagnosis

### Childrens health

**92%**

92% of 8-month old children were fully immunused on-time

## Quality and Safety

The services we provide are safe and effective

**70**

Lowest hospital standardised mortality ratio in the country

**100%**

We were 100% compliant across all Health Quality and Safety Commission markers

## Patient experience

Our patients provide excellent feedback about our services

Nine out of ten patients felt staff always treated them with respect and dignity while in hospital*

Nine out of ten patients felt they always had confidence and trust in their doctor*

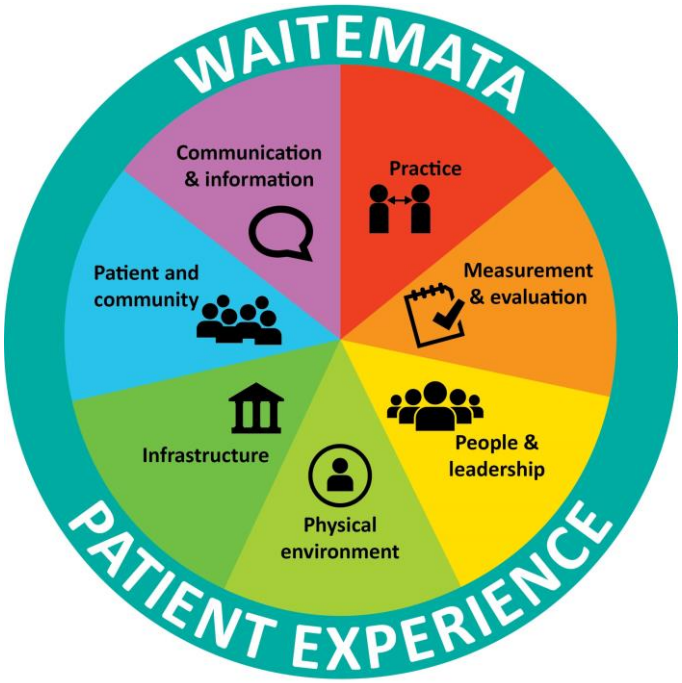
Nine out of ten patients felt they were always treated with kindness and understanding while in hospital*

*Results HQSC survey - May 2016

# THE WAITEMATA EXPERIENCE

Improving patient experience is one of our two Board priorities. We know that a postive experience has real benefits to patients and improves outcomes.

The Waitemata Experience is a programme of activity to co-design and deliver an excellent experience for patients, whānau and staff.




The programme aligns all the patient experience work occurring in the DHB allowing improved focus and a better use of resources.

Patient experience work is grouped into 8 areas of activity:
**Practice** includes improving clinical systems and processes.
**Measurement and Evaluation** sets out our tools for understanding experience to inform improvement activities.
**People and Leadership** supports our leaders to develop skills and behaviours we want to see evident in our culture
**Environment** ensures that our physical environment meets everyone's needs
**Governance** includes mechanisms that provide oversight, drive the programme, and ensure that we meet our goals
**Aligning Behaviours** supports teams and individuals to engage with our values, standards and behaviours framework
**Patient and Community Participation** makes sure our activities meet the needs of our patients, their families and the wider community
**Communication and Information** includes reviewing communications channels (websites etc.) to ensure they meet the needs of the Waitemata community.

## How we are learning from Experience

### Welcoming and Friendly

Feedback tells us that one of the most important things we can do to is to be welcoming and friendly. In response, we started a campaign to become the most welcoming DHB in New Zealand.

### Waitemata 2025

We have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whanau, and will accommodate our increasing population.

### Communication and Information

Thousands of people access information through our website every week. We have installed free WiFi throughout our hospitals. Every year we publish a Quality Account detail what we are doing to improve people's experience: www.qualityaccounts.health.nz

## Community Engagement

We have a strategy to ensure that the voices of our community are heard in everything we do.

Consumer representatives are an important part of many projects and activities within the DHB providing a community perspective in decision-making processes. Representatives come from a range of backgrounds and with a range of experiences of using health services .

In January, the DHB ran a community consultation to better understand what a primary birthing unit should look like. Two youth health expos took place in Rodney to raise awareness of the health services available to youth in the region.

### Health Links

Healthlinks are community organisations which aim to improve health in the Waitemata region by fostering community participation in health decision making.

# INNOVATION AND IMPROVEMENT

Waitemata DHB is recognised as a leader in the movement toward a more mobile, electronic health record. National comparisons, using an international measure of electronic adoption in hospitals, rank Waitemata in the top three DHBs.

The EMRAM scale tracks healthcare organisations' progress towards achieving a paperless patient record environment from Stage 0- 7, where few hospitals globally have achieved Stage 7. Waitemata DHB scored 5.275 against an overall national average of 2.78.

Many of the digital systems we have implemented were fast-tracked through the Leapfrog programme. These projects are at the core of our transition to a mobile, digital way of working for the benefit of our patients.

## Leapfrog Programme

The Leapfrog programme, a hothouse for the DHB's set of strategic innovation projects, continues to improve patient outcomes and experiences through innovation. The Leapfrog Programme was established as a means to take a large leap in moving Waitemata DHB from where we are, to where we want to be. Combining the projects under one programme provides greater visibility, attention and support from senior management and allows projects to move at a faster pace. An ability to network and share resources when the projects interlink is also an advantage.

One of the first projects in this work stream has been the implementation of fast free Wi-Fi across all facilities for staff and patients to access.

Ward 7 at North Shore Hospital was the first ward in the country where every patient is provided with a bedside iPad. The devices are part of a pilot to help patients keep connected with their lives outside of the hospital with considerable benefit to their recovery journey.


**Free Wi-Fii across all facilities not only improves patients' experience, but many other improvements to clinical productivity such as ePrescribing and eVital sign assessment.**

This year, e-Vitals, a new system for the digital collection of nursing observations went live resulting in improved safety and more time for our clinicians to focus on patient care.

We are rolling out electronic ordering systems for laboratory and radiology tests. Electronic and automated systems will help reduce administration time, duplication and unnecessary testing.

ePrescribing is now fully embedded in the DHB with 950 beds using this technology to enhance medication safety. The DHB is now the most advanced in Australasia with regard to ePrescribing integration into its hospital services.

We will be developing a system that will bring together information from multiple patient surveys into one place. Our aim is to display patient experiences and patient reported outcomes as they relate to the organisation's values in a visually engaging and easy to understand manner that will allow staff to design improvements around this patient feedback.

# Improving outcomes

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

# OUTCOMES FRAMEWORK

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

Our outcomes framework (over page) forms an essential part of the way we are held to account for making a difference to the health of our population. Overall the progress against our indicators suggests we are delivering on our vision and we are a high performing DHB that is truly making a difference to the health of our population.

*Waitemata DHB residents have the highest life expectancy in the country at 83.9 years*

*Our mortality rate from cardiovascular disease is the lowest in the country at 81.6 per 100,000 population*

*Mortality from cancer continues to decline and is lower than the national rate at 103.5 per 100,000*

Our outcomes framework focuses on the two high-level outcomes we want to achieve across the health system and beyond.

These outcomes are to:

- Increase life expectancy and improve quality of life (measured by life expectancy at birth)
- Reduce the difference in life expectancy between different ethnic groups (measured by the ethnic gap in life expectancy)

Our long-term outcomes are focused on developing and maintaining positive trends over time rather than achieving fixed annual targets. The nature of population health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change.

Sitting underneath the long-term outcome indicators, we have a set of impact measures which assess the direct impact of the services we provide over a shorter time period (one to five years).

General measures for the quality of life are not well developed therefore we have not identified a single measure of quality of life. Our outcome and impact measures contribute to overall health gain which is one domain of quality of life.

The Statement of Performance, in the 'Our People, our performance' section of this report, provides a snapshot of the services provided for our population and comprises a set of cornerstone output indicators that contribute to our outcomes framework. We monitor performance against these indicators annually.

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

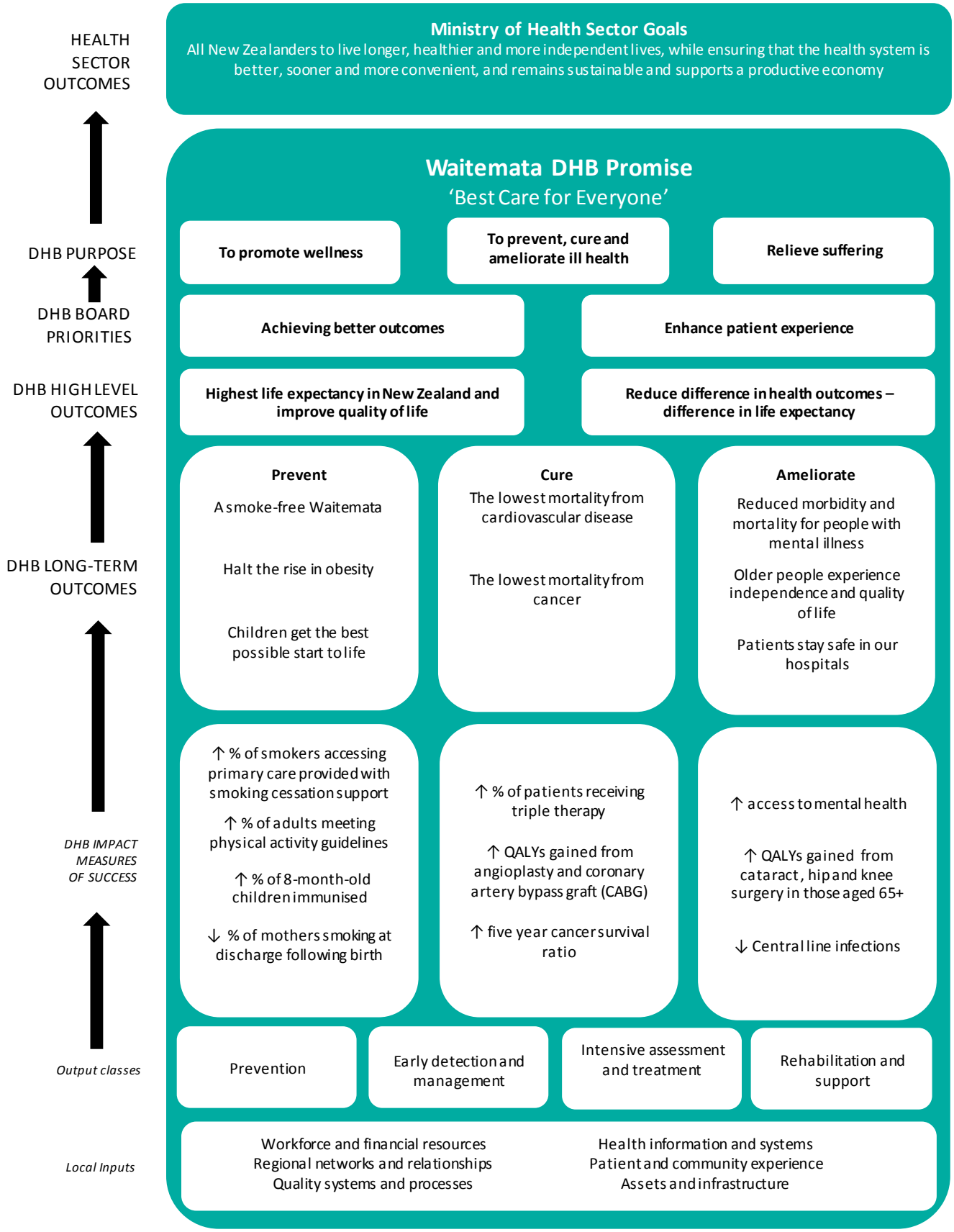
Life expectancy continues to improve, reaching 83.9 years (2013-15), the highest in the country and an increase of 2.7 years over the past decade. The gap in life expectancy has improved for Pacific, reducing by nearly 2 years, although the gap has risen slightly for Māori.

Mortality rates from cardiovascular disease and cancer continue to decline to 81.6 and 103.5 per 100,000 population respectively – both lower than national rates.

Our suicide rates are declining – 9.3 per 100,000 population compared with 10.2 per 100,000 in 2002-04.

Our infant mortality rate is amongst the lowest in the country at 3.7 per 1,000 live births (2014-15 two year combined rate) versus the national rate of 4.8 per 1,000 live births.

## Waitemata DHB Outcomes Framework



# HIGH LEVEL OUTCOMES

The high level outcomes that we aim to achieve are to increase life expectancy and quality of life and to reduce inequalities between different ethnic groups in our population. Our outcome and impact indicators can act as measures for overall health gain, which is one of the domains contributing to quality of life.

WAITEMATA HAS THE LONGEST LIFE EXPECTANCY IN NEW ZEALAND, AT

**83.9** YEARS

LIFE EXPECTANCY HAS INCREASED

**2.7** YEARS

OVER THE PAST DECADE

INEQUALITIES ARE DECREASING - LIFE EXPECTANCY OF OUR PACIFIC POPULATION HAS INCREASED

**5** YEARS

OVER THE PAST DECADE

Note: The most recent mortality data available is for the 2015 calendar year. Three-year combined estimates have been presented to reduce the effect of year to year variations in death rates.

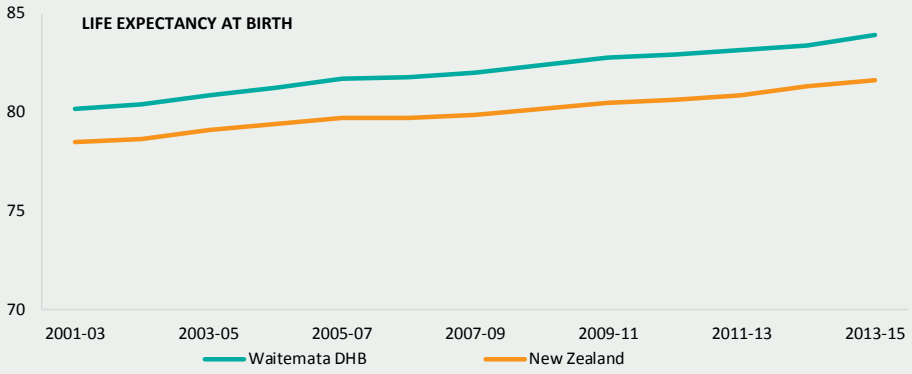
## Improving life expectancy for everyone

Life expectancy at birth (LEB) is recognised as a general measure of population health status. We have the highest life expectancy in New Zealand at 83.9 years (2013–15), which is 2.2 years higher than NZ as a whole. Half of this difference in life is attributed to our lower mortality rates from cardiovascular disease and cancer. In Waitemata, life expectancy has increased by 2.7 years over the last decade, which is 0.4 years more than the increase for the whole of New Zealand.

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 5.9 years for Māori and 5.7 years for Pacific (2013–15). Although life expectancy has increased in our Māori (2.6 years) and Pacific (5.0 years) populations over the past decade, the gap has increased slightly for our Māori population and reduced by nearly 2 years in our Pacific population. Mortality at a younger age from diseases of the circulatory system and cancers account for around 3.1 years of the life expectancy gap (2010–12, compared with European and other) in Māori, and around 3.7 years of the gap in Pacific.

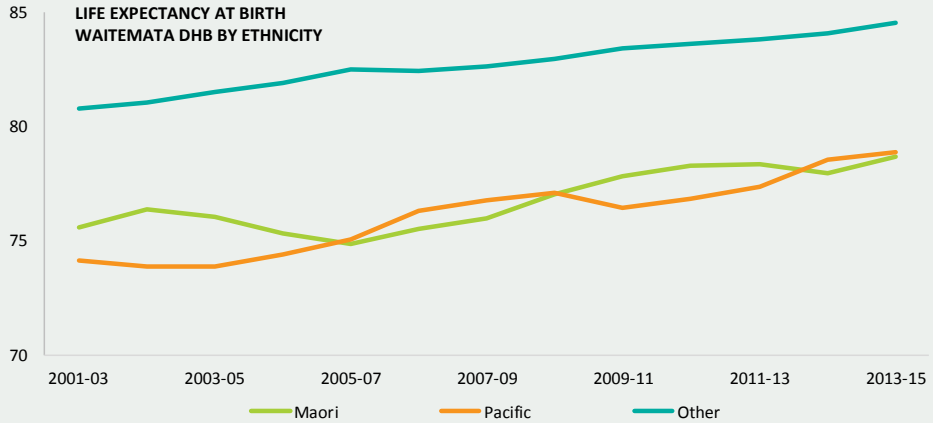
**An increase in life expectancy**

Our population has the highest life expectancy in the country at 83.9 years.




**A reduction in the ethnic gap in life expectancy**

Life expectancy for Māori is 5.9 years lower than all other ethnicities, and 5.7 years lower for Pacific people.



# PREVENTING ILL HEALTH

**'Support people to be healthier and take more responsibility for their health'**

Supporting health at all stages of a person's life helps to increase life expectancy and adds to the number of years lived in good health. We encourage people to take responsibility for their health by making healthy lifestyle choices, and engaging in preventative strategies such as childhood immunisation programmes and disease risk assessments. Our focus is on ensuring our children have a healthy start to life, and tackling the two largest causes of preventable ill health - smoking and obesity.

**12%**

OF ADULTS WERE ACTIVE SMOKERS IN 2013, A DECREASE FROM 20% IN 2001

**64,927**

SMOKERS (32%) RECEIVED CESSATION SUPPORT, AN INCREASE FROM 31% IN 2014/15

**98%**

OR 13,027 SMOKERS HOSPITALISED IN WAITEMATA FACILITIES RECEIVED SMOKING CESSATION ADVICE

**90%**

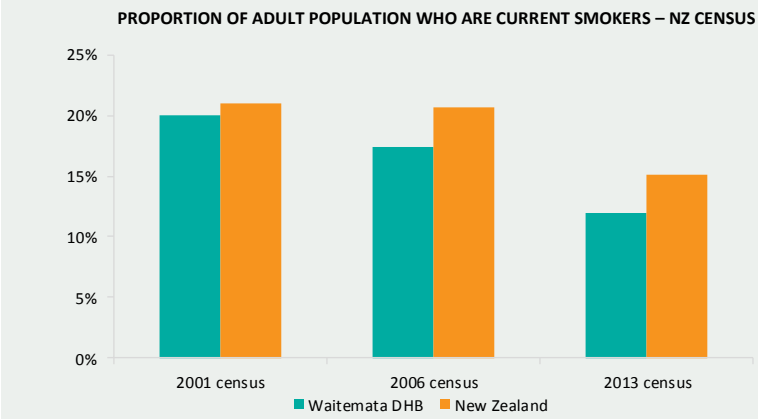
OR 232 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION ADVICE

## A smoke-free Waitemata

New Zealand has comprehensive tobacco control policies and programmes, yet smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the deaths of around 350 of our residents every year. Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities. Targeting smoking is an opportunity to significantly reduce health inequalities and drive improvements in the overall health of our population.

**A reduction in the prevalence of smoking**

Smoking rates in Waitemata are declining, and are lower than the overall NZ rate. 12% of adults identified as active smokers in 2013, down from 20% in 2001.




Providing smokers with brief advice to quit increases their chances of making a quit attempt. The chance of that quit attempt being successful is increased if medication and/or cessation support are also provided.

In 2015/16 we provided brief smoking cessation advice to 98% of smokers attending our hospitals, and 89% in primary care. PHO Smokefree co-ordinators work with GP practices to identify and assist their smoking patients. Our PHOs have programmes in place to text and phone patients to provide brief advice to those who do not regularly visit their GP.

One in three (32%) identified smokers accessing primary care are now provided with cessation support, either through a referral to 'quit smoking' services or provided with smoking cessation medication. This rate of support is slightly higher than the national rate (31% in Q4 2015/16).

Throughout 2015/16 we have had a focus on supporting pregnant women to quit smoking. 90% of women smokers registered with a DHB-employed midwife or Lead Maternity Carer were offered brief advice to quit. "Living Smokefree – It starts with YOU", our Smoking in Pregnancy Incentives programme, provided professional support to stop smoking, and incentive vouchers on the successful completion of the programme.

# Better help for smokers to quit

## *Building smokefree communities*

**89% of smokers seen in primary care were offered advice and help to quit smoking.**

Since 2011/12, Waitemata DHB has met the national health target for giving help to smokers in hospital to quit. And at local GP level there is similar success, with community-based interventions hitting the 90% target in Q4 2015/16.

Most smokers want to quit, but it's no easy mission. According to the Ministry of Health, approximately 80% of smokers wished they have never started and 65% have tried to quit in the last 5 years.

The smoking cessation programme continued to be prioritised in 2015/16, with PHOs providing project team resources to support General Practices. Influential initiatives, such as giving advice via phone calls and text messages are well received by patients.

"Living Smokefree – It starts with YOU", our Smoking in Pregnancy incentives programme, ran in 2015/16. Women referred to the programme received professional support to stop smoking, and incentive vouchers on the successful completion of the programme. Our Smokefree Pregnancy team worked with midwives to encourage referrals to the programme.

Waitemata PHO's Smokefree Communities team ran Weaving Wellness - a support group to help pregnant women and their whānau create healthier environments for future generations while having fun weaving.

Smokefree Communities also provide the Asian Smokefree Service. Experienced staff provide support in many different languages . Over the last ten years 3,500 people have been referred to the service.

The mobile Waka Auahi Kore (Quit Bus) service reaches priority populations with limited access to smoking cessation services. The service takes quit smoking messages to the whānau, hapū and iwi who most need it in venues that they are familiar with, such as marae, churches, shopping malls, work places and schools .

## *WERO stop smoking challenge*

Another success story is the WERO stop smoking team challenge. Smoking prevalence is high amongst people using mental health and addictions services, and some mental health staff also smoke. In September 2015 a WERO programme specifically for mental health services was launched. 31 teams from across Auckland competed and a large proportion of the participants were Maori and Pacific, with staff quitting alongside service users/tangata whaiora. After the 12 week programme 62% of the 114 participants were no longer smoking.

The Fono, a mental health NGO in Henderson, won overall joint 1st place in their pool. Community support worker Mileta said group support, weekly incentives and competing alongside other teams for a final prize were all key motivators for staff and group participants.


**The mobile Waka Auahi Kore (Quit Bus)**

## Halt the rise in obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Obesity impacts on quality of life and is a significant risk factor for many chronic conditions, including cardiovascular disease and some cancers. In Waitemata DHB we estimate that 18% of all male deaths and 14% of female deaths in the 15+ age group are attributable to overweight and/or obesity.

Many of the drivers of obesity sit outside the direct control of health, however not outside of our influence. We support the creation of health promoting environments that encourage and aid people to adopt healthier lifestyle choices, and provide medical intervention where appropriate.

**23%**

OF OUR ADULT POPULATION ARE OBESE, LESS THAN NZ AS A WHOLE (29%)

**43%**

OF OUR ADULT POPULATION WERE MEETING PHYSICAL ACTIVITY GUIDELINES (NZHS 2011-14, AGE STANDARDISED), A DECREASE FROM 48% IN 2006/07

**7,206**

GREEN PRESCRIPTION REFERRALS WERE MADE, AN 11% INCREASE FROM THE PREVIOUS YEAR

**81%**

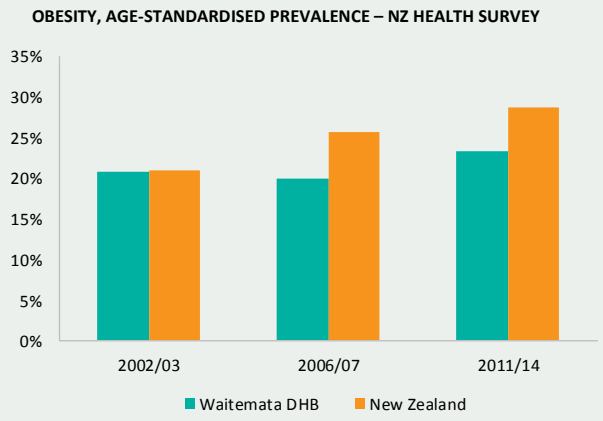
OF MOTHERS WERE BREASTFEEDING AT DISCHARGE FOLLOWING BIRTH

**58**

BARIATRIC SURGICAL PROCEDURES WERE PERFORMED

**Outcome measure: Halt the rise in adult obesity**

Although the prevalence of obesity is lower in Waitemata compared to New Zealand as a whole, it is increasing. Nearly one in four of our adult population are considered to be obese (23.4%, 2011-14). Significantly higher rates of obesity are seen in our Māori (43%) and Pacific (65%) communities (2011-13).




Our impact measure of the success of our obesity programmes is the proportion of adults meeting daily physical activity guidelines. In 2011-14, only 43% of our adult population did at least 30 minutes of exercise on 5 or more days in a week, compared with 48% in 2006/07.

We have invested in a number of programmes to tackle obesity in our district, including lifestyle interventions such as Green Prescription and Enua Ola - a community development programme funded by Waitemata DHB. A total of 35 Pacific churches and community groups across West Auckland and North Shore worked together with two health providers The Fono (West Auckland) and Pasifika Integrated Health Care (North Shore) to implement the Aiga Challenge Weightloss Competition (8 weeks), now in its third year of operation. We are also working to improve access to bariatric surgery.

We support healthy public policies, such as improving the built and food environments in which people live and work. One initiative is 'Healthy Auckland Together' which is an intersectoral, regional obesity prevention initiative and is focused on four initial key priorities; healthy food environments, children and young persons' settings, supporting Healthy Families NZ, and increasing physical activity through environmental change. The DHB has also updated and amended its organisational healthy food policies.

## Healthy Auckland Together

**Nearly 29% of our four year-old children are obese or overweight and the rates are even higher for Maori and Pacific children.**

Healthy Auckland Together (HAT) is a coalition of 21 organisations representing local government, mana whenua, health agencies – including Waitemata and Auckland DHBs - NGOs, university and consumer interest groups. We are working together to change policy and urban design, so that our environments can encourage physical activity and good nutrition.

Many drivers of obesity, inactivity and ill health exist outside the health sector, and changing these can be more effective than asking individuals to amend their ways.

### *Water-only schools*

Sugary drinks are one of the most significant causes of poor oral health and contribute to childhood obesity and Type 2 diabetes. Sugary drink consumption is associated with problem behaviours, and poor diet and nutrition are associated with lower academic achievement.

A survey of schools last year showed 10 per cent are now water-only, and just five per cent still sell full-sugar 'fizzy' drinks.

While every school will make its own decision, the Ministries of Education and Health are keen to help all schools become free of sugary drinks by the end of the year.

When Royal Rd Primary School in Massey made the move to water-only nearly a decade ago, student concentration and health improved.

*Principal Wayne Leighton says "It's just a part of the school's way now. We know their concentration levels go up and they are generally healthier drinking water."*

Healthy Families Waitakere is getting behind the water-only initiative and urging all West Auckland schools to take on the challenge. Manager Kerry Allan says as well as improving student health and wellbeing a water-only policy helps make schools healthier places.

"We support good health in places where people spend their time, such as schools and workplaces. We encourage all schools in Waitakere to see the benefits of being water-only, just as Royal Rd School has," Allan says.


**Students at Royal Road Primary benefit from the water-only policy – Healthy Families Waitakere is urging all West Auckland schools to become free of sugary drinks.**

**3.7**

PER 1,000 LIVE BIRTHS OUR INFANT MORTALITY RATE IS LOWER THAN THE NATIONAL RATE

**92%**

OF WAITEMATA CHILDREN WERE FULLY IMMUNISED BY EIGHT MONTHS OF AGE, AN INCREASE FROM 91% IN 2012/13

**93%**

OF NEW MOTHERS WERE SMOKEFREE AT POSTNATAL DISCHARGE, NO CHANGE FROM 2014/15

**4,530**

PEOPLE PARTICIPATED IN RHEUMATIC FEVER AWARENESS EVENTS

**107,271**

VISITS WERE MADE TO SCHOOL DENTAL SERVICES

**93%**

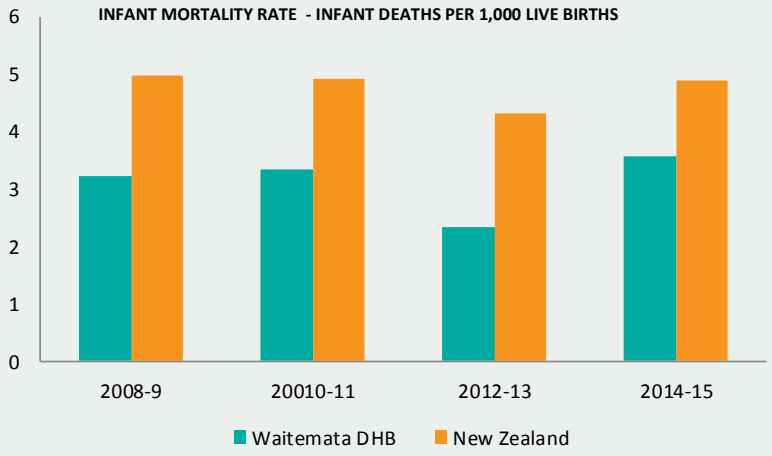
OF CHILDREN RECEIVED A COMPREHENSIVE BEFORE SCHOOL CHECK IN 2015/16

## Children get the healthiest start to life

The creation of healthy generations of children, who can enjoy their lives to the fullest and reach their potential, is critical to the region's future. The most effective time to intervene to reduce inequalities and improve long term health and wellbeing outcomes is before birth and in early childhood.

**A reduction in infant mortality**

The infant mortality rate (death of a baby in the first year of life) within Waitemata was 3.7 per 1,000 live births, lower than the national rate of 4.8 (2014-15 two year combined rate).




During 2015/16 we fully immunised 92% of children by eight months of age, an increase from 91% in 2012/13. We are in a good position to reach the national 95% target over the coming year. The equity gap is also closing with the eight month immunisation rate in Māori children increasing from 85% in 2012/13 to 90% in 2015/16.

The Before School Check is a universal, comprehensive screening and health education programme for four-year-old children. We have continued our strong performance this year with coverage rates of 97% in Māori, 99% in Pacific and 93% overall, exceeding the 90% national target.

We provide free oral health care for children from birth to 17 years. A focus of the oral health service is to ensure that all eligible children are enrolled and seen on time. The service has recognised that many children are missing out on accessing dental services and are working to address this. In 2015 the service employed a preschool coordinator to promote the importance or dental care through a variety of channels including maternity wards and early childhood centres. We are trying to make it easier for families to access our oral health services by offering family appointments, increased utilisation of mobile vans in the school holidays and extended hours.

Through our Rheumatic Fever prevention programme we are reducing rheumatic fever in our population. There were only 7 new cases of rheumatic fever reported in 2015, the lowest number since 2005. We provide free sore throat clinics in the community and school based sore throat programmes in low decile schools. In 2015/16 there has been a focus on reinforcing the campaign's key message of *'have every child's sore throat checked, every time'*, and promoting an understanding of entitlement to free sore throat treatment. 245 localised engagement sessions were held, reaching 4,530 participants, largely Maori and Pacific.

## Increasing Immunisation

### *Kids Need Hugs Not Bugs*

**92% of our 8 month old children were immunised on time in 2015/16.**

Our aim is to protect as many children as possible from once common infectious diseases, at a time they are most vulnerable. We fully immunised 92% of 8 month olds 2015/16, falling just short of the national target. We have worked to close historic equity gaps with immunisation rates for Maori babies increasing 5% since 2012/13.

We work with PHOs and nurses and doctors in the GP network across the district on initiatives including:

- Taking a whole-of-health service approach to ensure babies are offered immunisations whenever they come into contact with a health service.
- Developing general practice resources and providing education for midwives, general practice staff and secondary care staff
- Developing robust referral processes to Outreach Immunisation Services (OIS) and working to ensure all children are enrolled with a GP as soon as possible after birth.

*Since the introduction of the eight-month target in April 2013 our coverage has increased slightly overall, with a 5% increase for Māori, a significant improvement on what has been an historical equity gap.*

Immunisation Week took place in May 2016 with a key message – Protection starts in pregnancy – encouraging uptake of influenza and whooping cough (pertussis) immunisation antenatally. The campaign was a success with Maternity services seeing an increasing acceptability to recommend immunisations in pregnancy.

Our local primary care campaign 'Kids need Hugs – not Bugs' extended the promotion of on-time immunisation positive messages in communities.

We have had success with our rotavirus vaccine campaign, introduced in July 2014. At the time, rotavirus infection was the leading cause of hospitalisation for children with gastroenteritis. Taking a collaborative approach across the sector we quickly achieved a high uptake for the rotavirus vaccine.

**Rebecca and Francie, the face of our 'I immunise' campaign.**

# CURING ILL HEALTH

**'Support people to stay well with early detection and effective management'**

We continue to improve the management of ill health. This is reflected in the reduction in the rates of mortality from cardiovascular disease and cancer. Our focus is on improving the detection and management of these diseases, as well as providing rapid assessment and treatment for patients when they are ill.

**81.6**

PER 100,000 LOWEST CVD MORTALITY IN NZ

**54%**

OF PATIENTS WITH CVD ARE RECEIVING TRIPLE THERAPY MEDICATION, A DECREASE FROM 54.9% THE PREVIOUS YEAR

**867**

CORONARY REVASCULARISATIONS WERE PERFORMED ADDING A TOTAL OF

**1,348**

QUALITY ADJUSTED LIFE YEARS TO OUR POPULATION (A DECREASE FROM 1,517 QALYS IN 2014/15)

**136,370**

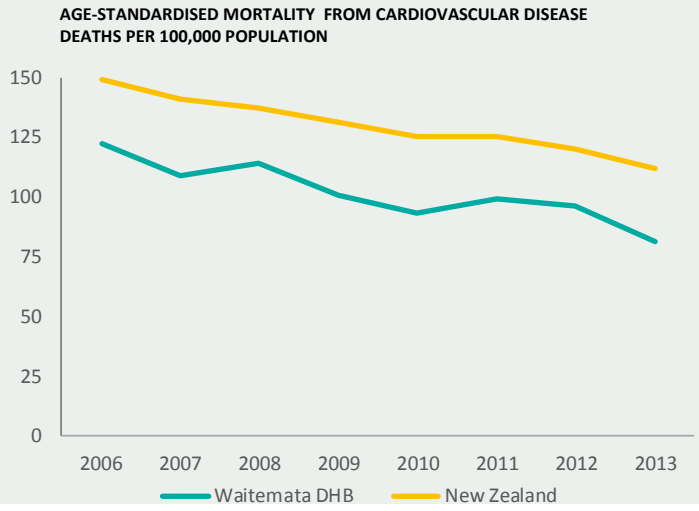
PEOPLE HAVE COMPLETED A CVD RISK ASSESSMENT IN THE LAST 5 YEARS, OR **91%** OF TARGET POPULATION, AS AT JUNE 2016

## The lowest mortality from cardiovascular disease

Cardiovascular disease (CVD) is a leading cause of mortality in Waitemata and it contributes significantly to premature deaths. Early identification of those at risk, lifestyle advice and treatment can prevent the development or progression of CVD.

**A reduction in mortality from cardiovascular disease**

Mortality due to cardiovascular disease is steadily declining. The rate in Waitemata (81.6 per 100,000 population) is lower than the national rate (111.3) and is the lowest of any NZ DHB.




91% of our eligible population have had their cardiovascular disease risk assessed in the last 5 years, an increase from 89% at the end of the 2013/14. For those with CVD, there is strong evidence that treatment with triple therapy (aspirin, a statin and a blood pressure lowering drug) reduces the risk of future ischaemic CVD events. In the 12 months to March 2016 , 54% of those with prior CVD received triple therapy medication.

For those in our population who required surgical intervention to treat their CVD, 867 coronary revascularisations (angioplasty and coronary artery bypass grafts) were performed. Quality-adjusted life years are a measure of health benefits – one QALY is equal to one year of life in perfect health. The 867 coronary reascularistations performed in 2015/16 resulted in an additional 1,348 quality-adjusted life years (QALYs) for our population.

In June 2016, Waitemata DHB launched a pilot programme to screen eligible Maori people for Abdominal Aortic Aneurysm (AAA). AAA in an enlargement of the abdominal aorta. If untreated it can rupture which is usually fatal. Research indicates that Māori suffer disproportionately from this disease, and appear to develop it at a younger age. The pilot aims to screen approximately 500 eligible Māori enrolled with Coast to Coast, Waitakere Union Health Centre and Te Puna Hauora practices. All patients with an enlarged aorta are referred to vascular service in Auckland where they will enter a surveillance programme, and if the aorta reaches a dangerously large size they will be offered surgical repair.

## Improving Stroke Outcomes

**86% of stroke patients received their care in our dedicated stroke unit.**

The impact of stroke in New Zealand is significant. It is the third leading cause of death and the greatest cause of disability in older people. A stroke can be a sudden, life-changing event for the person it happens to and those around them. The consequences can be devastating, but advances in technology along with a continued focus on evidence-based practice is having a profound impact on outcomes for patients of stroke.

There is overwhelming evidence that the most important intervention that can improve outcomes for all people with stroke is the provision of organised stroke services, a vital component of which is a stroke unit (NZ stroke guidelines, 2003).

Thrombolytic therapy - IV tissue plasminogen activator (TPA), which works by dissolving the clot and and improving blood flow to the affected part of the brain - is of proven and substantial benefit for select patients with acute cerebral ischemia.

There are national targets set to ensure patients admitted with a stroke are cared for on a dedicated stroke unit and patients who are eligible receive thrombolytic therapy.

### *Developing the Stroke Pathway*

At the end of 2014 the DHB was not consistently meeting the national health performance indicators for stroke.

80% of stroke patients admitted to hospital should be admitted to a dedicated stroke unit (at North Shore Hospital, this is currently within Ward 2 and at Waitakere Hospital within Wainamu ward); and 6% of eligible patients should receive thrombolysis.

A working group was established in early 2015 under the support of Richard Bohmer to review stroke services at WDHB and develop systems that would improve patient outcomes. Clinical staff were keen to assist in this process and rose to the challenge.

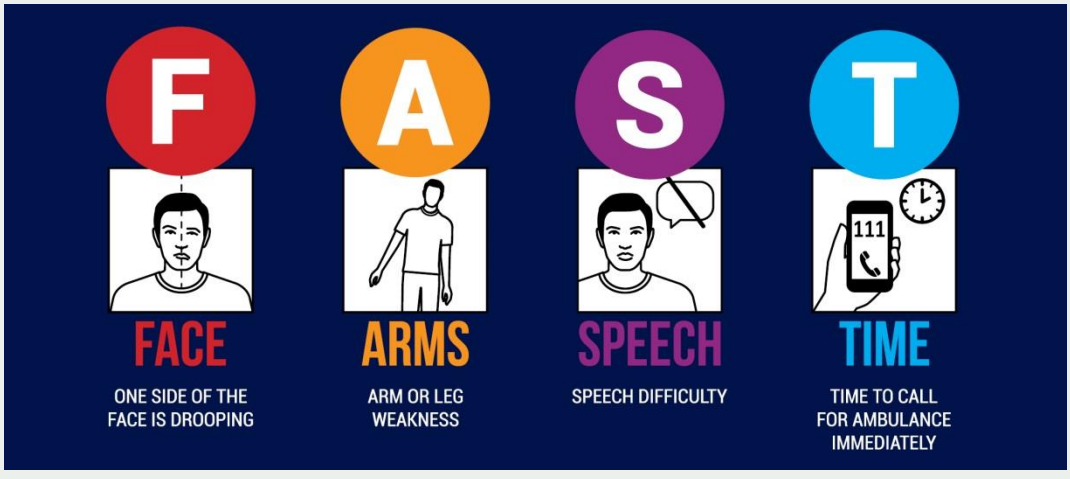
It was important to listen to patients' stories and focus on establishing a standardised pathway that would reach not only the national targets but greatly improve outcomes for patients.

The hyper acute stroke pathway enabled the standardisation of care processes; it is one of the main tools used to manage the quality in assessment of stroke at the front door. Assessment of patients at the front door quickly improved with the rollout of the pathway.

### *The launch of the stroke pathway means more patients are being treated in stroke units and are receiving thromobolysis.*

We are now meeting both of the national targets for stroke. Quarter 2 2015/16 (Oct-Dec 2015) saw 7% of patients thrombolysed at Waitemata and Quarter 3 saw 6%. 87% of patients received their care in a stroke unit in Quarter 2 and 86% in Quarter 3.

Work on the pathway continues with patient outcomes remaining at the forefront of all decision making for stroke services. This initial improvement in the stroke patient pathway has proved a great example of successful collaboration between clinicians and management.




**It is vital to recognise when someone is having a stroke and to start treatment as soon as possible.**

## The lowest mortality from cancer

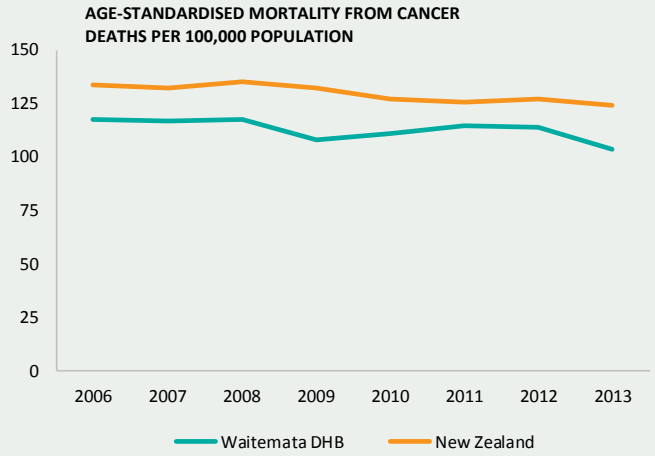
Cancer is the second leading cause of mortality in Waitemata DHB and contributes to a high proportion of all premature deaths. To ensure that there continues to be a reduction in mortality from cancer, there needs to be concerted action in prevention, early detection and treatment.

**104**

PER 100,000 OUR CANCER MORTALITY RATE IS ONE OF THE LOWEST IN NZ

**A reduction in mortality from cancer**

Mortality due to cancer is steadily declining. The rate in Waitemata (104 per 100,000 population) is lower than the national rate (123 per 100,000 population), and is one of the lowest in the country.




**69%**

OF PEOPLE DIAGNOSED WITH CANCER SURVIVE FIVE YEARS AFTER THEIR DIAGNOSIS, THE HIGHEST SURVIVAL RATE IN NEW ZEALAND. THIS HAS INCREASED FROM 66% IN 2006/07

Our five-year survival rates from cancer are the best in the country - our main impact measure in lowering our mortality rate from cancer. For individuals diagnosed with cancer in 2008-2009, the five year survival rate was 69%, the highest of any DHB, increasing from 63% in 1998-1999. We have made strong gains in cancer screening coverage and reducing the time patients with a high suspicion of cancer wait before receiving their first specialist assessment and their first cancer treatment.

**75%**

OF PATIENTS RECEIVED THEIR FIRST CANCER TREATMENT (OR OTHER MANAGEMENT) WITHIN 62 DAYS OF BEING REFERRED WITH A HIGH SUSPICION OF CANCER (JAN-JUN 2016), AN INCREASE FROM 66% IN 2014.*

We have made significant progress towards achieving the new cancer health target. In Q4 2015/16, 75% of patients received their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer compared with 66% in Q2 2014/15, when the target was launched.

**76%**

WOMEN AGED 25-69 HAVE BEEN SCREENED FOR CERVICAL CANCER

Cervical screening three-year-coverage rates have remained stable at 76%. However, we are beginning to see a reduction in ethnic inequalities. Between June 2013 and June 2016 Māori coverage increased from 53% to 59%, Pacific from 66% to 76% and Asian coverage from 60% to 65%. Breast screening coverage has increased to 67% from 66% three years ago. Coverage within our Pacific population (77%) remains above the national target of 70%, however breast screening rates in Māori remain lower at only 64%.

**67%**

OF WOMEN AGED 50-69 HAVE BEEN SCREENED FOR BREAST CANCER

Since late 2011, the Bowel Screening Pilot has been run in Waitemata DHB and in 2016 the Government announced the programme would be rolled out nationwide. The second round of the pilot concluded in December 2015. For all those who received an invite in round two, 53% participated and 84% of those screened in the first round returned for a second screening. As of March 2016, 328 people had had a cancer detected through a colonoscopy delivered as part of the Bowel Screening Pilot (public or privately funded).

*Note: this result does not include patients that have not yet received their first treatment. If a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.

## Faster cancer treatment

**92% of lung cancer pathway patients received their treatment within 62 days of referral.**

Cancer is a leading cause of morbidity and mortality in New Zealand, accounting for nearly one third of all deaths. We want to improve the quality of care and the patient's experience across the cancer pathway. Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.

The faster cancer treatment health target - 85% of patients referred with a high risk of cancer to be seen within two weeks and to receive treatment within 62 days of the initial referral by June 2017 - aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins.

## *Fast tracking lung cancer patients*

Lung cancer is the biggest cause of cancer death in New Zealand, accounting for 19% of all the cancer deaths (almost 1,650 people per year). Survival from lung cancer in NZ, especially for Māori is poor. In NZ only 10% of people diagnosed with lung cancer will survive beyond five years, compared with 14% in Australia and Canada.

For Māori the 5 year survival rate is close to 7%.

Poor survival in NZ is largely related to late diagnosis and advanced stage cancer at the time of diagnosis. Patients diagnosed early have the greatest chance of cure.

An audit of new lung cancer patients across the four Auckland-Northland DHBs showed that only 57% met the 62-day target. Most delays occurred in the diagnostic pathway between the FSA (First Specialist Appointment) and the decision to treat. To address this, the Single Point of Access for Cancer (SPOAC) pilot project was conducted.

A robust grading system was developed to detect patients with high suspicion on lung cancer based on referral information. Patients assessed as having curable lung cancer at the grading stage were offered upfront PET-CT scans.

Dedicated lung cancer slots were set up in respiratory clinics for patients with high suspicion of lung cancer, and virtual clinics to avoid delays during the diagnostic stage of the pathway. A total of 135 patients completed the pathway, with 80 having a lung cancer diagnosis. Improvements to the pathway meant that 92% received their treatment within 62 days of referral, with the average referral to treatment time reducing by 21 days.

The SPOAC pathway was formally adopted for lung cancer at Waitemata DHB from the 1st of October 2015.

**Eligible patients were offered a PET-CT scan upfront, reducing the time from initial referral to treatment.**

# AMELIORATING ILL HEALTH

'People receive timely, high quality, supportive and safe services'

Health services play a major role in providing intensive assessment and treatment when people are ill. Services also support people to regain functionality after illness and to remain healthy and independent. Patients want assurance that when they access our services they are receiving the best and safest care possible. Our focus in this area has been ensuring people suffering mental ill health are able to access high quality and timely support, our older population experience independence and quality of life, and our patients stay safe when in our hospitals.

SUICIDE RATES ARE

**LOW**

COMPARED TO THE REST OF NEW ZEALAND

**3.44%**

OF 0-19 YEAR OLDS (2.68 2013/14) AND

**3.55%**

OF 20-64 YEAR OLDS (3.50% 2013/14) ACCESSED MENTAL HEALTH SERVICES

**88%**

OF ADULT MENTAL HEALTH CLIENTS AND

**93%**

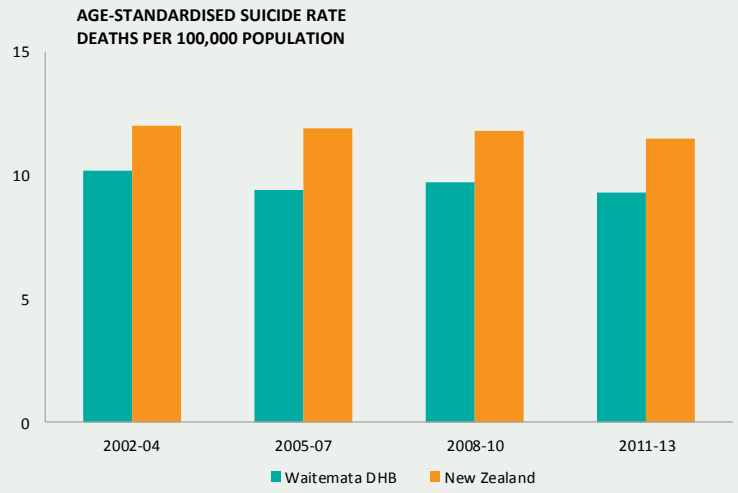
OF ADDICTIONS CLIENTS WERE SEEN WITHIN THREE WEEKS OF REFERRAL

## Reduced morbidity and mortality for people with mental illness

Mental illness is one of the leading causes of disability and overall health loss in our population. Many common mental health problems, such as depression, anxiety and substance abuse, emerge early in life and have life-long consequences. Ensuring early access to appropriate services will have a positive impact on health and social outcomes for our population.

**A reduction in suicide rates**

Our three-year suicide rate (9.3 per 100,000 population) is the third lowest in the country and has declined since 2008-2010. Our rate remains below the national rate (11.5 per 100,000 population).




Access rates to mental health services, our main impact measure, have increased in 0-19 year olds from 2.68% in 2013/14 to 3.44% and from3.50 to 3.55% in our 20-64 year olds. 88% of adult mental health clients were seen within 3 weeks, exceeding the 80% target. 94% were seen within eight weeks. Waiting times for access to specialist alcohol and drug services remain short, with 93% accessing services within three weeks and 97% within eight weeks of referral.

Waitemata DHB and Goodwood Park Healthcare Group are developing a service to deliver safe and effective support and accommodation for people with high and complex needs. The service, which commenced in December 2015, provides a home-like environment and supports residents to be as independent as possible.

We have had a focus on suicide prevention in 2015/16. Training workshops were delivered to community members and health professionals. A draft plan is being developed to improve the clinical pathway for people who attempt suicide or are at risk of suicide. Our Suicide Prevention Inter-Agency Working Group is well established, working as a central agent in ensuring that there is a commitment from key agencies to act to support families, whānau, and communities after a suicide.

## Suicide Prevention

### *Our collective effort*

**Our three-year suicide rate (9.3 per 100,000 population) is the third lowest in the country and has declined since 2008-2010.**

Suicide is a serious concern for New Zealand communities. Every year, around 500 New Zealanders die by suicide, with many more attempting suicide. 58 Waitemata residents lost their lives to suicide in 2013.

This has a tragic impact on the lives of many others – families, whānau, friends, and workmates, communities and society as a whole.

The Ministry of Health has tasked DHBs with implementing the Government's New-Zealand Suicide Prevention Strategy (2006-2016) and the Suicide Action Plan (2013-2016). DHBs are required to co-ordinate cross-agency suicide prevention activities and provide support to family/whanau after the suicide of a loved one.

Implementation of the joint Auckland and Waitemata DHBs' Suicide Prevention and Postvention Action Plan (SPPAP) began in 2015/16. The SPPAP sets out a programme of activities, in partnership with NGOs and the community, with a focus on high-risk groups including Maori, Paskifa, youth, migrants and the rural community.

Training was facilitated for community support services staff, families, whānau, and community members to identify and support individuals at risk of suicide and refer them to agencies that can help.

Many frontline community workers engaged in Question Persuade Refer (QPR) online training with wide representation from Pacific, Māori, Asian support services, clinical services, school nurses, and frontline support workers from youth, adult and older adult services.
Climate and economic pressures are impacting on the mental wellbeing of rural communities. Four rural SafeTALK training workshops aimed at upskilling health and social service professionals were delivered in Kumeu, Warkworth, Wellsford and Great Barrier Island.

Further SafeTALK workshops facilitated by Lifeline were delivered to family and whanau focusing on different community groups: Helensville (Māori community), Glenn Innes (Pacific Community), Grafton (general public) and Newmarket (Asian community).

**Manu Fotu - Auckland and Waitemata DHBs' Suicide Prevention Programme Manager**

The Suicide Prevention and Postvention Inter-Agency Working Group is well established and works as a central agent in ensuring that families, whānau, and communities are supported after a suicide. This support includes ensuring follow-up with schools and support services, and identifying and addressing any risks and needs for the community. This coordinated, timely support has particular benefit for young people who are still at school and under significant stress after a suicide or suicidal behaviour of close associates.

WAVES is a grief education programme for people bereaved by suicide. The group process allows people to connect with others who have been bereaved by suicide, to support their understanding and management of grief. Eight frontline community workers were trained as facilitators and a referral pathway has been developed for the community to access this support.

We are working to improve the clinical pathways between the Emergency Department (ED) and Primary Care – being the two critical intervention points in the health system, and ED and secondary mental health services for people who attempt suicide or are at risk of suicide.

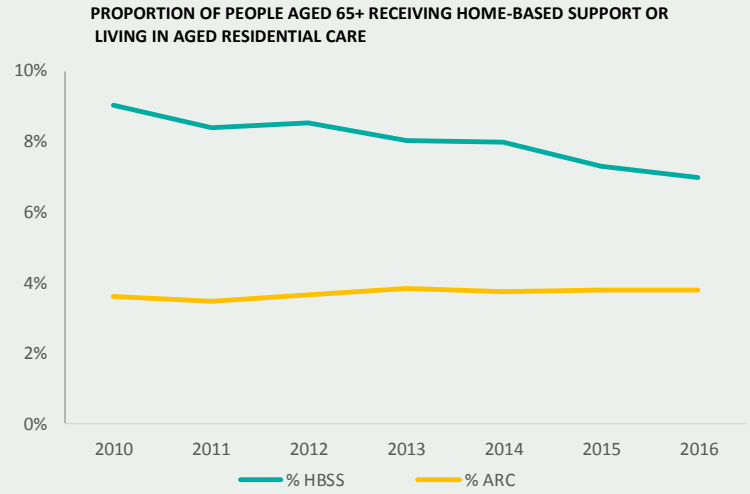
## Older people experience independence and quality of life

For a number of older people, the care they require can only be provided within an aged residential care (ARC) environment. However, those who are able to live in their own homes and remain connected with their local community generally have better long-term health outcomes.

**10.6%**

OF PEOPLE AGED 65+ LIVED IN AGED RESIDENTIAL CARE OR RECEIVED SUPPORT SERVICES IN 2015, A DECREASE FROM 12.7% IN 2010

**A decrease in the proportion of older people receiving home-based support or living in aged residential care**




A decrease in the proportion of the 65+ population living in ARC and a decrease in those receiving home-based support services (HBSS) is a potential proxy indicator for the health of the older population and how well the health system is managing age-related long-term conditions.

We have seen a steady decline in the percentage of our 65+ years population receiving funded HBSS and a relatively stable percentage living in funded ARC. This suggests that our older population are gradually becoming healthier and are able to live more independently.

People aged 65 years and over make up around 13% of our population, but account for around 30% of medical or surgical admissions to hospital and 45% of beds used. Annually there are more than 500 medical/surgical admissions for every 1,000 older people living in Waitemata.

Cataract surgery as well as knee and hip replacements can significantly improve the independence and overall quality of life for those requiring and receiving them. Using previously estimated QALY values, we can estimate how many years of quality life are gained by our 65+ population through the aforementioned procedures.

In 2015/16 our 65+ population gained 2,831 QALYs from cataract surgery and hip and knee replacements. Nearly 70% of these additonal quality years were gained through cataract surgery.

OUR OLDER POPULATION RECEIVED 715 HIP AND KNEE REPLACEMENTS, AND 1,441 CATARACT SURGERIES, ADDING A TOTAL OF

**2,831**

QUALITY ADJUSTED LIFE YEARS TO OUR POPULATION (AN INCREASE FROM 2,589 IN 2014/15)

THE CARE PROGRAMME WHICH PROVIDES BETTER CARE TO AT RISK OLDER PEOPLE WAS ROLLED OUT FURTHER THIS YEAR WITH A TOTAL OF

**676**

PATIENTS PARTICIPATING IN PHASE 1

## Cognitive Impairment Clinical Pathway

### *Living well with dementia*

Dementia is a devastating disorder of later life, having a profound impact on the person afflicted and their friends and family. With our ageing population, the number of people with dementia (PWD) is likely to double in the next 15-20 years.

The estimated total financial cost of dementia to New Zealand was $1 billion in 2011. The net value of the burden of dementia was estimated at $12.4 billion (2012 ).

Government required district health boards (DHBs) to better support people with dementia (PWD) to maximise their independence and wellbeing.

Many people with dementia in Waitemata DHB were receiving a diagnosis from a secondary health service at an advanced stage in their illness.

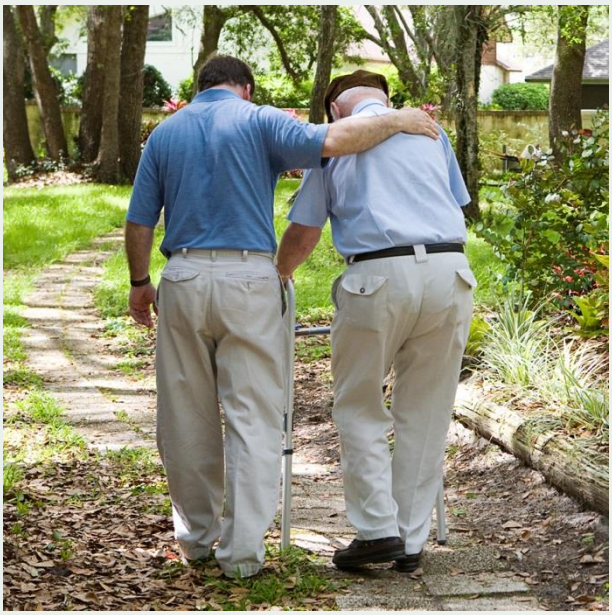
Strong evidence suggests that earlier diagnosis combined with regular specific psychosocial interventions won't stop progression of the underlying dementia disease, but can slow down the cognitive and functional decline in significant numbers of PWD. This directly improves the quality of life and health outcomes for PWD and their family/whānau carer who carries the burden of care.

Waitemata DHB, in partnership with 12 GP teams, Alzheimers Auckland, and with 60 patients, developed and piloted a pathway for the initial diagnosis and management of people with cognitive impairment in primary care. Later it became the Northern Region Cognitive Impairment Pathway.

The Cognitive impairment Pathway provides earlier assessment, diagnosis, and management of dementia in primary care and connection for the person and their family/whanau carer with appropriate education and support. The 5 component 'dementia education and support programme' includes regular home visiting and telephone calls, a family/whānau carer education course; carer support groups, and for PWD, cognitive stimulation therapy and socialisation activities. Secondary care is focused on atypical and complex presentations of cognitive impairment.

The University of Auckland (2015) evaluation of the Waitemata DHB Pilot showed the Cognitive Impairment Pathway is safe and acceptable to all key parties. The evaluation demonstrated integrated care management between general practice and NGOs was fundamental to improving health outcomes and the quality of life for PWD and their family/ whānau carers.

The Cognitive Impairment pathway enables the problems of dementia to be anticipated and managed as they arise, rather than responding to crises. It has the potential to reduce presentations at emergency departments and prevent hospital admissions.



"I've learnt a lot... One is that I'm not alone, there's always help" - Patient

"To actually have people suddenly come, recognise... and get things in progress was like, literally like a weight off my shoulders... I'm not the only one seeing that she really isn't quite as good as she presents to other people. Coz she does present very well" - Carer

**Feedback from the pilot**

## Patients stay safe in our hospitals

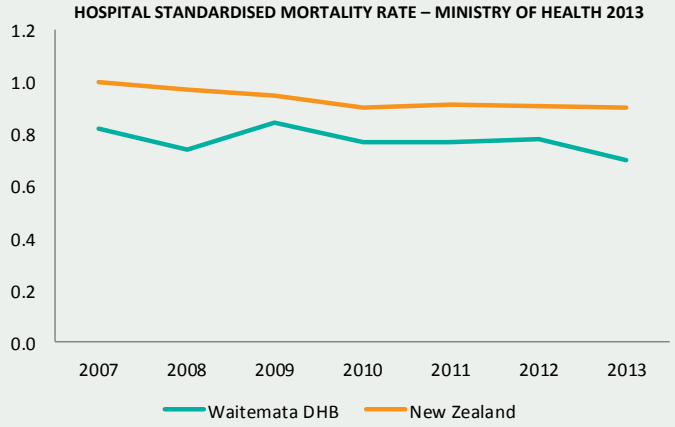
To provide the very best care for all our patients, we need to ensure that the care we provide is safe and clinically effective. We have continued improving quality and safety through our First, Do No Harm programme, being open and transparent about our performance and monitoring the Health Quality and Safety Commission's (HQSC) quality and safety markers (HQSMs). We have aimed to improve in all areas of harm identified in the national patient safety campaign: Open for better care.

**0.7**

OUR HSMR IS THE LOWEST IN NEW ZEALAND

**A reduction in the Hospital Standardised Mortality* Ratio**

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality and safety that measures whether the death rate at a hospital is higher or lower than would be expected. Our HSMR has consistently been lower than the national figure and is the lowest in the country.




**<1**

CENTRAL LINE INFECTIONS OCCURED PER 1,000 LINE DAYS
(0.01 in 2015/16,
0.65 IN 2014/15)

* The HSMR reports the ratio of observed in-hospital deaths to the number predicted, adjusted for demographic and casemix variables. An HSMR of less than one 1 indicates a hospital has lower mortality rate than predicted for its population/casemix.

**97%**

OF OLDER PATIENTS HAD THEIR RISK OF FALLING ASSESSED
(Q4 2015/16)

During 2015/16 we improved or maintained our compliance across the HQSC markers:

| **Health Quality** and **Safety Markers** | **Q3 2012/13** | **Q4 2015/16** |
|---|---|---|
| 80% compliance with good hand hygiene practice | 73% | 83% |
| Health care associated staphylococcus aureus bacteremia per 1000 bed days | 0.05 | 0.05 |
| 90% of older patients assessed for the risk of falling | 64% | 97% |
| % of patients assessed at risk of falling who received an individualised care plan | 66% | 98% |
| Number of in hospital falls causing fractured neck of femur | 1 | 1 |
| 100% of hip and knee arthroplasty primary procedures given antibiotic in right time | 92%[1] | 92%[2] |
| 95% of hip and knee arthroplasty procedures given right antibiotic in right dose | 66%[3] | 94%[2] |
| 100% of hip and knee arthroplasty procedures given appropriate skin preparation | 95%[3] | 100%[2] |
| Surgical site infections per 100 hip and knee operations | 0.68 | 0.52 |

[1] Q2 2013/14
[2] Q3 2015/16
[3] Q1 2013/14

**83%**

COMPLIANCE WITH THE FIVE MOMENTS FOR HAND HYGIENE
(Q4 2015/16)

## Waitemata DHB's Quality and Safety Programme

**Nearly all (97%) older patients are assessed for the risk of falling and 98% of those at risk are given an individualised care plan.**

The Quality and Safety programme supports the delivery of our Promise Statement to our community, 'Best Care for Everyone'. As a result of this promise we seek continuous improvement in everything we do. We aim to provide care that is safe, clinically effective, and focused on the individual needs of every patient and their whānau that enters our care.

To achieve our quality vision, the DHB has set out 3 aims which reflect three key elements of quality:

- Safe care – there will be no avoidable harm to patients from the healthcare they receive
- Clinically effective care – provide our patients with the most effective treatments, support and services
- Patient and family centred care – provide everyone with compassionate care, information and support

To achieve these aims, we have identified 6 priorities:

- Reduce all avoidable harm
- Improve systems and processes
- Promote best clinical practice and clinical leadership
- Increase quality capability and accountability
- Strengthen patient, family and community engagement
- Optimise the patient's experience

### *Reducing harm from falls*

The national Reducing Harm from Falls programme is one the HQSC's four 'Open for better care' priority areas. The programme aims to reduce the harm that people can suffer if they fall and hurt themselves – especially older people receiving care, whether in hospital, residential care, or in their own home.

**Marianne spent 2 months in hospital with a fractured arm after falling while walking to her letterbox.**

**Peter's mother had a fall while she was an inpatient at North Shore hospital.**

*"Mum seemed uncomfortable in her bed…..and this is when we found out that she'd had a fall in the night and the patient opposite informed us that she'd tried to get out of bed during the night, had fallen in the dark and had obviously injured herself. My mum has attended North Shore Hospital three times previously …as a result of serious falls. And therefore, our expectation is that North Shore Hospital….would have clear records of the fact that she is a falls risk….For me not to be informed that she had fallen overnight only to find that out from the patient opposite …is for me, unacceptable."* ***Peter***

The Falls Prevention Programme at Waitemata DHB was put in place to ensure that people like Peter and Peter's mother do not have experiences like these.

The Programme includes a number of key activities on each ward/area: each ward has a 'falls champion' (staff nurse); there are regular falls champion training days; and fortnightly auditing occurs on every ward and is tracked on quality boards. All falls with serious harm are investigated by the charge nurses and nursing heads of department and findings and recommendations presented to the Adverse Event Committee.

Now nearly all (97% in Q4 2015/16) older patients are assessed for the risk of falling and 98% of those at risk are given an individualised care plan.

There were 10 falls in WDHB hospitals resulting in a fractured neck of femur in 2015/16, a decrease from 13 in the previous 12 months. Nationally there has been a significant decrease in the rate of falls resulting in a fractured neck of femur since December 2014.

# Our people, our performance

## Delivering on our plans

# STATEMENT OF PERFORMANCE

## Overview

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

Measuring our outputs helps us to understand how we are progressing towards our impacts and outcomes set out in the improving outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitemata DHB population is now 83.9 years, an increase of 2.7 years over the last decade. The life expectancy gap is 5.9 years for Māori and 5.7 years for Pacific.

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures in each section reflect the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Waitemata DHB Māori Health Plan 2015/16.

## National health targets

2015/16 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show the full year's performance as well as the fourth quarter's result where relevant.

| Health Targets | | Target | Q4 2015/16 | Full Year |
|---|---|---|---|---|
| Shorter Stays in Emergency Departments | 95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours | **95%** | **95%** | **95%** |
| Improved Access to Elective Surgery | An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)* | **20,773** | **n/a** | **21,994 (106%)** |
| Faster Cancer Treatment | 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment** | **85%** | **75%*** | **72%*** |
| Increased Immunisation | 95% of eight months olds will have their primary course of immunisation on time | **95%** | **92%** | **92%** |
| Better Help for Smokers to Quit | 95% of hospitalised smokers provided with advice to help quit | **95%** | **99%** | **98%** |
| | 90% seen in primary care provided with advice to help quit | **90%** | **91%** | **89%** |
| | 90% of newly registered pregnant women provided with advice to help quit | **90%** | **97%** | **90%** |
| More Heart and Diabetes Checks | 90% of the eligible population have had their cardiovascular risk assessed over the last five years | **90%** | **n/a** | **91%** |

* Waitemata DHB's targeted increase (share of the NZ total additional 4,000 discharges) was 797 additional discharges

**This result does not include patients that have not yet received their first treatment. If a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.

## Output class measures

The criteria against which we measure our output performance for the year was revised in 2014/15 and we continue with this grading system for 2015/16. This has been applied to assess performance against each indicator in the Output Measures section. A rating has not been applied to demand driven indicators.

| Criteria | | Rating | |
|---|---|---|---|
| On target or better | | Achieved | |
| 95-99.9% | 0.1% - 5% away from target | Substantially Achieved | |
| 90-94.9% | 5.1% - 10% away from target* | Not achieved, but progress made | |
| <90% | >10% away from target** | Not Achieved | |

*and improvement on previous year

** or 5.1-10% away from target and no improvement on previous year

The tables in this section include our output measures from the 2015/16 Statement of Performance Expectations by Output Class. Outputs are goods or activities provided by the DHB and other entities and provide a snapshot of the services we deliver. Output measures are intended to reflect our performance for the year.

The measure type symbols define the type of measure and are included in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, and these have been assigned the below symbols in the target column.

| Symbol | Definition |
|---|---|
| Measure type | |
| Q | Measure of quality |
| V | Measure of volume |
| T | Measure of timeliness |
| C | Measure of coverage |
| Ω | Measure is demand driven |
| Target symbols | |
| Ω | Measure is demand driven – not appropriate to set target or grade the result |
| ↓ | A reduction on the baseline value is expected |
| ↑ | An increase on the baseline value is expected |

## Output Class 1: Prevention Services

Prevention services help to protect and promote health in the whole population or identifiable sub-populations by targeting changes to physical and social environments that engage, influence and support people to make healthier choices, thereby reducing inequalities in health status. Prevention services include health promotion to help prevent the development of disease; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services such as immunisation and screening services. Outputs provided by General Practice teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class. A significant portion of the work of Primary Care is preventive in nature.

| Output Measures | Baseline period | Baseline | 2014/15 Results | 2015/16 Target | 2015/16 Results | Achievement |
|---|---|---|---|---|---|---|
| **HEALTH PROMOTION** | | | | | | |
| Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking (Q) | Q2 2014/15 | 98% | 98% | 95% | 98% | |
| Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking (Q) | Q2 2014/15 | 100% | 97% | 90% | 89%[1] | |
| Number of people accessing Green Prescriptions (V) | Q2 2014/15 | 6,182 | 6,511 | 7,033 | 7,206 | |
| % of decile 1-4 schools engaged in Health Promoting Schools (Q) | Nov-14 | 49% | n/a | 75% | 66%[2] | |
| *Enforcement of the Smokefree Environments Act 1990*[3] | | | | | | |
| Number of retailer compliance checks conducted (V) | 2013/14 | 302 | 284 | 300 | 341 | |
| Proportion of retailers visited during Controlled Purchase Operations (CPOs) in which tobacco is sold to minors (Q) | 2013/14 | 3% | 3% | Ω | 11%[4] | |
| **HEALTH PROTECTION** | | | | | | |
| *Tuberculosis (TB)*[2] | | | | | | |
| Number of TB contacts followed up (V) | 2013/14 | 1,080 | 821 | 750 | 1,158 | |
| Percentage of TB and LTBI (latent TB Infection) cases who have started treatment and have a recorded start date for treatment (Q) | 2013/14 | 84% | 100% | ≥85% | 98% | |
| Percentage (and number) of eligible infants vaccinated with a BCG (vaccine against tuberculosis) (C) | 2013/14 | 98% (4,613) | 97% (6,226) | ≥98% | 73%[5] (4,999) | |
| **POPULATION BASED SCREENING** | | | | | | |
| *Breast Screening* | | | | | | |
| Coverage rates among eligible groups (C) | Sep -14 | 68% | 68% | 70% | 67% | |
| *Bowel Cancer Screening Programme Pilot* | | | | | | |
| Percentage of people invited to participate who returned a correctly completed test kit (C) | Round 1 Jun-14 | 54% | 56.8%[6] | 60% | 53.4%[7] | |
| % of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 55 working days (T) | Jul-Dec 2014 | 99% | 99% | 95% | 96%[8] | |
| *Children* | | | | | | |
| Percentage of referred children with a completed referral waiting within the contracted timeframe for a Gateway Assessment [9](T) | | new measure | | 85% | 25%[10] | |
| Percentage of B4 School Checks completed (C) | May-15 | 86% | 93% | 90% | 93% | |

[1] As of 2015/16 denominator no longer adjusted to only count those 'seen by a health practioner' leading to a significant increase in the denominator volume.
[2] 2015 academic year. There has been a reduction in Ministry-contracted FTE resource, however dedicated resource has been assigned to the HPS contract, professional development provided to the HPS advisor, and tools used to identify schools' areas of need to support health and learning outcomes.
[3] These services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data is for all 3 DHBs.
[4] Target premises includes those in high deprivation areas, close to transport hub and retailers who have previously failed a CPO. All retailers found to fail the CPO were issued $500 infringement notices by the MoH.
[5] There is ongoing worldwide shortage of BCG vaccine. The BCG programme was suspended Dec 15 to Mar 16, and again since June 2016.
[6] Round 2 participation (January 2014 – March 2015)
[7] Round 2 participation (January 2014-September 2015, data as at March 2016). Participation in the bowel screening pilot did not reach the ambitious target for a new programme of 60%, however the pilot meets the acceptable level set in the European guidelines which is having a minimum uptake level of 45% .
[8] January – June 2016
[9] Health and education assessement for children in, or at high risk of needing, CYF care. Priority referrals to be assessed within 20 days, all others within 40 days.
[10] High DNA rate has impacted on the service's productivity and wait times. A plan has been implemented with CYF to improve attendance. DNA and wait times are being monitored monthly.

## Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals including general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services. These services are preventative and treatment services focused on individuals and smaller groups of individuals.

Ensuring good access to early detection and management services for all population groups, we can support people to maintain good health, and through prompt diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long term outcomes. These services also enable patients to maintain their functional independence and reduce complications or acute illness, reducing the need for specialist intervention.

| Output Measures | Baseline period | Baseline | 2014/15 Results | 2015/16 Target | 2015/16 Results | Achievement |
|---|---|---|---|---|---|---|
| **PRIMARY HEALTHCARE** | | | | | | |
| Primary care enrolment rates (C) | Mar-15 | 93% | 95% | 95% | 94%[11] | |
| Percentage of children fully immunised at 5 years (C) | Q2 2014/15 | 78% | 80% | 90% | 83%[12] | |
| Seasonal influenza immunisation rates – 65+ (C) | Q1 2014/15 | 63% | 57% | 75% | n/a[13] | |
| HPV immunisation coverage (dose 3) (C) | Dec-14 | 54% | 54% | 65% | 60.2% | |
| Cervical screening coverage (C) | Dec-14 | 76% | 76% | 80% | 76% | |
| Percentage of diabetes patients receiving retinal screening (C) | 2014/15 | 72% | 72%[14] | 72% | 56%[15] | |
| Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years (C) | Q2 2014/15 | 90% | 90% | 90% | 91.3% | |
| **COMMUNITY REFERRED TESTING AND DIAGNOSTICS** | | | | | | |
| Number of community laboratory tests (V) | Oct-13 - Sep-14 | 3,723,168 | 3,729,244 | Ω | 3,930,853 | |
| Number of radiological procedures referred by GPs to hospital (V) | 2013/14 | 52,976 | 62,139 | Ω | 31,486[16] | |
| Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks (T) | Dec-14 | CT 99% MRI 58% | CT 98% MRI 90% | CT 95% MRI 85% | CT 96%[17] MRI 88% | |
| **ORAL HEALTH**[18] | | | | | | |
| Enrolment rates in children under five (C) | Dec-14 | 83% | 79% | 87% | 84% | |
| Utilisation rates for adolescents (C) | CY2013 | 64% | 67% | 85% | 64%[19] | |
| Arrears rates (T)[20] | CY2014 | 6.6% | 9.2% | 7% | 10.6%[21] | |
| **PHARMACY** | | | | | | |
| Number of prescription items subsidised (V) | 2013/14 | 6,470,285 | 6,784,126 | Ω | 7,067,601 | |

[11] Numerator 2016-Q2 enrolments, denominator 2015/16 population projections (2015 update)
[12] 12 months final dose
[13] Previously reported under the PHO Performance Programme, which transitioned to the Integrated Performance and Incentive Framework (IPIF), however only included vaccinations provided by GPs. This indicator no longer reported under IPIF. Reporting (which will include all providers, eg pharmacy) is being developed by the National Immunisation Register.
[14] Baseline/2014-15 and target values incorrectly entered in 2015/16 AP.
[15] The Diabetes Service Level Alliance is currently undertaking a comprehensive review of the screening service across both DHBs and recommendations to improve coverage are expected in October 2016. Following this business cases will be put forward to implement the future service delivery model.
[16] Previous results incorrectly included OP referrals. CY2015 GP only referrals = 30,875.
[17] June 2016 result
[18] CY2015 rates (Oral health targets set for calendar years, not financial years)
[19] A significant number of adolescents living in WDHB are enrolled with contracting dentists in ADHB area – combined Auckland & Waitemata utilisation 70%. A strategy to improve adolescent coverage has been developed and is currently being consulted on.
[20] Pre-school and primary children who are overdue for their planned recall dental examination
[21] Baseline/2014-15 results incorrectly entered in AP. Extended hours and mobile clinics used to improve access and pathways introduced to support vulnerable families to attend appointments.

## Output Class 3: Intensive Assessment and Treatment

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

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.

These services are at the complex end of treatment services and focused on individuals. Equitable and timely access to intensive assessment and treatment improves outcomes for patients. Effective and prompt resolutution of medical and surgical emergencies and acute conditions reduces mortality and elective surgery restores functional independence and improves health-related quality of life, thereby improving population health.

| Output Measures | Baseline period | Baseline | 2014/15 Results | 2015/16 Target | 2015/16 Results | Achievement |
|---|---|---|---|---|---|---|
| **ACUTE SERVICES** | | | | | | |
| Number of ED attendances (V) | 2013/14 | 110,989 | 117,292 | Ω | 121,524 | |
| Acute WIES total (DHB Provider)[22] (V) | 2013/14 | 56,384 | 56,230 | 56,561 | 60,322 | ● |
| Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival (T) | Q2 2014/15 | 97% | 96% | 95% | 95% | ● |
| Compliance with Faster Cancer Treatment national health target - 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016[23] (T) | Q3 2014/15 | 69.3% | 77.4% | 85% | 71.5%[24] | ● |
| Percentage of eligible stroke patients thrombolysed (T) | Q2 2014/15 | 3.8% | 4.7% | 6% | 5.5% | ● |
| Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (Q) | Q1 2014/15 | 81% | 78% | 80% | 86% | ● |
| Percentage of acute coronary syndrome (ACS) inpatients receiving coronary angiography within 3 days (T) | Dec-14 | 68.3% | 79% | 70% | 81% | ● |
| **MATERNITY** | | | | | | |
| Number of births (V) | 2014 | 6910 | 6,950 | Ω | 6725 | |
| Proportion of all births delivered by caesarean section (Q) | 2014 | 30% | 29.5% | ↓ | 29.2% | ● |
| Established exclusive breastfeeding at discharge excluding NICU admissions (Q) | 2014 | 81% | 77% | 80% | 81% | ● |
| Third/fourth degree tears for all primiparous vaginal births (Q) | 2013 | 3.6% | 4.40% | ↓ | 2.7% | ● |
| Admission of term babies to NICU (Q) | 2014 | 5.9% | 5.3%[25] | ↓ | 4.8% | ● |
| Number of women booking before end of 1st trimester (Q) | 2013 | 67% | 68% | 80% | 72%[26] | ● |
| **ELECTIVE (INPATIENT/OUTPATIENT)** | | | | | | |
| Delivery of health target for elective surgical discharges (V) | 2013/14 | New measure | 20,687[27] | 20,773 | 21,994 | ● |
| Surgical standardised intervention rates, per 10,000 pop - SIR (C)<br>Joints<br>Cataracts<br>Cardiac<br>Angioplasty (PCR)<br>Angiogram | Oct-13 to Sep-14 | <br>25.54<br>30.54<br>6.38<br>15.08<br>44.66 | <br>26.42<br>30.49<br>6.12<br>14.22<br>41.53 | <br>21<br>27<br>6.5<br>12.5<br>34.7 | <br>21.40[28]<br>33.17<br>6.83<br>14.63<br>40.83 | ● |

[22] Weighted inlier equivalent seperations (WIES) – relative cost measure for inpatient episodes.
[23] This result does not include patients that have not yet received their first treatment. That is even if a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.
[24] Delays due to incorrect referrals or inconsistent use of triaging guidelines are being addressed with staff. Some delays are due to patient choice, co-morbidities or requirements for further investigations. As of August 2016, this target has been met. See p22 for improvements underway for cancer services.
[25] Includes admissions to both SCBU and NICU. Incorrectly calculated in 2014/15 annual report, correct value reported here.
[26] MOH MAT data 2015. Independent LMCs only.
[27] HT definition changed in 2015/16. Volume shown in using 15/16 methodology, not 14/15 HT result.
[28] All results April-15 to March-16. Standardised intervention rates (SIR) are a measure of a DHB's service delivery to their population relative to other DHBs, standardised to account for population variation.

| Output Measures | Baseline period | Baseline | 2014/15 Results | 2015/16 Target | 2015/16 Results | Achievement |
|---|---|---|---|---|---|---|
| **ELECTIVE (INPATIENT/OUTPATIENT)** | | | | | | |
| Patients waiting longer than 4 months for their first specialist assessment (T) | Jan-15 | 0.18% | 0.8% | 0% | 0% | |
| Patients given a commitment to treatment but not treated within 4 months (T) | Jan-15 | 0.38% | 0.7% | 0% | 0.5%[29] | |
| **QUALTIY AND PATIENT SAFETY** | | | | | | |
| Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC (Q) | 2014 | 0.05 | 0.06 | ↓ | 0.05 | |
| Post-operative sepsis and DVT/PE rates – HQSC (Q) | 2013 | 8.3 sepsis<br>6.8 DVT/PE | 7.6<br>4.7 | ↓<br>↓ | 5.4<br>5.4 | |
| Central Line Associated Bacteraemia rate per 1,000 line days (Q) | Jan-15 | 0.70 | 0.65 | <1 | 0.01 | |
| In-hospital fractured neck of femur (total) – HQSC (Q) | CY2013 | 11 | 13 | ↓ | 10 | |
| **ASSESSMENT TREATMENT AND REHABILITATION (INPATIENT)** | | | | | | |
| AT&R bed days (V) | 2013/14 | 38,871 | 40,262 | Ω | 40,297 | |
| % referrals to AT&R seen within 2 working days[30] (T) | 2013/14 | 99% | 99% | 95% | 95% | |
| **MENTAL HEALTH** | | | | | | |
| *Improving the Health Status of People with Severe Mental Illness* | | | | | | |
| Access to mental health services (C) | | | | | | |
| Age 0-19 | Nov-13 | 2.84% | 3.04% | 3.0% | 3.44% | |
| Age 20-64 | to | 3.43% | 3.46% | 3.5% | 3.55% | |
| Age 65+ | Oct-14 | 2.02% | 2.11% | 3.0% | 2.05%[31] | |
| *Improving Mental Health Services using Transition (Discharge) Planning and Employment* | | | | | | |
| Child and Youth with a Transition (discharge) plan (Q) | Q2 2014/15 | 26.5 | 66% | 95% | 73%[32] | |
| *Shorter Waits for Non-urgent Mental Health and Addiction Services for 0-19 year olds* | | | | | | |
| % of clients seen within 3 weeks (T) | | | | | 61%[34] | |
| - Mental Health | Oct-13 | 71%[33] | 61% | 80% | 85% | |
| - Addictions | to | 73% | 84% | | | |
| % of clients seen within 8 weeks | Sep-14 | | | | 91% | |
| - Mental Health | | 96% | 95% | 95% | 99% | |
| - Addictions | | 99% | 98% | | | |

[29] Rated yellow by MOH (ESPI5 <0.99%)

[30] Time from referral to assessmemt

[31] Some older people who require mental health support receive this from primary care, the aged residential sector and non-mental health hospital based services. We are actively seeking to expand services and develop closer links with primary care as well as developing the psychiatry liaison service at Waitakere Hospital.

[32] The percentage of C&Y clients with a transition plan increased dramatically since the beginning of 2014/15 . Additional training has been provided for administrators to ensure all events closed correctly and discharge plans recorded.

[33] Baseline values incorrectly entered in 2015/16 AP

[34] Referrals to CAMHS services have risen 21% over the past year. Additional FTE have been approved to cater to the increased demand, and some mild/moderate referrals are being redirected to a private provider.

## Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including palliative care, home-based support services and residential care services.

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

| Output Measures | Baseline period | Baseline | 2014/15 Results | 2015/16 Target | 2015/16 Results | Achievement |
|---|---|---|---|---|---|---|
| **HOME-BASED SUPPORT** | | | | | | |
| Average number of hours per month of home-based support services for: (V)<br>• Personal care<br>• Household management | 2014/15 | <br>64,183<br>19,001 | <br>65,098<br>16,915 | <br>Ω<br>Ω | <br>68,550<br>17,170 | |
| 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 (Q) | Q2 2014/15 | 74% | 77% | 75% | 98%[35] | |
| Percentage of NASC clients assessed within 6 weeks (T) | 2014/15 | 77% | 75% | ↑ | 75% | |
| **PALLIATIVE CARE** | | | | | | |
| Number of Advance Care Plan conversations recorded in Collaborative Care Management System (CCMS) will increase by 20% (V) | 2014/15 target | 1,316 | 1,431 | 1,579 | 1,670 (+27%) | |
| Number completing at least one module of Advanced Care training as Level 1 practitioners each year (Q) | 2014/15 target | 68 | 90 | 89 | 57[36] | |
| Number of contacts (V) | 2014/15 | 20,563 | 19,647 | Ω | 22,181 | |
| Proportion of hospice patient deaths that occur at home (Q) | Jul-Dec 2014 | 36% | 37% | ↑ | 38% | |
| Proportion of patients acutely referred who waited >48 hours for a hospice bed (T) | Jul-Dec 2014 | 9% | 7.8% | ↓ | 7.4% | |
| **RESIDENTIAL CARE** | | | | | | |
| Total number of subsidised aged residential care bed days (V)<br>- Rest homes<br>- Hospitals<br>- Dementia<br>- Psychogeriatric | Oct-13 to Sep-14 | 847,743<br>273,103<br>451,337<br>98,059<br>25,244 | 843,822 | Ω | 905,263<br>269,600<br>481,643<br>120,553<br>33,467 | |
| Proportion of aged care providers with 4 year audit certification (Q) | Feb-14 | 13% | 16% | ↑ | 19% | |

[35] Q4 2015/16 result, NRA InterRAI report

[36] As a result of resource constraints, level 1 training is only done on an adhoc basis, resulting in a lower than expected volume.

## Cost of Service Statement – for year ended 30 June 2016

| | Prevention Services | | Early Detection & Management | | Intensive Assessment & Treatment | | Rehabiliation & Support | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | $000 Actual | $000 Plan | $000 Actual | $000 Plan | $000 Actual | $000 Plan | $000 Actual | $000 Plan | $000 Actual | $000 Plan |
| **Total Revenue** | 29,057 | 31,527 | 403,563 | 364,852 | 943,614 | 973,514 | 200,296 | 193,569 | 1,576,531 | 1,563,461 |
| **Expenditure** | | | | | | | | | | |
| Personnel | 9,851 | 9,655 | 70,020 | 67,688 | 475,549 | 463,302 | 26,798 | 26,155 | 582,218 | 566,800 |
| Outsourced Services | 1,286 | 1,317 | 11,528 | 11,972 | 53,690 | 48,447 | 5,067 | 5,288 | 71,571 | 67,023 |
| Clinical Supplies | 1,850 | 1,697 | 12,483 | 11,445 | 91,694 | 84,076 | 4,593 | 4,211 | 110,621 | 101,429 |
| Infrastructure & Non-Clinical Supplies | 1,699 | 1,481 | 9,448 | 8,673 | 91,175 | 81,023 | 2,896 | 2,554 | 105,219 | 93,732 |
| Payments to Providers | 13,908 | 17,299 | 285,437 | 264,087 | 254,550 | 295,507 | 151,158 | 154,773 | 705,054 | 731,666 |
| **Total Expenditure** | 28,594 | 31,449 | 388,916 | 363,864 | 966,659 | 972,356 | 190,514 | 192,981 | 1,574,682 | 1,560,650 |
| **Net Surplus / (Deficit)** | 463 | 78 | 14,647 | 987 | (23,044) | 1,158 | 9,783 | 588 | 1,849 | 2,811 |

# BEING A GOOD EMPLOYER

**100%**
COMPLIANCE WITH GOOD EMPLOYER PRINCIPLES (1ST EQUAL IN NZ)

**7,100**
EMPLOYEES AT WAITEMATA DHB (6,100 FTE)

**23%** MALE
**77%** FEMALE

**51%** NZ/EUROPEAN
**4%** MĀORI
**4%** PACIFIC
**26%** ASIAN
**15%** OTHER ETHNICITIES

Waitemata DHB strives to be a good employer across our diverse workforce and at every stage in our employees' careers. We are committed to being an Equal Employment Opportunities (EEO) employer through our organisation-wide good employer practices relating to the recruitment, development, management and retention of all staff and have been an employer member of Diversity Works for the last 6 years.

The strategic aims of our Good Employer policy are to provide:

- Good and safe working conditions
- An equal employment opportunities programme
- Recognition of the employment requirements of women and men
- Recognition of the employment requirements of people with disabilities
- The impartial selection of suitably qualified persons for employment
- Recognition of the aims, aspirations, cultural differences and employment requirements of Māori, Pacific and other ethnic groups
- Opportunities for the enhancement of the abilities of individual employees.

We have a number of programmes to fulfil our good employer commitment, and demonstrate our strength as an equal opportunity employer. These programmes have significant staff input and are discussed at Board meetings, union/staff forums, and our new health, safety and wellbeing committee.

## Our Good and Equal Employment Programmes

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

### Recruitment, Selection and Development

**Professional Development Fund:** The fund supports individual professional development for workforces that do not normally have access to specific funding.

**Support for Nursing and Medical New Graduates:** In 2016 the DHB supported 106 new nursing graduates in primary care, mental health and hospital services. Over 45 new graduate resident doctors were recruited in December 2015 and are half way through their first year of practice. Waitemata DHB has a comprehensive training programme to equip these new graduates with clinical and professional skills. There is also a training programme to support the transition of post graduate year-two Interns to vocational training.

**Registrar training:** In conjunction with the Specialty Colleges the DHB has training programmes in place to assist Registrars in preparing for their specialist exams.

**NZQA Training**: The DHB supports our Orderly, Cleaning, Therapy Assistants, Dental Assistants and Heath Care Assistants through NZQA accredited training via Careerforce.

**Nursing and Health Care Assistant Assessment Programme:** Since 2014, the DHB has run assessment programmes allowing nurses and health care assistants from overseas or returning to practice to showcase their skills, knowledge and experience. The DHB actively recruits from this programme, with 67% of applicants assessed gaining employment.

*"I had fun with the activity, recalling my experiences working in an acute setting back in the Philippines"*

*"Was relaxing and very positive"*

*"I really enjoyed the day and had a lot of fun doing the group exercises. Got the opportunity to meet the head nurses and they were very helpful and friendly"*

**Feedback from the Nursing Assesssment Centre**

THE AVERAGE WAITEMATA EMPLOYEE IS

**44** YEARS OLD

**16%** AGED <30

**46%** AGED 30-50

**38%** AGED OVER 50

**44%**

OF OUR EMPLOYEES WORK PART TIME (2,130 FTE)

**0.3%**

OF OUR EMPLOYEES HAVE DECLARED A DISABILITY

## Management and Leadership development

The DHB provides a comprehensive leadership development programme including modules and sessions designed to develop new leaders, and grow new skills in giving feedback, coaching, managing culturally diverse teams, promoting healthy working relationships by preventing bullying and harassment, supervision, and leading our values.

**Transforming Care**

Waitemata DHB introduced a clinical leadership programme in 2013. This programme - *Enhanced Care Management and Clinical Leadership* (ECMCL) - was led by Richard Bohmer, a Fellow at the Kings Fund in London. The ECMCL programme was delivered to three cohorts of clinical teams in the organisation. In this programme, participants worked together in clinically led teams to (re)design systems of care for key population subgroups.

In 2016 the DHB launched *Transforming Care* - a three-tiered development programme designed to support delivery of care redesign and enhanced care management work at Waitemata DHB:

- Tier 1 is a foundational programme directed at all frontline staff. Compulsory modules include organisational values, patient experience, quality improvement, change management, measurement and evaluation, and clinical costing
- Tier 2 is a clinical practice improvement and leadership programme directed at staff involved in care redesign work within a service or department
- Tier 3 is an advanced programme for senior leaders wanting to take on responsibility and accountability for service design and operations.

**Fellows programme**

Launched in 2015, the Fellows Programme was informed by the UK's Darzi Fellowships in Clinical Leadership and is the only programme of its type in New Zealand. The programme enables service redesign and transformation by matching high performing individuals to areas of high organisational need. Fellowships are 12-month fixed term roles that incorporate projects in an identified key area. In 2016, key areas include medical education, health innovation, health informatics, quality improvement, and health management. Fellow roles also include ring-fenced time and other resource for leadership development activities and clinical duties.

**Regional Management Graduate programme**

In 2015, the Northern region DHBs introduced a management graduate programme aimed at growing future managerial skill sets. Waitemata DHB has taken one new graduate in 2016 applying a mix of on the job training, cohort based leadership, coaching and cultural training and academic training to build their leadership competencies.

## Growing our Māori and Pacific Health workforce

The DHB has a strong focus on growing and building the capacity of our Māori and Pacific Health workforces and the following programmes contribute to this priority.

**Pacific Health Science Academies**: The Academies provide funding to support selected students to gain additional science courses and mentoring, enabling them to move into health related tertiary training prior to taking up a health related career in the Auckland region.

**The Rangatahi Programme:** Provides Māori and Pacific senior secondary school students with career experience in healthcare, and promotes tertiary education and transition into employment. Five students were given summer work placements at Waitemata DHB in 2015/16.

**Health Scholarships:** Since 2009 the DHB has supported over 45 Māori and Pacific students through their tertiary study. In 2015, all scholarship graduates who applied for roles in the health sector gained employment.

**Youth Connections:** The DHB participates in this multi-agency partnership aimed at engaging in employment activities for Māori and Pacific youth in the Auckland region.

**OCCUPATION TYPE:**

**43%** NURSING

**25%** ALLIED HEALTH

**13%** MEDICAL

**19%** OTHER

### Volunteers

There are approximately 360 volunteers currently involved with the DHB who work across both North Shore and Waitakere Hospitals. This includes the Green Coats and front-of-house at Waitakere, Friends of Emergency Departments (FEDS) from St Johns, Meals on Wheels (Red Cross), the Volunteer Stroke Service (VSS) and the women's auxiliary.

In early 2016, a review took place with volunteers and with staff who work with volunteers to gain a better understanding of where people are working, what is working well and what needs to be improved.

The review found that the work volunteers do is very much appreciated by the DHB but identified a number of areas of improvement including a demand for more volunteers, a need for greater diversity of age groups and ethnicities within our volunteers as well as a need to provide opportunities to bring our volunteers together more often and make them feel more appreciated and a valued part of the DHB.

A strategy is now being developed to build on the review recommendations.

## Organisational culture and values

In 2015/16 Waitemata DHB was recognised by two national bodies for our extensive work over the last four years linking patient experience to our organisation's values:

- Institute of Public Administration New Zealand (IPANZ) award for Excellence in Integrity and Trust, July 2015
- Human Resources Institute of New Zealand – Talent Development and Management award, February 2016.

The patient experience work takes feedback from patients and their families and maps these comments against the DHB's values to measure performance and drive improvements in care.


## Remuneration and recognition

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

- Chief Executive awards - an award provided to staff who are recognised for a specified activity or action which demonstrates a DHB goal, priority or value
- Health Hero - a bi-monthly award to a staff member who demonstrates outstanding achievement of the organisation's values, standards and behaviours
- Team Health Hero – a bi-monthly award to the team demonstrating the organisation's values, standards and behaviours
- Long service awards - recognition of staff who have 15 years plus service with the DHB.

Living within our means is central to our success as an organisation. We actively participate in the national Employment Relations Strategy Group which establishes the parameters to ensure bargaining will deliver organisational and sector expectations. Any agreements negotiated nationally or locally are approved by the Ministry of Health as per established protocols.

## In Partnership with Unions

We value our relationships with our union partners, establishing partnership agreements for health and safety and engaging in bipartite committees both nationally and locally. This allows us to have dialogue about programmes of work such as our wellbeing strategy, policies, workplace design and change, training and education and progress with improving our patient outcomes and enhancing our patient experience.

## Workplace flexibility and design

A large building programme has started across our sites. Staff are involved in planning discussions about construction and design to enable appropriate and future-proofed spaces that staff can work in, are safe and which aid the delivery of the best patient care.

**3,925**

EMPLOYEES RECEIVED A FLU VACCINATION IN 2016

The DHB offers flexible hours, as noted by our large part time workforce. Rosters aim to meet organisational and personal needs, and we provide opportunities for staff to adapt working patterns that provide for work-life balance, eg the Summer Flexi Hours programme.

## Policies

The DHB has reviewed all our people based policies including contemporary changes to recruitment, conflict of interest, bullying and harassment, performance management, and recruitment and retention of staff with disabilities and leave management. Key employee policies are sent to union partners for their feedback and then endorsed by our Senior Leadership team.

## Health and Safety

Waitemata DHB attaches great importance to the health, safety and wellbeing of its staff, patients, visitors, contractors, students and all others who come into our facilities. It continues to be a top priority for the Board, with a significant amount of work currently underway in this area.

Engagement of our people is at the heart of our business, with over 260 health and safety representatives involved in the day to day operational aspects of our safety systems. We have also identified seven lead representatives who provide strategic advice to the DHB wide Health, Safety and Wellbeing Committee.

The DHB takes pride in its commitment to staff wellbeing, with a three year healthy workplaces strategy recently approved, aimed at making work a safer, healthier, and a more engaging and satisfying experience. The strategy uses the World Health Organisation's (WHO) healthy workplaces framework as a basis for looking at staff engagement with, and attitudes and behaviours about, health and safety, workplace environment, design, psychosocial factors, and workforce diversity. We are also proud of our ten year participation in the ACC partnership programme at tertiary status, and the Enviro-Mark programme where we were recently awarded Gold status for the second time.

With such a diverse range of hazards, the DHB has many systems in place to assess risk; put in place safe working methods; make available appropriate signage and personal protective equipment; manage traffic, security, maintenance and contracting work on sites; and provide for training to manage identified hazards. Self-managed ward and unit based audits, building site and specific governance audits and reviews ensure that we know our system is world class and working in practise.

# ABOUT OUR ORGANISATION

## Waitemata DHB Attendance at Board and Committee Meetings: July 2015 – June 2016

| Board member | | Board *(9 meetings)* | HAC *(9 meetings)* | Audit and Finance *(8 meetings)* | CPHAC *(8 meetings)* | DiSAC *(4 meetings)* | MaGAC *(4 meetings)* |
|---|---|---|---|---|---|---|---|
|  | Lester Levy, CNZM | 9 | 7 | 6 | * | * | * |
|  | Anthony Norman, MNZM | 7 | 7 | 8 | x | x | x |
|  | Max Abbott | 8 | 7 | 6 | 5 | 3 | x |
|  | Kylie Clegg (appointed from 5 November 2015) | 5 | 5 | x | x | x | x |
|  | Sandra Coney | 7 | 7 | x | 6 | 4 | x |
|  | Warren Flaunty | 7 | 7 | 7 | 7 | x | x |
|  | James Le Fevre | 7 | 7 | x | x | x | 4 |
|  | Morris Pita | 9 | 7 | 8 | x | x | 2 |
|  | Christine Rankin | 7 | 6 | 6 | 5 | x | x |
|  | Allison Roe | 7 | 7 | x | 7 | x | 2 |
|  | Gwen Tepania-Palmer | 8 | 7 | x | 8 | x | 4 |

x *not a member of the committee*
* *ex-officio member*
^ *leave of absence*

## 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.

The following waiver was given during the 2015/16 year: meeting of the Waitemata DHB Board 29 June 2016 (public excluded agenda).
Anthony Norman disclosed an interest in the item: 'Appointment of a Waitemata DHB Representative on the healthAlliance Board of Directors'. His interest was as a Director of both the healthAlliance NZ Ltd Board and healthAlliance (FPSC) Ltd Board. The Board resolved under Schedule 3, clause 36(4) that Anthony Norman could participate in deliberations on this item, the reason being that he has resigned from his role as both Director of the healthAlliance NZ Ltd Board and healthAlliance (FPSC) Ltd Board, effective from 1 July 2016. Anthony Norman remained in the meeting for the discussion of this item.

## Trusts

Waitemata DHB controls the Three Harbours Health Foundation.

Wilson Home Trust: Waitemata DHB is trustee for this trust, the primary functions of which are: provision and maintenance of building and grounds at the Wilson Home and the funding of equipment and amenities for children with physical disabilities. Waitemata DHB leases from the Trust premises on the Wilson Home site from which the DHB provides services for children with physical disabilities.

Waitemata DHB also holds a 20% shareholding in South Kaipara Medical Centre Limited Partnership. This is a joint venture with the Helensville District Health Trust and two local GPs to ensure sustainability of a rural general practice.

## Ministerial Directions

Directions issued by a Minister during the 2015/16 financial year, or that remain current are as follows:

- Direction to support a whole of government approach as to implementation of a NZ Business Number, issued in May 2016 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in July 2008, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

## Vote Health: Health and Disability Support Services – Waitemata DHB Appropriation

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas.

An assessment of what has been achieved with Waitemata DHB's 2015/16 appropriations is detailed below:

### Appropriations allocated and scope

Health and Disability Support Services appropriation allocated to Waitemata DHB is a non-departmental output expenses incurred by the Crown.

The funding of personal and mental health services included services for the health of older people, provision of hospital and related services and management outputs from Waitemata DHB.

### What is intended to be achieved with this appropriation

The DHB provides services that aligns with:

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

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

The performance measures outlined in Waitemata DHB's Statement of Intent are used to assess our performance. For performance results, refer to our Statement of Service Performance.

### Amount of appropriations

| | 2014/15 | | 2015/16 | | |
|---|---|---|---|---|---|
| | Budgeted $000 | Estimated Actual $000 | Estimates $000 | Supplementary estimates[37] $000 | Total $000 |
| **Total appropriations** | 1,311,848 | 1,311,848 | 1,342,072 | 7,249 | 1,349,321 |

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

[37] Reasons for change in appropriation can be found in Vote Health – Supplementary Estimates of Appropriations 2015/16.

# Financial performance


## Where the money came from and what we spent it on

# FINANCIAL STATEMENTS

## Statement of Responsibility

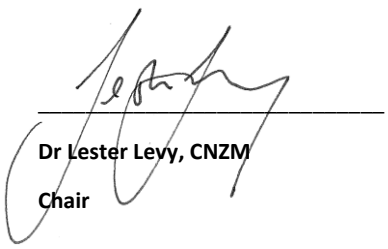
We are responsible for the preparation of the Waitemata District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waitemata District Health Board for the year ended 30 June 2016.

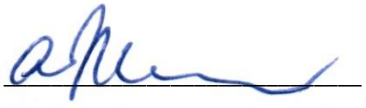
Signed on behalf of the Board:



**Dr Lester Levy, CNZM**

**Chair**

**Dated: 28 October 2016**



**Anthony Norman, MNZM**

**Deputy Chair**

**Dated: 28 October 2016**

# Statement of comprehensive revenue and expense for the year ended 30 June 2016

| | Notes | Group | | Parent | Group and Parent | Parent |
|---|---|---|---|---|---|---|
| | | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Budget 2016 $000 | Actual 2015 $000 |
| **Revenue** | | | | | | |
| Patient care revenue | 2 | 1,545,758 | 1,509,335 | 1,545,758 | 1,531,480 | 1,509,335 |
| Interest revenue | | 5,802 | 8,199 | 5,454 | 6,010 | 7,841 |
| Other revenue | 3 | 25,319 | 23,602 | 25,319 | 25,971 | 23,602 |
| Total revenue | 30 | 1,576,879 | 1,541,136 | 1,576,531 | 1,563,461 | 1,540,778 |
| | | | | | | |
| **Expenditure** | | | | | | |
| Personnel costs | 4 | 582,218 | 568,097 | 582,218 | 566,650 | 568,097 |
| Depreciation and amortisation expense | 12,13 | 27,173 | 23,517 | 27,173 | 25,621 | 23,517 |
| Outsourced services | | 71,571 | 74,280 | 71,571 | 67,023 | 74,280 |
| Clinical supplies | | 102,033 | 98,463 | 102,033 | 93,967 | 98,463 |
| Infrastructure and non-clinical expenses | | 39,550 | 46,545 | 39,550 | 33,213 | 46,545 |
| Other district health boards | | 348,404 | 331,623 | 348,404 | 342,212 | 331,623 |
| Non-health board provider expenses | | 356,650 | 349,778 | 356,650 | 389,454 | 349,778 |
| Capital charge | 5 | 24,501 | 18,618 | 24,501 | 18,999 | 18,618 |
| Interest expense | | 10,712 | 12,492 | 10,712 | 11,136 | 12,492 |
| Other expenses | 6 | 11,110 | 14,705 | 11,870 | 12,375 | 15,278 |
| Total expenditure | 30 | 1,573,922 | 1,538,118 | 1,574,682 | 1,560,650 | 1,538,691 |
| | | | | | | |
| Share of associates and jointly controlled entities | 11 | 0 | 0 | 0 | 0 | 0 |
| **Surplus / (deficit)** | | **2,957** | **3,018** | **1,849** | **2,811** | **2,087** |
| | | | | | | |
| **Other comprehensive revenue and expense** | | | | | | |
| Gain on property revaluations | 18 | 29,398 | 54,245 | 29,398 | 0 | 54,245 |
| Total other comprehensive revenue and expense | | 29,398 | 54,245 | 29,398 | 0 | 54,245 |
| | | | | | | |
| **Total comprehensive revenue and expense** | | **32,355** | **57,263** | **31,247** | **2,811** | **56,332** |

Explanations of major variances against budget are provided in note 30.
The accompanying notes form part of these financial statements.

## Statement of changes in net assets/equity for the year ended 30 June 2016

| | Notes | Group Actual 2016 $000 | Group Actual 2015 $000 | Parent Actual 2016 $000 | Group and Parent Budget 2016 $000 | Parent Actual 2015 $000 |
|---|---|---|---|---|---|---|
| Balance at 1 July | | 313,722 | 256,459 | 304,723 | 238,897 | 248,391 |
| **Comprehensive Income** | | | | | | |
| Surplus | | 2,957 | 3,018 | 1,849 | 2,811 | 2,087 |
| **Other comprehensive revenue and expense** | | | | | | |
| Gain on property revaluations | | 29,398 | 54,245 | 29,398 | 0 | 54,245 |
| **Total comprehensive revenue and expense for the year** | | **32,355** | **57,263** | **31,247** | **2,811** | **56,332** |
| **Balance at 30 June** | 18 | **346,077** | **313,722** | **335,970** | **241,708** | **304,723** |

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 2016

| | Notes | Group | | Parent | Group and Parent | Parent |
|---|---|---|---|---|---|---|
| | | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Budget 2016 $000 | Actual 2015 $000 |
| **Assets** | | | | | | |
| **Current assets** | | | | | | |
| Cash and cash equivalents | 7 | 55,682 | 144,900 | 53,631 | 63,188 | 143,393 |
| Receivables | 8 | 48,051 | 39,593 | 47,953 | 34,300 | 39,240 |
| Investments | 9 | 28,732 | 1,936 | 28,000 | 3,300 | 0 |
| Inventories | 10 | 6,614 | 6,370 | 6,614 | 5,700 | 6,370 |
| Prepayments | | 1,113 | 335 | 1,113 | 500 | 335 |
| Total current assets | | 140,192 | 193,134 | 137,311 | 106,988 | 189,338 |
| **Non-current assets** | | | | | | |
| Investments | 9 | 7,256 | 5,170 | 0 | 5,155 | 0 |
| Investments in associates and joint ventures | 11 | 33,270 | 25,855 | 33,270 | 32,174 | 25,855 |
| Property, plant and equipment | 12 | 710,189 | 637,183 | 710,189 | 644,668 | 637,183 |
| Intangible assets | 13 | 5,011 | 5,113 | 5,011 | 6,903 | 5,113 |
| Total non-current assets | | 755,726 | 673,321 | 748,470 | 688,900 | 668,151 |
| **Total assets** | | **895,918** | **866,455** | **885,781** | **795,888** | **857,489** |
| **Liabilities** | | | | | | |
| **Current liabilities** | | | | | | |
| Payables | 14 | 118,290 | 126,013 | 118,260 | 154,763 | 126,046 |
| Borrowings | 15 | 26,049 | 26,049 | 26,049 | 3,967 | 26,049 |
| Employee entitlements | 16 | 110,686 | 113,798 | 110,686 | 89,874 | 113,798 |
| Provisions | 17 | 704 | 619 | 704 | 800 | 619 |
| Total current liabilities | | 255,729 | 266,479 | 255,699 | 249,404 | 266,512 |
| **Non-current liabilities** | | | | | | |
| Borrowings | 15 | 251,519 | 251,848 | 251,519 | 272,126 | 251,848 |
| Employee entitlements | 16 | 42,593 | 34,406 | 42,593 | 32,650 | 34,406 |
| Total non-current liabilities | | 294,112 | 286,254 | 294,112 | 304,776 | 286,254 |
| **Total liabilities** | | **549,841** | **552,733** | **549,811** | **554,180** | **552,766** |
| **Net assets** | | **346,077** | **313,722** | **335,970** | **241,708** | **304,723** |
| **Equity** | | | | | | |
| Contributed Capital | 18 | 103,015 | 103,015 | 103,015 | 103,015 | 103,015 |
| Accumulated surpluses / (deficits) | 18 | (40,936) | (42,785) | (40,936) | (51,553) | (42,785) |
| Property Revaluation Reserves | 18 | 273,891 | 244,493 | 273,891 | 190,246 | 244,493 |
| Trust funds | 18 | 10,107 | 8,999 | 0 | 0 | 0 |
| **Total equity** | | **346,077** | **313,722** | **335,970** | **241,708** | **304,723** |

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 2016

| | Notes | Group | | Parent | Group and Parent | Parent |
|---|---|---|---|---|---|---|
| | | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Budget 2016 $000 | Actual 2015 $000 |
| **Cash flows from operating activities** | | | | | | |
| Receipts from patient care: | | | | | | |
| MoH | | 1,522,006 | 1,519,457 | 1,522,006 | 1,535,310 | 1,519,457 |
| Other | | 47,035 | 40,658 | 46,527 | 22,140 | 39,554 |
| Interest received | | 5,118 | 7,562 | 5,082 | 6,010 | 7,528 |
| Payments to suppliers | | (944,826) | (941,893) | (944,826) | (931,492) | (941,263) |
| Payments to employees | | (575,928) | (540,677) | (575,928) | (566,801) | (540,677) |
| Payments for capital charge | | (24,299) | (18,919) | (24,299) | (18,996) | (18,919) |
| Interest paid | | (10,630) | (15,605) | (10,630) | (11,136) | (15,605) |
| GST (net) | | (71) | (1,190) | (71) | (6,600) | (1,190) |
| Net cash flow from operating activities | 19 | 18,405 | 49,393 | 17,861 | 28,435 | 48,885 |
| **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 | 0 | 0 | 0 | 0 |
| Purchase of property, plant and equipment | | (72,208) | (44,393) | (72,208) | (85,652) | (44,393) |
| Purchase of intangible assets | | 0 | (226) | 0 | 0 | (226) |
| Acquisition of investments | | (35,415) | (1,821) | (35,415) | 0 | (1,576) |
| Net cash flow from investing activities | | (107,623) | (46,440) | (107,623) | (85,652) | (46,195) |
| **Cash flows from financing activities** | | | | | | |
| Capital contributions from the Crown | | 0 | 0 | 0 | 0 | 0 |
| Proceeds from loans | | 0 | 17,300 | 0 | 0 | 17,300 |
| Repayment of loans | | 0 | 0 | 0 | (1,000) | 0 |
| Net cash flow from financing activities | | 0 | 17,300 | 0 | (1,000) | 17,300 |
| **Net (decrease) / increase in cash and cash equivalents** | | **(89,218)** | **20,253** | **(89,762)** | **(58,217)** | **19,990** |
| Cash and cash equivalents at the start of the year | | 144,900 | 124,647 | 143,393 | 121,405 | 123,403 |
| **Cash and cash equivalents at the end of the year** | 7 | **55,682** | **144,900** | **53,631** | **63,188** | **143,393** |

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 2016

### Reporting entity

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

The Waitemata District Health Board'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 (PBE) for financial reporting purposes.

The consolidated financial statements of Waitemata DHB for the year ended 30 June 2016 comprise Waitemata DHB and its subsidiaries (together referred to as "Group"). The Waitemata DHB group consists of the controlling entity, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board).

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

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 2016, and were approved by the Board on 28 October 2016.

### Basis of preparation

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

**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 have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements comply with PBE accounting standards.

**Presentation currency and rounding**

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

### Summary of 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 controlled entity Milford Secure Properties Limited as it is dormant and 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. The investments in joint ventures are accounted for in the parent entity financial statements at cost.

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. The Group recognises its interest in healthAlliance using the equity method. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the Group's share of the surplus or deficit of healthAlliance after the date of acquisition. The Group's share of the surplus or deficit of healthAlliance is recognised in the surplus or deficit. The investment in healthAlliance is carried at cost in the Waitemata DHB parent entity's financial statements.

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 in the group financial statements using the equity method as it is not material to the group.

**Associates**
An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The investment in an accociate is recognised at cost. The interests in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) are not accounted for in the group financial statements using the equity method as it is not material to the group.
Waitemata DHB is party to a Limited Partnership agreement, with 20% share of initial capital contributed to the South Kaipara Medical Centre Limited Partnership established on 1 November 2013.

**Revenue**
The specific accounting policies for significant revenue items are explained below:

*MOH revenue*
The DHB is primarily funded through revenue received from the Ministry of Health. This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

It is recognised as revenue at the point of entitlement, when services are delivered or when conditions relating to the revenue are satisfied.

The fair value of revenue from the Ministry has been determined to be equivalent to the amounts due in the funding arrangements.

*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 is recognised when a patient treated within the Waitemata DHB region is domiciled outside of Waitemata. The Ministry 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.

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

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

*Rental revenue*
Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

*Provision of services*
Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion in the Statement of Comprehensive Revenue and Expense.

*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.

**Borrowing costs**
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 where the DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

*Operating leases*

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

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

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

**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 spot exchange rates 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 and with NZ Health Partnerships Limited, other short-term highly liquid investments with original maturities of three months or less.

**Receivables**

Short term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

**Investments**

*Bank term deposits*

Investments in bank term deposits are initially measured at the amount invested.
After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

**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.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

**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 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 (including fit outs and underground infrastructure)
- Clinical Equipment
- IT Equipment
- Other Equipment and Motor Vehicles

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

*Revaluations*
Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to 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 revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

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

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

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

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

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

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

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

- Buildings (including components) 5 to 80 years (1.67%-20%)
- 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%)

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

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.
Work in progress is recognised at cost, less impairment, and is not amortised.

**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.

*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 but are reviewed annually for impairment.

*FPSC rights*

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by New Zealand Health Partnerships Limited (NZHPL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and is tested for impairment annually.

**Impairment of property, plant, and equipment and intangible assets**

The DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

*Non-cash generating assets*

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

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

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit.

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

**Payables**

Short-term payables 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.

**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 to but not yet taken at balance date, continuing medical education, 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 and a reliable estimate of the obligation can be made.

*Long-term entitlements*

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

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

*Presentation of employee entitlements*

Sick Leave, continuing medical education, annual leave and vested long service and, sabbatical leave, are classified as a current liability. Non-vested long service leave, sabbatical leave, retirement gratuities, sick leave and continuing medical education 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.

*Defined benefit schemes*

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

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

If the other participating employers ceased to participate in the Scheme, the employer could be responsible for any deficit of the Scheme. Similarly, if a number of employers cease to have employees participating in the Scheme, the DHB could be responsible for an increased share of the deficit.

**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 an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

*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 Accredited Employers Programme*

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. 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 Accredited 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:

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- trust funds.

*Property Revaluation reserve*
This reserve is related to the revaluation of land and buildings to fair value.

*Trust funds*
This reserve records the unspent amount of donations and bequests provided to the DHB.

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

**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 DHB 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 and building 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.

*Estimating the fair value of land and building revaluations*
The significant assumptions applied in determining the fair value and buildings are disclosed in note 12.

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

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the statement of financial position. The DHB minimises the risk of this estimation uncertainty by:

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

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

*Retirement and long service leave*
Note 16 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

**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. Therefore the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

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

## 2 Patient care revenue

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Health and disability services (MOH contracted revenue) | 1,447,641 | 1,413,424 | 1,447,641 | 1,413,424 |
| ACC contract revenue | 10,008 | 9,586 | 10,008 | 9,586 |
| Inter district patient inflows | **77,001** | 76,139 | **77,001** | 76,139 |
| Revenue from other district health boards | 5,704 | 5,359 | 5,704 | 5,359 |
| Other patient sourced revenue | 5,404 | 4,827 | 5,404 | 4,827 |
| **Total patient care revenue** | **1,545,758** | **1,509,335** | **1,545,758** | **1,509,335** |

## 3 Other revenue

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Clinical Training Agency | 9,201 | 8,615 | 9,201 | 8,615 |
| Donations and bequests received | 1,407 | 213 | 1,407 | 213 |
| Rental revenue | 621 | 594 | 621 | 594 |
| Professional, training and research | 3,368 | 3,478 | 3,368 | 3,478 |
| Other revenue | 10,722 | 10,702 | 10,722 | 10,702 |
| **Total other revenue** | **25,319** | **23,602** | **25,319** | **23,602** |

## 4 Personnel costs

| | Group | | Parent | |
|---|---|---|---|---|
| Notes | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Salaries and wages | 562,927 | 534,052 | 562,927 | 534,052 |
| Contributions to defined contribution schemes | 17,477 | 17,696 | 17,477 | 17,696 |
| Increase/(decrease) in liability for employee entitlements | 1,814 | 16,349 | 1,814 | 16,349 |
| **Total personnel costs** | **582,218** | **568,097** | **582,218** | **568,097** |

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 2016 was 8% (2015: 8%).

## 6 Other expenses

| | | Group | | Parent | |
|---|---|---|---|---|---|
| | | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Audit fees for Waitemata DHB financial statement audit | | 209 | 204 | 209 | 204 |
| Audit fees (for subsidiary financial statements) | | 10 | 15 | 10 | 15 |
| Operating lease expense | | 9,866 | 10,040 | 9,866 | 10,040 |
| Impairment of debtors | | 1,473 | 1,386 | 1,473 | 1,386 |
| Board members fees | 23 | 360 | 372 | 360 | 372 |
| Loss on bond forward rate agreements | | 0 | 3,291 | 0 | 3,291 |
| Koha | | 0 | 0 | 0 | 0 |
| Other expenses | | (808) | (603) | (48) | (30) |
| **Total other expenses** | | **11,110** | **14,705** | **11,870** | **15,278** |

## 7 Cash and cash equivalents

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Cash at bank and on hand | 18 | 17 | 0 | 0 |
| Call deposits | 2,033 | 1,490 | 0 | 0 |
| NZ Health Partnerships Limited | 53,631 | 143,393 | 53,631 | 143,393 |
| **Total cash and cash equivalents for the purposes of the statement of cash flows** | **55,682** | **144,900** | **53,631** | **143,393** |

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 $2,051k (2015: $1,507k) 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 New Zealand Health Partnerships Limited and the participating DHBs. This Agreement enables New Zealand Health Partnerships Limited 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 NZ Health Partnerships Limited, which will incur interest at on-call interest rate received by New Zealand Health Partnerships Limited 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 $55.803m (2015: $46.709m).

## 8 Receivables

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Ministry of Health | 23,421 | 19,970 | 23,421 | 19,970 |
| Other receivables | 10,020 | 8,765 | 9,922 | 8,765 |
| Other accrued revenue | 17,391 | 13,962 | 17,391 | 13,609 |
| Less: Provision for impairment | (2,781) | (3,104) | (2,781) | (3,104) |
| **Total receivables** | **48,051** | **39,593** | **47,953** | **39,240** |

## 8 Receivables (continued)

*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 2016 | | | Group 2015 | | |
|---|---|---|---|---|---|---|
| | Gross | Impairment | Net | Gross | Impairment | Net |
| | $000 | $000 | $000 | $000 | $000 | $000 |
| Not past due | 44,313 | (57) | 44,256 | 36,178 | (281) | 35,897 |
| Past due 1-30 days | 1,246 | (269) | 977 | 1,246 | (263) | 983 |
| Past due 31-60 days | 1,823 | (207) | 1,616 | 1,823 | (196) | 1,627 |
| Past due 61-90 days | 615 | (536) | 79 | 615 | (522) | 93 |
| Past due > 90 days | 2,835 | (1,712) | 1,123 | 2,835 | (1,842) | 993 |
| **Total** | **50,832** | **(2,781)** | **48,051** | **42,697** | **(3,104)** | **39,593** |

| | Parent 2016 | | | Parent 2015 | | |
|---|---|---|---|---|---|---|
| | Gross | Impairment | Net | Gross | Impairment | Net |
| | $000 | $000 | $000 | $000 | $000 | $000 |
| Not past due | 44,802 | (57) | 44,745 | 35,825 | (281) | 35,544 |
| Past due 1-30 days | 650 | (269) | 381 | 1,246 | (263) | 983 |
| Past due 31-60 days | 1,465 | (207) | 1,258 | 1,823 | (196) | 1,627 |
| Past due 61-90 days | 641 | (536) | 105 | 615 | (522) | 93 |
| Past due > 90 days | 3,176 | (1,712) | 1,464 | 2,835 | (1,842) | 993 |
| **Total** | **50,734** | **(2,781)** | **47,953** | **42,344** | **(3,104)** | **39,240** |

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 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Balance at 1 July | 3,104 | 3,094 | 3,104 | 3,094 |
| Additional provisions made | 1,473 | 1,386 | 1,473 | 1,386 |
| Receivables written off | (1,796) | (1,376) | (1,796) | (1,376) |
| **Balance at 30 June** | **(2,781)** | **(3,104)** | **(2,781)** | **(3,104)** |

## 9 Investments

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Current portion** | | | | |
| Term deposits with maturities greater than 3 months and remaining duration less than 12 months | 28,732 | 1,936 | 28,000 | 0 |
| Total current portion | 28,732 | 1,936 | 28,000 | 0 |
| **Non-current portion** | | | | |
| Term deposits with maturities greater than 3 months and remaining duration greater than 12 months | 7,256 | 5,170 | 0 | 0 |
| Total non-current portion | 7,256 | 5,170 | 0 | 0 |
| **Total investments** | **35,988** | **7,106** | **28,000** | **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 $7.256m (2015: $5.170m). The fair value has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs.

## 10 Inventories

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Pharmaceuticals | 603 | 598 | 603 | 598 |
| Surgical and medical supplies | 6,011 | 5,772 | 6,011 | 5,772 |
| **Total inventories** | **6,614** | **6,370** | **6,614** | **6,370** |

The write-down of inventories held for distribution amounted to $nil (2015: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2015: $nil). However, some inventories are subject to retention of title clauses.

## 11 Investments in associates and joint ventures

| | Interest held 30-Jun-16 | Balance date |
|---|---|---|
| **Investments in joint ventures** | | |
| healthAlliance N.Z. Limited – Class A shares | 25% | 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 |
| South Kaipara Medical Centre | 20% | 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 associates, joint ventures and partnerships*

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| healthAlliance N.Z. Limited | 33,138 | 25,767 | 33,138 | 25,767 |
| South Kaipara Medical Centre | 132 | 88 | 132 | 88 |
| **Total investments** | **33,270** | **25,855** | **33,270** | **25,855** |

There were no impairment losses in the value of associates and joint ventures assessed for 2015 (2015: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $33.138m (2015: $25.767m).

*Summary of financial information of joint ventures and associates*

| | Assets $000 | Liabilities $000 | Equity $000 | Revenues $000 | Surplus/(Deficit) $000 |
|---|---|---|---|---|---|
| **2016** | | | | | |
| healthAlliance N.Z. Limited | 154,951 | 26,549 | 128,402 | 125,839 | (900) |
| New Zealand Health Innovation Hub Limited Partnership | 1,759 | 699 | 1,060 | 500 | (602) |
| Northern Regional Alliance Ltd (formerly Northern DHB Support Agency) | 10,556 | 9,041 | 1,515 | 15,377 | 5 |
| South Kaipara Medical Centre | 520 | 253 | 267 | 2,151 | (21) |
| **Total** | **167,786** | **36,542** | **131,244** | **143,867** | **(1,518)** |
| **2015** | | | | | |
| healthAlliance N.Z. Limited | 125,389 | 23,492 | 101,897 | 123,276 | (37) |
| New Zealand Health Innovation Hub Limited Partnership | 1,157 | 185 | 972 | 699 | (389) |
| Northern Regional Alliance Ltd (formerly Northern DHB Support Agency) | 11,627 | 10,117 | 1,510 | 14,969 | 124 |
| South Kaipara Medical Centre | 509 | 221 | 288 | 2,099 | (47) |
| **Total** | **138,682** | **34,015** | **104,667** | **141,043** | **(349)** |

*Share of surplus / (deficit) of associates and jointly controlled entities.*

| | 2016 $000 | 2015 $000 |
|---|---|---|
| Share of surplus / (deficit) before tax: | (378) | (75) |
| Less: Tax expense | 0 | 0 |
| **Share of surplus / (deficit)** | **(378)** | **(75)** |

The Group's share of the surplus / (deficit) in associates and jointly controlled entities has not been accounted for on the grounds of materiality.

## 12 Property, plant, and equipment

| Parent and Group | Land $000 | Buildings $000 | Clinical Equipment $000 | Other Equipment $000 | IT Equipment $000 | Work in Progress $000 | $000 |
|---|---|---|---|---|---|---|---|
| **Cost or valuation** | | | | | | | |
| Balance at 1 July 2014 | 162,063 | 368,524 | 100,813 | 26,968 | 3,981 | 20,531 | 682,880 |
| Additions from WIP | 0 | 29,512 | 11,260 | 2,802 | 87 | (43,661) | 0 |
| Revaluation increase/(decrease) | 23,497 | (7,874) | 0 | 0 | 0 | 0 | 15,623 |
| Additions to WIP | 0 | 0 | 0 | 0 | 0 | 43,470 | 43,470 |
| Disposals | 0 | 0 | 0 | (451) | 0 | (442) | (893) |
| Balance at 30 June 2015 | 185,560 | 390,162 | 112,073 | 29,319 | 4,068 | 19,898 | 741,080 |
| | | | | | | | |
| Balance at 1 July 2015 | 185,560 | 390,162 | 112,073 | 29,319 | 4,068 | 19,898 | 741,080 |
| Additions from WIP | 9,428 | 24,691 | 4,294 | 1,389 | 11 | (39,813) | 0 |
| Revaluation increase/(decrease) | 29,322 | 76 | 0 | 0 | 0 | 0 | 29,398 |
| Additions to WIP | 0 | 0 | 0 | 0 | 0 | 71,624 | 71,624 |
| Disposals | 0 | (414) | (417) | (337) | 0 | (752) | (1,920) |
| Balance at 30 June 2016 | 224,310 | 414,515 | 115,950 | 30,371 | 4,079 | 50,957 | 840,182 |
| | | | | | | | |
| **Accumulated depreciation and impairment losses** | | | | | | | |
| Balance at 1 July 2014 | 0 | 29,420 | 66,808 | 19,428 | 3,951 | 0 | 119,607 |
| Depreciation expense | 0 | 14,290 | 7,243 | 1,815 | 22 | 0 | 23,370 |
| Impairment losses | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Elimination on disposal/transfer | 0 | 0 | 0 | (458) | 0 | 0 | (458) |
| Elimination on revaluation | 0 | (38,622) | 0 | 0 | 0 | 0 | (38,622) |
| Balance at 30 June 2015 | 0 | 5,088 | 74,051 | 20,785 | 3,973 | 0 | 103,897 |
| | | | | | | | |
| Balance at 1 July 2015 | 0 | 5,088 | 74,051 | 20,785 | 3,973 | 0 | 103,897 |
| Depreciation expense | 0 | 17,262 | 7,673 | 2,017 | 30 | 0 | 26,982 |
| Impairment losses | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Elimination on disposal/transfer | 0 | 67 | (614) | (339) | 0 | 0 | (886) |
| Elimination on revaluation | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Balance at 30 June 2016 | 0 | 22,417 | 81,110 | 22,463 | 4,003 | 0 | 129,993 |
| | | | | | | | |
| **Carrying amounts** | | | | | | | |
| At 1 July 2014 | 162,063 | 339,104 | 34,005 | 7,540 | 30 | 20,531 | 563,273 |
| At 30 June and 1 July 2015 | 185,560 | 385,074 | 38,022 | 8,534 | 95 | 19,898 | 637,183 |
| **At 30 June 2016** | **224,310** | **392,098** | **34,840** | **7,908** | **76** | **50,957** | **710,189** |

The net carrying amount of assets held under finance leases is $862k (2015: $1.191m) for clinical equipment.

IT assets in Work In Progress $4.153m (2015: $3.628m) will be transferred to healthAlliance N.Z. Limited once completed.

*Land*

Land is valued at fair value using market-based evidence based 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.

## 12 Property, plant, and equipment (continued)

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 2016 and the land values were adjusted accordingly.

*Buildings*
Specialised hospital buildings and underground infrastructure are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

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

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

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

The most recent valuation of buildings was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2015.

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

| Parent and Group | 2016 $000 | 2015 $000 |
|---|---|---|
| Buildings | 42,385 | 15,065 |
| Clinical equipment | 2,722 | 846 |
| Other equipment | 1,697 | 359 |
| IT equipment | 4,153 | 3,628 |
| **Total work in progress** | **50,957** | **19,898** |

**Impairment**
No impairment loss identified in property, plant and equipment in 2016 (2015: Nil).

**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.

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 has been estimated in the value of the land.

## 13 Intangible assets

Movements for each class of intangible assets are as follows:

| Parent and Group | FPSC Rights $000 | Acquired Software $000 | Total $000 |
|---|---|---|---|
| **Cost** | | | |
| Balance at 30 June 2014 | 4,593 | 3,247 | 7,840 |
| Additions | 226 | 114 | 340 |
| Balance at 30 June 2015 | 4,819 | 3,361 | 8,180 |
| Additions | 0 | 88 | 88 |
| Balance at 30 June 2016 | 4,819 | 3,449 | 8,268 |
| | | | |
| **Accumulated amortisation and impairment losses** | | | |
| Balance at 30 June 2014 | 0 | 2,920 | 2,920 |
| Amortisation expense | 0 | 147 | 147 |
| Balance at 30 June 2015 | 0 | 3,067 | 3,067 |
| Amortisation expense | 0 | 190 | 190 |
| Balance at 30 June 2016 | 0 | 3,257 | 3,257 |
| | | | |
| **Carrying amounts** | | | |
| At 1 July 2014 | 4,593 | 327 | 4,920 |
| At 30 June 2015 | 4,819 | 294 | 5,113 |
| **At 30 June 2016** | **4,819** | **192** | **5,011** |

At 30 June 2016, the DHB had made payments totalling $4.819m (2015: $4.819m) to NZHPL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme. This is a national initiative facilitated by NZHPL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of NZHPL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

NZHPL 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 surplus after tax earned by NZHPL 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 FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and other shared services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by New Zealand Health Partnerships Limited (NZHPL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and other shared services.

## 13 Intangible assets (continued)

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

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

## 14 Payables

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Creditors and accrued expenses | 109,765 | 117,516 | 109,735 | 117,549 |
| Revenue in advance | 1,683 | 1,785 | 1,683 | 1,785 |
| GST payable | 6,640 | 6,712 | 6,640 | 6,712 |
| Capital charge payable | 202 | 0 | 202 | 0 |
| **Total payables** | **118,290** | **126,013** | **118,260** | **126,046** |

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.

## 15 Borrowings

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Current portion** | | | | |
| Finance leases | 339 | 339 | 339 | 339 |
| New Zealand Debt Management Office loans | 25,710 | 25,710 | 25,710 | 25,710 |
| Total current portion | 26,049 | 26,049 | 26,049 | 26,049 |
| **Non-current portion** | | | | |
| Finance leases | 523 | 852 | 523 | 852 |
| New Zealand Debt Management Office loans | 250,996 | 250,996 | 250,996 | 250,996 |
| Total non-current portion | 251,519 | 251,848 | 251,519 | 251,848 |
| **Total borrowings** | **277,568** | **277,897** | **277,568** | **277,897** |
| **Borrowing facility limits** | | | | |
| New Zealand Debt Management Office loan facility limit | 277,820 | 277,820 | 277,820 | 277,820 |
| Overdraft facility | 0 | 0 | 0 | 0 |
| **Total borrowing facility limits** | **277,820** | **277,820** | **277,820** | **277,820** |

**New Zealand Debt Management Office (NZDM) loans**
The NZDMO loans are secured by a negative pledge.

Without the NZDMO'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.

## 15 Borrowings (continued)

All financial covenants have been waived by the NZDMO.

The fair value of NZDMO borrowings is $296.328m (2015: $285.104m). Fair value has been determined using the contractual cash flows discounted by the Government bond rate plus 15 basis points.

**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.

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Minimum lease payments payable:** | | | | |
| No later than one year | 322 | 256 | 322 | 256 |
| Later than one year and not later than five years | 822 | 1,250 | 822 | 1,250 |
| Later than five years | 0 | 0 | 0 | 0 |
| Total minimum lease payments | 1,144 | 1,506 | 1,144 | 1,506 |
| Future finance charges | (282) | (315) | (282) | (315) |
| **Present value of minimum lease payments** | **862** | **1,191** | **862** | **1,191** |
| | | | | |
| **Present value of minimum lease payments** | | | | |
| No later than one year | 339 | 339 | 339 | 339 |
| Later than one year and not later than five years | 523 | 852 | 523 | 852 |
| Later than five years | 0 | 0 | 0 | 0 |
| **Total present value of minimum lease payments** | **862** | **1,191** | **862** | **1,191** |

**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.

## 16 Employee entitlements

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Current portion** | | | | |
| Accrued salaries and wages | 2,802 | 7,267 | 2,802 | 7,267 |
| Annual leave | 68,374 | 63,757 | 68,374 | 63,757 |
| Sick leave | 1,600 | 1,100 | 1,600 | 1,100 |
| Sabbatical leave | 3,620 | 3,620 | 3,620 | 3,620 |
| Continuing medical education | 7,915 | 7,905 | 7,915 | 7,905 |
| Work related entitlements | 1,913 | 1,824 | 1,913 | 1,824 |
| Unpaid payroll | 6,090 | 9,109 | 6,090 | 9,109 |
| Payroll provisions | 9,900 | 9,974 | 9,900 | 9,974 |
| Unsettled CEAs | 2,601 | 3,347 | 2,601 | 3,347 |
| Accrued long service awards | 3,261 | 3,285 | 3,261 | 3,285 |
| Long service leave | 461 | 461 | 461 | 461 |
| Retirement gratuities | 2,149 | 2,149 | 2,149 | 2,149 |
| Total current portion | 110,686 | 113,798 | 110,686 | 113,798 |
| **Non-current portion** | | | | |
| Continuing medical education | 10,073 | 10,061 | 10,073 | 10,061 |
| Long service leave | 8,371 | 7,642 | 8,371 | 7,642 |
| Retirement gratuities | 19,149 | 14,503 | 19,149 | 14,503 |
| Sick leave | 5,000 | 2,200 | 5,000 | 2,200 |
| Total non-current portion | 42,593 | 34,406 | 42,593 | 34,406 |
| Total employee entitlements | **153,279** | **148,204** | **153,279** | **148,204** |

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 3.5% (2015: 4%) was used.

## 17 Provisions

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Current portion** | | | | |
| ACC Partnership Programme | 704 | 619 | 704 | 619 |
| Total current portion | 704 | 619 | 704 | 619 |
| **Total provisions** | **704** | **619** | **704** | **619** |

## 17 Provisions (continued)

Movements for each class of provision are as follows:

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Balance at 1 July | 619 | 736 | 619 | 736 |
| Movement in provisions | 85 | 0 | 85 | 0 |
| Amounts used | 0 | (117) | 0 | (117) |
| **Balance at 30 June** | **704** | **619** | **704** | **619** |

**ACC Partnership Programme**

*Liability valuation*

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2016. 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% (2015: 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.

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

- an average assumed rate of inflation of 1.7% (2015: 2.1%);
- a weighted average discount factor of 2.5% (2015: 3%) 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 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Crown equity** | | | | |
| Balance at 1 July | 103,015 | 103,015 | 103,015 | 103,015 |
| Capital contributions from the Crown | 0 | 0 | 0 | 0 |
| 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 | (42,785) | (44,872) | (42,785) | (44,872) |
| Prior year adjustments | 0 | 0 | 0 | 0 |
| | (42,785) | (44,872) | (42,785) | (44,872) |
| | | | | |
| Surplus/(deficit) for the year | 2,957 | 3,018 | 1,849 | 2,087 |
| Revaluation reserves transfer on disposal | 0 | 0 | 0 | 0 |
| Transfer from/(to) trust funds | (1,108) | (931) | 0 | 0 |
| Balance at 30 June | (40,936) | (42,785) | (40,936) | (42,785) |
| | | | | |
| **Revaluation reserves** | | | | |
| Balance at 1 July | 244,493 | 190,248 | 244,493 | 190,248 |
| Impairment loss | 0 | 0 | 0 | 0 |
| Revaluations | 29,398 | 54,245 | 29,398 | 54,245 |
| Balance at 30 June | 273,891 | 244,493 | 273,891 | 244,493 |
| | | | | |
| Revaluation reserves consist of: | | | | |
| Land | 209,396 | 180,074 | 209,396 | 180,074 |
| Buildings | 64,495 | 64,419 | 64,495 | 64,419 |
| Total revaluation reserves | 273,891 | 244,493 | 273,891 | 244,493 |
| | | | | |
| **Trust funds** | | | | |
| Balance at 1 July | 8,999 | 8,068 | 0 | 0 |
| Movement | 1,108 | 931 | 0 | 0 |
| Balance at 30 June | 10,107 | 8,999 | 0 | 0 |
| **Total equity** | **346,077** | **313,722** | **335,970** | **304,723** |

## 19 Reconciliation of net surplus/(deficit) to net cash flow from operating activities

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Net surplus/(deficit)** | 2,957 | 3,018 | 1,849 | 2,087 |
| **Add/(less) non-cash items** | | | | |
| Depreciation and amortisation expense | 27,173 | 23,517 | 27,173 | 23,517 |
| Total non-cash items | 27,173 | 23,517 | 27,173 | 23,517 |
| **Add/(less) items classified as investing or financing activities** | | | | |
| Unrealised (gain)/ loss investments | 0 | 0 | 0 | 0 |
| (Gains)/losses on disposal of property, plant and equipment | 0 | 0 | 0 | 0 |
| Total items classified as investing or financing activities | 0 | 0 | 0 | 0 |
| **Add/(less) movements in statement of financial position items** | | | | |
| Debtors and other receivables | (9,236) | (3,757) | (9,491) | (3,100) |
| Inventories | (244) | (912) | (244) | (912) |
| Creditors and other payables | (7,405) | 4,460 | (6,586) | 4,226 |
| Provisions | 85 | (117) | 85 | (117) |
| Employee entitlements | 5,075 | 23,184 | 5,075 | 23,184 |
| Net movements in working capital items | (11,725) | 22,858 | (11,161) | 23,281 |
| **Net cash flow from operating activities** | **18,405** | **49,393** | **17,861** | **48,885** |

## 20 Capital commitments and operating leases

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Capital commitments** | | | | |
| Property | 25,597 | 31,241 | 25,597 | 31,241 |
| **Total capital commitments** | **25,597** | **31,241** | **25,597** | **31,241** |

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

**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 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| Not later than one year | 6,279 | 8,677 | 6,279 | 8,677 |
| Later than one year and not later than five years | 6,557 | 15,011 | 6,557 | 15,011 |
| Later than five years | 214 | 574 | 214 | 574 |
| **Total non-cancellable operating leases as lessee** | **13,050** | **24,262** | **13,050** | **24,262** |

The DHB leases a number of buildings under operating leases.

## 21 Contingencies

**Contingent liabilities**

*Lawsuits against the DHB*

Waitemata DHB and its associates have been notified of potential legal claims at 30th June 2016 which creates a contingent liability totalling approximately $230k.

At balance date, Unitec Institute of Technology have granted $435k (2015: $435k) towards the refurbishment of Awhina Health Campus which was completed on 2 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.

## 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.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

**Significant transactions with government-related entities**

The DHB has received funding from the Crown and ACC of $1.455b (2015: $1.423b) to provide health services in the Waitemata area for the year ended 30 June 2016.

**Transactions with key management personnel**

| Key management personnel compensation | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Board members: | | |
| Remuneration | 360 | 371 |
| Full-time equivalent members | 11 | 11 |
| Salaries and other employee benefits of Executive Leadership Team | 3,260 | 3,040 |
| Full-time equivalent members | 10 | 9 |
| **Total key management personnel remuneration** | **3,620** | **3,411** |
| **Total full-time equivalent personnel** | **21** | **20** |

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board Members.

Key management personnel include the Chief Executive and the other ten members of the management team (2015: nine members).

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2015: $nil).

## 23 Board member remuneration

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

| | Actual 2016 $000 | Actual 2015 $000 |
|---|---|---|
| Dr Lester Levy (Chair) | 69 | 69 |
| Prof Max Abbott | 31 | 31 |
| Pat Booth | 0 | 28 |
| Sandra Coney | 30 | 30 |
| Kylie Clegg - appointed 5th November 2015 | 18 | 0 |
| Warren Flaunty | 31 | 31 |
| James Le Fevre | 27 | 28 |
| Anthony Norman (Deputy Chair) | 36 | 36 |
| Morris Pita | 29 | 29 |
| Christine Rankin | 30 | 30 |
| Allison Roe | 29 | 29 |
| Gwen Tepania–Palmer | 30 | 30 |
| **Total board member remuneration** | **360** | **371** |

**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 (2015: $4k) - Norman Wong (Audit and Finance Committee), Rev Featunai Liuaana (CPHAC) and Prof Elsie Ho (CPHAC).

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 affected 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 (2015: $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 2016 | Actual 2015 | | Actual 2016 | Actual 2015 |
|---|---|---|---|---|---|
| $100,000 – 109,999 | 250 | 180 | $340,000 – 349,999 | 15 | 9 |
| $110,000 – 119,999 | 145 | 121 | $350,000 – 359,999 | 7 | 10 |
| $120,000 – 129,999 | 85 | 64 | $360,000 – 369,999 | 7 | 6 |
| $130,000 – 139,999 | 57 | 33 | $370,000 – 379,999 | 6 | 5 |
| $140,000 – 149,999 | 35 | 22 | $380,000 – 389,999 | 8 | 5 |
| $150,000 – 159,999 | 23 | 22 | $390,000 – 399,999 | 6 | 5 |
| $160,000 – 169,999 | 16 | 20 | $400,000 – 409,999 | 3 | 2 |
| $170,000 – 179,999 | 22 | 16 | $410,000 – 419,999 | 3 | 3 |
| $180,000 – 189,999 | 26 | 24 | $420,000 – 429,999 | 1 | 2 |
| $190,000 – 199,999 | 24 | 21 | $430,000 – 439,999 | 3 | 1 |
| $200,000 – 209,999 | 18 | 32 | $440,000 – 449,999 | 0 | 1 |
| $210,000 – 219,999 | 23 | 24 | $450,000 – 459,999 | 0 | 1 |
| $220,000 – 229,999 | 26 | 21 | $460,000 – 469,999 | 1 | 1 |
| $230,000 – 239,999 | 18 | 23 | $470,000 – 479,999 | 0 | 0 |
| $240,000 – 249,999 | 19 | 12 | $480,000 – 489,999 | 2 | 0 |
| $250,000 – 259,999 | 21 | 17 | $490,000 – 499,999 | 0 | 0 |
| $260,000 – 269,999 | 21 | 16 | $500,000 – 509,999 | 0 | 0 |
| $270,000 – 279,999 | 20 | 24 | $510,000 – 519,999 | 1 | 2 |
| $280,000 – 289,999 | 20 | 16 | $520,000 – 529,999 | 0 | 0 |
| $290,000 – 299,999 | 16 | 16 | $530,000 – 539,999 | 0 | 0 |
| $300,000 – 309,999 | 15 | 10 | $540,000 – 549,999 | 0 | 1 |
| $310,000 – 319,999 | 13 | 8 | $550,000 – 559,999 | 1 | 0 |
| $320,000 – 329,999 | 13 | 11 | $560,000 – 569,999 | 0 | 1 |
| $330,000 – 339,999 | 10 | 8 | $580,000 – 589,999 | 1 | 0 |
| | | | **Grand Total** | **1,001** | **816** |

During the year ended 30 June 2016 there were 129 (2015: 96) employees who received compensation and other benefits in relation to cessation totalling $2.109m (2015: $1.326m).

## 25 Events after the balance date

There were no significant events after the balance date.

## 26a Financial instrument categories

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

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Loans and receivables** | | | | |
| Cash and cash equivalents | 55,682 | 144,900 | 53,631 | 143,393 |
| Debtors and other receivables | 48,051 | 39,593 | 47,953 | 39,240 |
| Investments | 35,988 | 7,106 | 28,000 | 0 |
| Total loans and receivables | 139,721 | 191,599 | 129,584 | 182,633 |
| | | | | |
| **Financial liabilities measured at amortised cost** | | | | |
| Creditors and other payables (excl revenue in advance & GST) | 109,967 | 117,516 | 109,937 | 117,549 |
| Borrowings – NZDMO loans | 276,706 | 276,706 | 276,706 | 276,706 |
| Finance leases | 1,144 | 1,506 | 1,144 | 1,506 |
| **Total financial liabilities measured at amortised cost** | **387,817** | **395,728** | **387,787** | **395,761** |

## 26b 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.

*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 NZDMO borrowings. The exposure on the on-call deposits and floating rate borrowings is not considered significant and is not actively managed.

*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 (2015: nil).

*Sensitivity analysis*

As at 30 June 2016, 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.

*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 NZ Health Partnerships 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 New Zealand Health Partnerships 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.

## 26b Financial instrument risks (continued)

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor (approximately 49%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

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

| | Group | | Parent | |
|---|---|---|---|---|
| | Actual 2016 $000 | Actual 2015 $000 | Actual 2016 $000 | Actual 2015 $000 |
| **Counterparties with credit ratings** | | | | |
| Cash, cash equivalents and investments: | | | | |
| AA | 157 | 160 | 0 | 0 |
| AA - | 21,649 | 2,488 | 18,000 | 0 |
| A+ | 10,000 | 328 | 10,000 | 0 |
| A | 345 | 0 | 0 | 0 |
| A- | 194 | 78 | 0 | 0 |
| BBB+ | 46 | 0 | 0 | 0 |
| BB+ | 200 | 203 | 0 | 0 |
| **Total counterparties with credit ratings** | 32,591 | 3,257 | 28,000 | 0 |
| **Counterparties without credit ratings** | | | | |
| Cash, cash equivalents | 53,631 | 143,393 | 53,631 | 143,393 |
| Investments | 5,448 | 5,356 | 0 | 0 |
| Total counterparties without credit ratings | 59,079 | 148,749 | 53,631 | 143,393 |
| **Total cash, cash equivalents and investments** | **91,670** | **152,006** | **81,631** | **143,393** |
| | | | | |
| **Debtors and other receivables** | | | | |
| Existing counterparty with no defaults in the past | 48,051 | 37,593 | 47,953 | 37,240 |
| Existing counterparty with defaults in the past | 0 | 0 | 0 | 0 |
| **Total debtors and other receivables** | **48,051** | **37,593** | **47,953** | **37,240** |

**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 NZ Health Partnerships. The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the treasury services agreement with NZ Health Partnerships Limited who maintain an overdraft facility. The DHB also receives funding from the Ministry of Health 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 of the Group.

## 26b 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 |
|---|---|---|---|---|---|---|
| **2015** | | | | | | |
| Cash on hand | 143,410 | 143,410 | 143,410 | 0 | 0 | 0 |
| On call deposits | 1,490 | 1,490 | 1,490 | 0 | 0 | 0 |
| Debtors and other receivables | 39,593 | 39,593 | 39,593 | 0 | 0 | 0 |
| Investments | 7,106 | 7,106 | 1,936 | 4,129 | 936 | 105 |
| **Total** | **191,599** | **191,599** | **186,429** | **4,129** | **936** | **105** |

| 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 |
|---|---|---|---|---|---|---|
| **2016** | | | | | | |
| Cash on hand | 53,649 | 53,649 | 53,649 | 0 | 0 | 0 |
| On call deposits | 2,033 | 2,033 | 2,033 | 0 | 0 | 0 |
| Debtors and other receivables | 48,051 | 48,051 | 48,051 | 0 | 0 | 0 |
| Investments | 35,988 | 35,988 | 28,732 | 5,666 | 314 | 1,276 |
| **Total** | **139,721** | **139,721** | **132,465** | **5,666** | **314** | **1,276** |

| 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 |
|---|---|---|---|---|---|---|
| **2015** | | | | | | |
| Cash on hand | 143,393 | 143,393 | 143,393 | 0 | 0 | 0 |
| On call deposits | 0 | 0 | 0 | 0 | 0 | 0 |
| Debtors and other receivables | 39,240 | 39,240 | 39,240 | 0 | 0 | 0 |
| Investments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **182,633** | **182,633** | **182,633** | **0** | **0** | **0** |

| 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 |
|---|---|---|---|---|---|---|
| **2016** | | | | | | |
| Cash on hand | 53,631 | 53,631 | 53,631 | 0 | 0 | 0 |
| On call deposits | 0 | 0 | 0 | 0 | 0 | 0 |
| Debtors and other receivables | 47,953 | 47,953 | 47,953 | 0 | 0 | 0 |
| Investments | 28,000 | 28,000 | 28,000 | 0 | 0 | 0 |
| **Total** | **129,584** | **129,584** | **129,584** | **0** | **0** | **0** |

## 26b 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 |
|---|---|---|---|---|---|---|
| **2015** | | | | | | |
| Creditors and other payables | 117,516 | 117,516 | 117,516 | 0 | 0 | 0 |
| Finance leases | 1,506 | 1,506 | 256 | 256 | 768 | 226 |
| NZDMO loans | 278,441 | 285,104 | 25,746 | 0 | 89,257 | 170,101 |
| **Total** | **397,463** | **404,126** | **143,518** | **256** | **90,025** | **170,327** |
| **2016** | | | | | | |
| Creditors and other payables | 109,967 | 109,967 | 109,967 | 0 | 0 | 0 |
| Finance leases | 1,144 | 1,144 | 256 | 256 | 632 | 0 |
| NZDMO loans | 328,512 | 328,512 | 35,725 | 31,301 | 125,325 | 136,161 |
| **Total** | **439,623** | **439,623** | **145,948** | **31,557** | **125,957** | **136,161** |

| 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 |
|---|---|---|---|---|---|---|
| **2015** | | | | | | |
| Creditors and other payables | 117,549 | 117,549 | 117,549 | 0 | 0 | 0 |
| Finance leases | 1,506 | 1,506 | 256 | 256 | 768 | 226 |
| NZDMO loans | 278,441 | 285,104 | 25,746 | 0 | 89,257 | 170,101 |
| **Total** | **397,496** | **404,159** | **143,551** | **256** | **90,025** | **170,327** |
| **2016** | | | | | | |
| Creditors and other payables | 109,937 | 109,937 | 109,937 | 0 | 0 | 0 |
| Finance leases | 1,144 | 1,144 | 256 | 256 | 632 | 0 |
| NZDMO loans | 328,512 | 328,512 | 35,725 | 31,301 | 125,325 | 136,161 |
| **Total** | **439,593** | **439,593** | **145,918** | **31,557** | **125,957** | **136,161** |

## 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.

There have been no material changes in DHB's management of capital during the period.

## 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 at cost of $nil (2015: $nil).

For the year ended 30 June 2016, THHF had total revenue of $1.376m (2015: $1.157m) and a net surplus of $1.108m (2015: $931k surplus). THHF had assets of $10.567m (2015: $9.013m) and liabilities of $460k (2015: $14.7k) as at 30 June 2016.

## 29 Patient trust monies and restricted funds

| | Actual $000 | Actual $000 |
|---|---|---|
| Balance at 1 July 2015 | 75 | 69 |
| Monies received | 666 | 1,040 |
| Payments made | (668) | (1,034) |
| **Balance at 30 June 2016** | **73** | **75** |

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

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

The major variances in the Statement of Comprehensive revenue and expense are due to –

- Total revenue for the year was $13.0m greater than budget due largely to additional funding received for services from the Crown after the finalisation of the budget, including new contracts for Mental Health, perinatal service and for additional discharges above production plan. Additional revenue was also received during the year for capital charge as a result of revaluations of land and buildings and for interest as a result of higher than budgeted cash balance in the Westpac sweep account held by New Zealand Health Partnerships Limited.
- Expenditure for the year was $14.0m greater than budget which is mostly due to the additional volumes and services purchased by the Crown and capital charge as stated in the point above.

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

- Debtors and other receivables were higher than planned due to higher than anticipated levels of accrued revenue
- Investments are greater than plan due to the placement of funds on deposit
- Property, plant and equipment is higher than plan due to land revaluations and greater than anticipated capital expenditure
- 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 Cash flow are attributed to –

- Decreased operating cash flow of $10.6m due to:
    - A higher variance in payments to suppliers
    - Increase in outstanding creditors and other payables.

# 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 2016

The Auditor-General is the auditor of Waitemata District Health Board and its subsidiaries and other controlled entities. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group consisting of Waitemata District Health Board and its subsidiaries and other controlled entities (collectively referred to as 'the Group'), on her behalf.

We have audited:

- the financial statements of Waitemata District Health Board and the Group on pages 47 to 80, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in net assets/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 Waitemata District Health Board and the Group on pages 12 to 37 and 44.

## Unmodified opinion on the financial statements

In our opinion:

- the financial statements of Waitemata District Health Board and the Group:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards.

## Qualified opinion on the performance information because of limited controls on information from third-party health providers

Some significant performance measures of Waitemata District Health Board and the Group (including some of the national health targets) rely on information from third-party health providers, such as primary health organisations and general practices. The Waitemata District Health Board and Group'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.

Our audit opinion on the performance information of Waitemata District Health Board and the Group for the period ended 30 June 2015, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of Waitemata District Health Board and the Group on pages 12 to 37 and 44:

- presents fairly, in all material respects, the Waitemata District Health Board and the Group's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 28 October 2016. 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 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 the 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 the performance information. We were unable to determine whether there are material misstatements in the statement of performance 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 the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of Waitemata District Health Board and the Group's financial statements and performance information 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 Waitemata District Health Board and the Group's internal control.

An audit also involves 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;
- the appropriateness of the reported performance information within Waitemata District Health Board and the Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and

- the overall presentation of the financial statements and the performance information.

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

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

## 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 and Public Benefit Entity Standards;
- present fairly Waitemata District Health Board and the Group's financial position, financial performance and cash flows; and
- present fairly Waitemata District Health Board and the Group's performance.

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

The Board is 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 the performance information, whether in printed or electronic form.

## Responsibilities of the Auditor

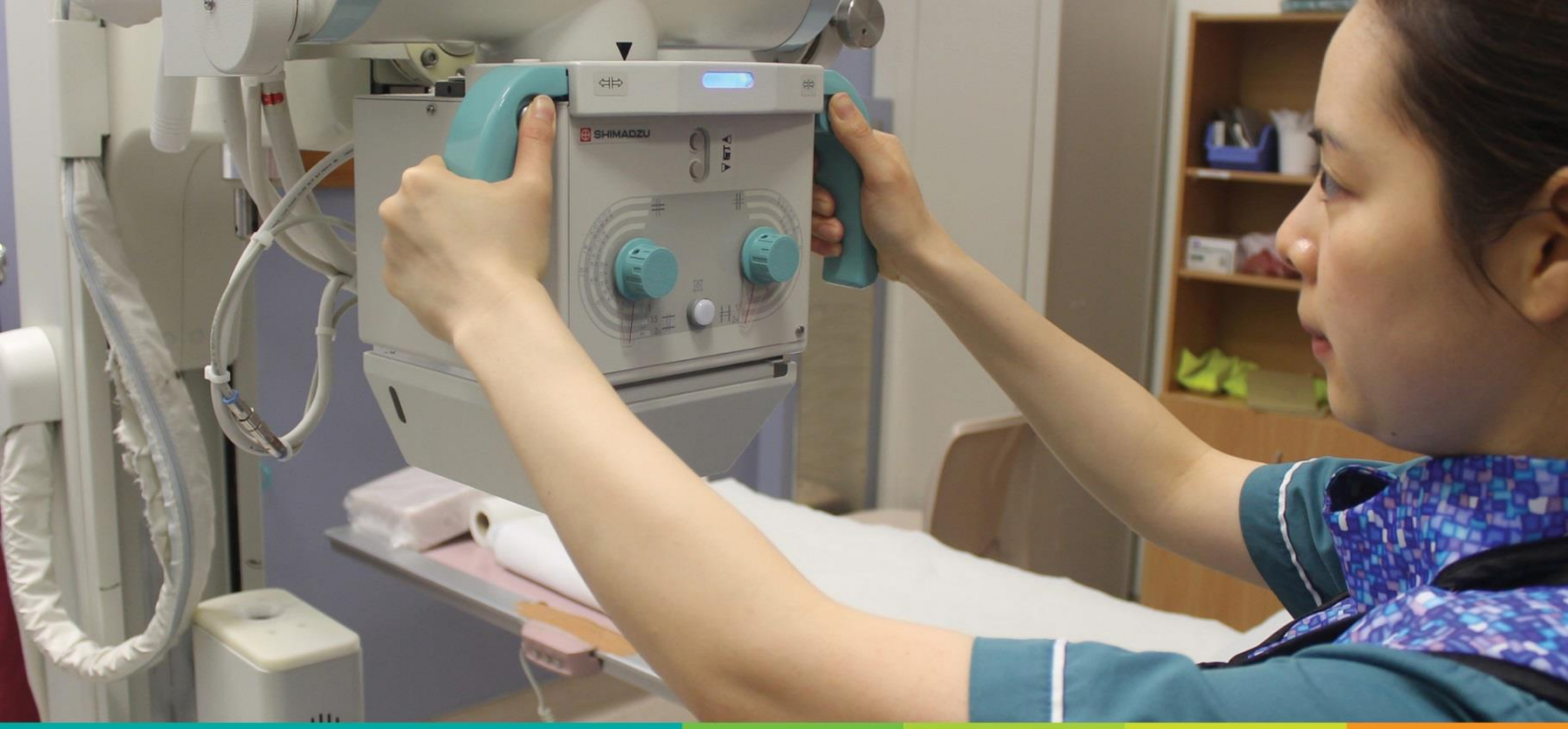
We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

## 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 Waitemata District Health Board or any of its subsidiaries and other controlled entities.

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




Waitemata
District Health Board

Best Care for Everyone