Waitemata District Health Board
Best Care for Everyone

WAITEMATA DISTRICT HEALTH BOARD

ANNUAL REPORT

2017/18

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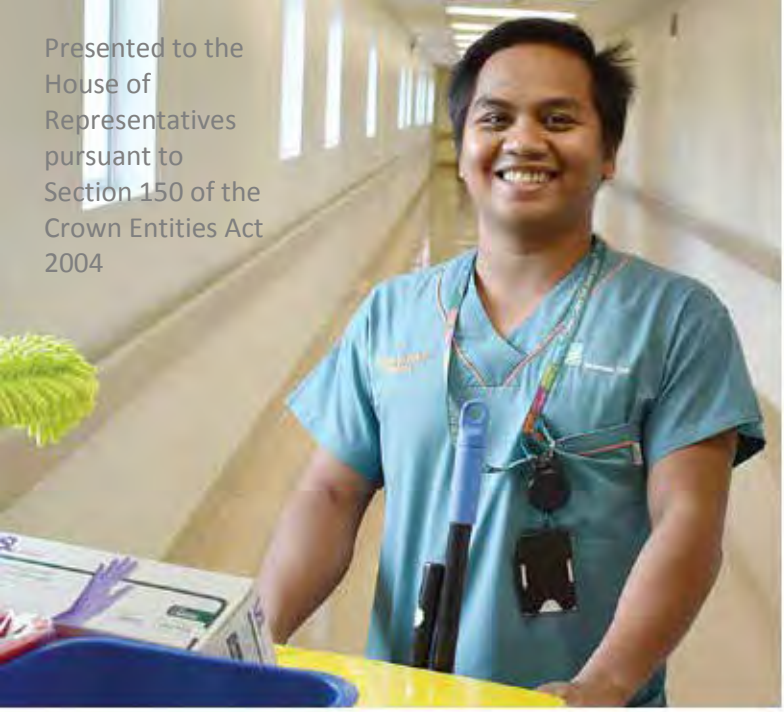


TABLE OF CONTENTS

OVERVIEW

CHAIR/CEO STATEMENT 1
TE TIRITI – PARTNERSHIP STATEMENT 3
ABOUT WAITEMATA DHB 4
WHAT ARE WE TRYING TO ACHIEVE? 5
KEY ACHIEVEMENTS 6
THE WAITEMATA COMMUNITY 7
INNOVATION AND IMPROVEMENT 8

IMPROVING OUTCOMES

PERFORMANCE FRAMEWORK 10
LONG-TERM OUTCOMES 12
SYSTEM LEVEL MEASURES 13
- Healthy Start 13
- Keeping children out of hospital 15
- Youth are happy, healthy and supported 17
- Fewer deaths from amenable conditions 19
- Using health resources effectively 21
- Ensuring patient-centred care 23

OUR PEOPLE, OUR PERFORMANCE

STATEMENT OF PERFORMANCE 26
- Overview 26
- National Health Targets 26
- Health Quality and Safety Commision markers 27
- Output class measures 27
- Output Class 1: Prevention services 28
- Output Class 2: Early detection and management 29
- Output Class 3: Intensive assessment and treatment 30
- Output Class 4: Rehabilitation and support services 32
- Cost of Service Statement 33

BEING A GOOD EMPLOYER 34
SUSTAINABILITY 37
ABOUT OUR ORGANISATION 38
- Waitemata DHB Board members 38
- Statement of Waivers 38
- Trusts 39
- Ministerial Directions 39
- Vote Health: Health and Disability Support Services – Appropriations 39

ASSET PERFORMANCE 40

FINANCIAL STATEMENTS 44

AUDIT REPORT 77

CHAIR/CEO STATEMENT

Professor Judy McGregor, CNZM
Chair

Dr Dale Bramley
Chief Executive Officer

Our ongoing drive to reduce health inequities and improve outcomes was clearly demonstrated in the past twelve months.

Our achievements would not have been possible without the efforts of our hard-working team of over 7,500 staff whose shared calling to relieve suffering and promote wellness is directly linked to our organisational promise to deliver the best care to everyone.

We take the opportunity to thank each and every one of them as we reflect on developments that are helping to bridge some of the gaps in health outcomes for our population, in particular our Māori and Pacific communities.

Milestones of significant note include:

- Awhi Tamariki - a new health assessment and education programme introduced across five Waitemata schools to give public health nurses a holistic view of children's health and a better chance of preventing common illnesses
- the Effective Stop Smoking Conversations with Pregnant Women Online Programme – a new training initiative for health professionals who work with women during pregnancy and through the immediate post-natal period. It is especially tailored to help them with conversations in communities where smoking rates are disproportionately higher than the rest of the population
- the Human Papillomavirus (HPV) Self Sampling Trial - a pilot study to assess the acceptability of simple and safe self-sampling for cervical screening, especially among Māori women who are twice as likely to be diagnosed with cervical cancer and three times more likely to die from the disease. A smaller number of Pacific and Asian women were also involved. The results, along with those from a larger study, will help in determining whether self-sampling becomes part of the national screening programme
- the expansion of the abdominal aortic aneurysm (AAA) screening programme for all Māori living in the district.

The success of our efforts continues to be reflected in the health of our people.

Our population's overall life expectancy is 84.1 years – 2.4 years higher than the national average. It is especially encouraging to see that life expectancy among Māori has increased by 5.5 years since 2005/07 and is gaining twice as fast as any other ethnic group. Māori life expectancy is now 80.9 years, 5.3 years higher than the average overall Māori life expectancy for the country.

Our five-year survival rates from cancer are among the highest in the country.

We are the largest and one of the fastest growing DHBs in New Zealand and our 2017/18 population of 614,000 people is projected to rise by 110,000 in the next decade.

That kind of growth makes equity more important than ever and we have stepped up efforts to ensure our workforce better represents the population we serve.

Our DHB is working to grow our Māori and Pacific workforces as evidence shows outcomes improve for patients where they are treated with cultural understanding by a skilled workforce that reflects our communities.

Approximately 6.7% of DHB staff are Māori and the number has risen from 276 in 2015 to 483 today (a 75% increase).

This year, we launched a targeted recruitment drive aimed at boosting the number of Māori nurses at all levels.

We also continue to work with local schools through our Pacific Health Science Academies programme, which is designed to walk Pacific youth through their last years of college into the tertiary health sector and beyond.

Waitemata is now the lead DHB for the Kia Ora Hauora programme, supporting more Māori into healthcare careers and complementing the work of the Māori Alliance Leadership Team (MALT).

Health Science Academies programme manager Tuliana Guthrie, right, and co-ordinator Malcolm Andrews

Our drive to meet the expectations of our fast growing population saw a number of new and upgraded services and facilities delivered in 2017/18.

A major refurbishment of the North Shore Hospital Pathology Unit took place and included an upgrade of the laboratory that provides histology and cytology services for thousands of inpatients and outpatients across the DHB's Hospital Pathology Unit and the laboratory that provides histology and cytology services for thousands of inpatients and outpatients across the DHB.

Professor Judy McGregor, CNZM

Chair
Waitemata District Health Board

The increased use of tele-clinics, where patients are seen by video conference without having to travel to the hospital for an appointment, provides a new level of convenience for patients.

Our general medicine wards were upgraded and renovated, improving facilities for staff, patients and whānau and a new CT scanner was installed in Waitakere Hospital's upgraded radiology department.

The successful rollout of eReferrals, an electronic referral system, ensures that patients referred to specialist services receive prompt care and advice from the right people via an online system that leaves no room for error, to improve patient safety.

Our Primary and Community Services Plan has led to significant investment into primary care, supporting our GPs to provide more local care options and helping avoid unnesessary emergency department visits and hospitalisations.

The DHB continues to increase the number of positive interventions to relieve suffering and support our patients to lead active, productive and independent lives. This is clearly evidenced by the delivery of 24,027 elective surgeries in 2017/18, exceeding the elective surgery Health Target by 9%.

Again, we thank our staff, as well as the many healthcare partners and community providers who support us in our never-ending drive to be better, best and brilliant in all that we do.

You all make a huge difference in the lives of so many in our communtity.

CEO Dr Dale Bramley and staff at the opening of the Waitakere Hospital's new CT scanner in October 2017.

Dr Dale Bramley

Chief Executive Officer
Waitemata District Health Board

TE TIRITI - PARTNERSHIP STATEMENT

Tū Tonu ngā Manaakitanga!

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

It is helpful to bear this whakatauākī in mind as we reflect on the achievements of the past year presented in this Annual Report. When I look back over the past year, and all of its achievements, the theme that emerges is partnership.

Dame Rangimarie Naida Glavish, DNZM JP

Chief Advisor Tikanga

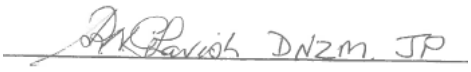
I am extremely pleased to note the efforts that are going into reducing obesity amongst our whānau, in particular our tamāriki. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities. Increased numbers of tamāriki are being immunised, and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

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

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

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

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with 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. Albeit we have much work still to do together to lift the performance of the health system for our diverse but important Māori communities.



Our Te Tiriti o Waitangi Partner: Dame Rangimarie Naida Glavish, DNZM JP
Te Rūnanga o Ngāti Whātua **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 614,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and one of the fastest growing DHBs in the country, and are expecting an extra 115,000 people by 2028.

We have 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 area. These individuals experience poorer health outcomes than those who reside in more affluent areas.

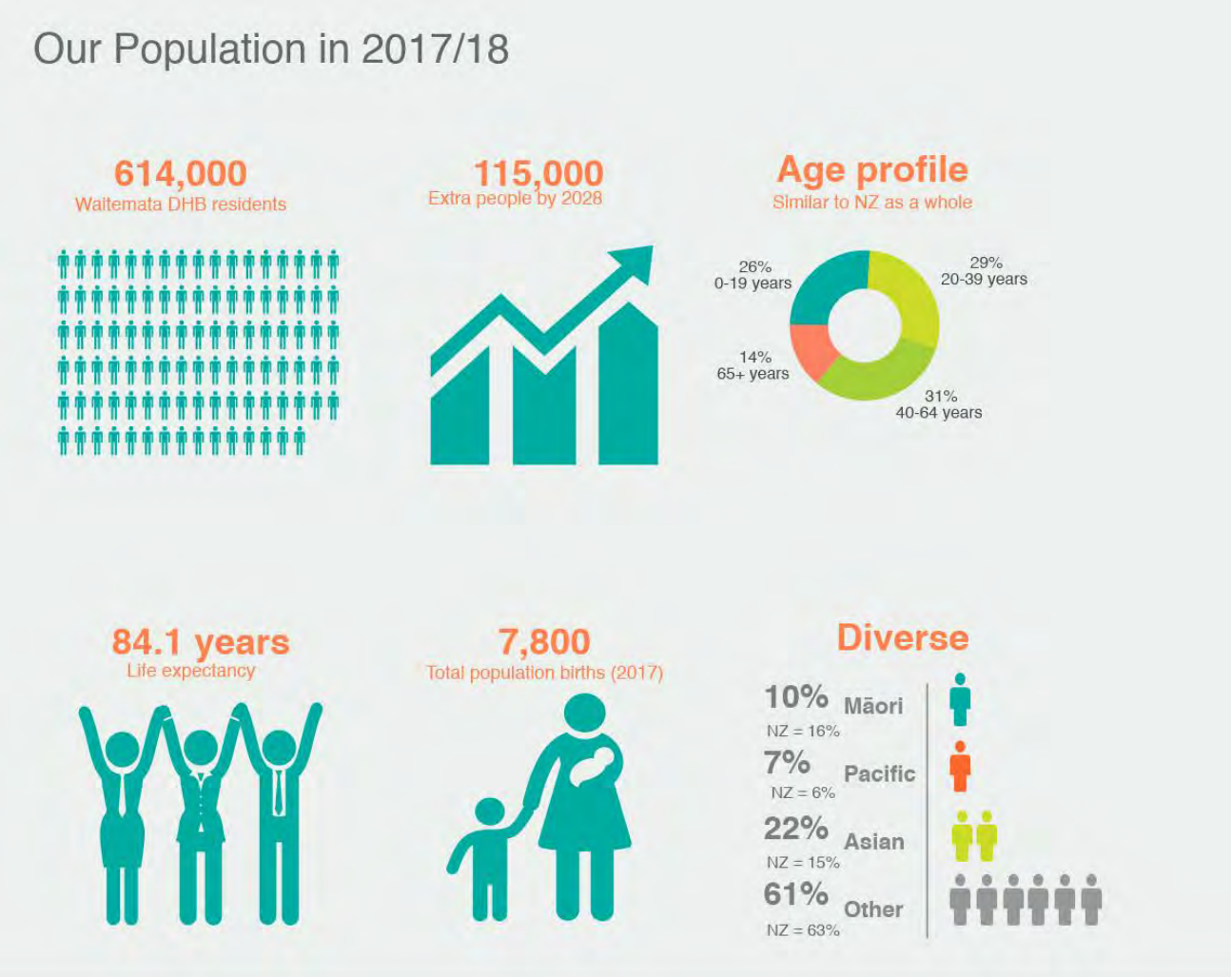
Waitemata DHB provides hospital and community services from 31 sites, including North Shore Hospital, Waitakere Hospital and the Mason Clinic.

More than 7,500 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 2017/18 was $1.7 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, make decisions and deliver services 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.

To realise our promise of providing '**best care for everyone'**, we have identified seven strategic themes. These provide an overarching framework for the way our services are planned, developed and delivered.

Community, family/whānau and patient centred model of care	Emphasis/investment on treatment and keeping people healthy	Service integration and/or consolidation	Intelligence and insight	Consistent evidence informed decision making practice	Outward focus and flexible service orientation	Operational and financial sustainability

Health Equity

Waitemata DHB is committed to achieving healthy equity for all those in our community, in particular for Māori. We are proud of the progress we have made so far, demonstrated by the increase in life expectancy observed for all population groups. Waitemata has the highest Māori life expectancy in the country at 80.9 years and Māori life expectancy is accelerating at twice the pace of non-Māori life expectancy. This means inequity is reducing and is a positive result although more work is required.

Work is underway to refresh our Equity Framework, aligning this with regional work programmes and the national *Achieving Health Equity* programme. Our CEO is the sector co-sponsor for this work alongside the Ministry of Health. We work with our Memoranda of Understanding (MOU) partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to further Māori health gain.

We want our patients to be cared for by a culturally aware workforce that reflects our communities. The Māori Advisory Leadership Team (MALT) is overseeing the implementation of the joint Waitemata and Auckland DHBs Māori Health Workforce Development Strategy. This has seen our total Māori workforce increase by 75% since 2015, to a total of 483 Māori employees now. By 2025 we aim to reach parity with the proportion of Māori and Pacific people in our working age population. Our Pacific Health Science Academies programme helps Pacific youth through their last years of college and towards study and a future career in health. We have designated Māori clinical nurse specialist roles in Diabetes, Gerontology and Cancer which respond to the need for health service delivery in key areas that better meets the needs of Māori people. In 2018 we launched the Āke Āke app, to help raise cultural awareness among our staff and community. Pronunciation of te reo Māori, cultural protocol and waiata are the main focus of the mobile app.

We are also reviewing health pathways and service provision to better fit our Māori, Pacific and high needs groups. We developed New Zealand's first Māori-specific Abdominal Aortic Aneurysm (AAA) screening programme, in partnership with mana whenua. The pilot resulted in a 77% participation rate, and prevented five AAA-related deaths and has now been expanded to Auckland DHB. In 2017/18, we implemented the Effective Stop Smoking Conversations with Pregnant Women Online Programme – a tool for health professionals who work with women in communities where smoking rates are disproportionately higher than the rest of the population. In consultation with Māori and Pacific patients, we have revised our Bariatric surgery patient selection criteria and pathway to remove barriers and improve outcomes for all patients.

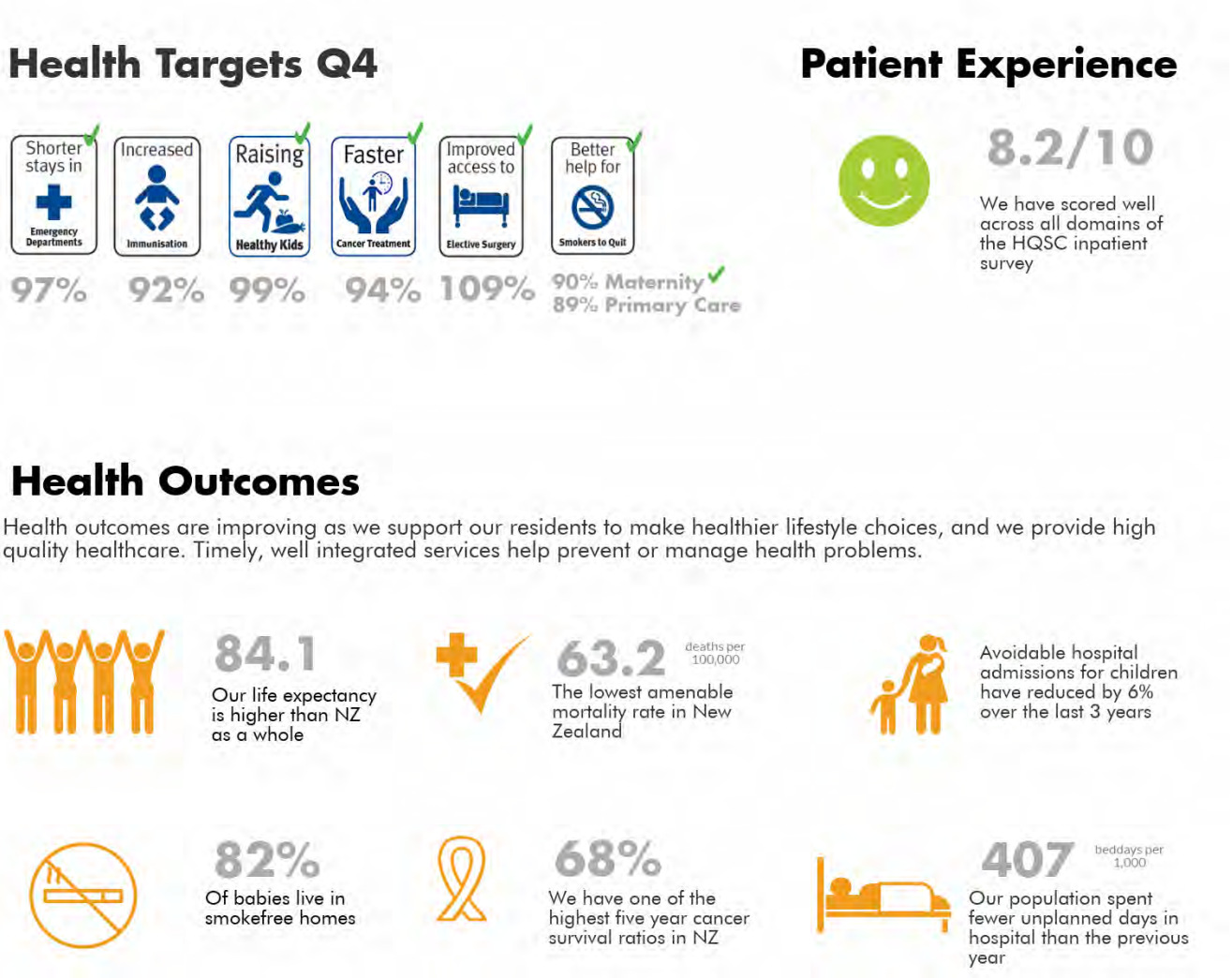
A new pipeline of projects is now being invited to explicitly further improve equity in outcomes across the population.

KEY ACHIEVEMENTS

Waitemata DHB is one of the healthiest communities in New Zealand and we have performed well against our key indicators in 2017/18. The life expectancy of our population is the highest in New Zealand, and we achieved five of the national Health Targets in quarter four.

Our achievements in 2017/18 include:

- The life expectancy of our population is the highest in New Zealand at 84.1 years and the gap for Māori is closing
- Our smoking rate is one of the lowest in New Zealand and declining
- We achieved 99.5% against the Raising Healthy Kids health target, meaning almost all children identified as obese were referred for further help. We were the first DHB in the country to achieve the 95% target
- Waitemata DHB achieved 94% against the Faster Cancer Treatment health target in quarter four. We also have one of the highest 5-year cancer survival rates in New Zealand
- We delivered 24,027 elective surgeries, exceeding the elective surgery health target by 9%.
- We also achieved the Shorter Stays in ED, and the Better Help for Smokers to Quit health target for pregnant women
- Ambulatory sensitive hospitalisation (ASH) rates for children aged 0-4 have been generally declining over the last four years and are lower than New Zealand as a whole
- Our amenable mortality rate has steadily declined over the past decade and is the lowest in New Zealand
- Most inpatients rated their care as very good or excellent, and our average score in the Health Quality and Safety Commission (HQSC) inpatient survey was 8.2 (out of 10).



THE WAITEMATA COMMUNITY

Improving patient experience is one of our two overarching Board Priorities, as we know that a positive experience has real benefits for patients.

To ensure that the services we provide really are working for our patients, we value community involvement in our day to day activities, future planning and the improvement of services. We have a strategy to ensure that the voices of our community are heard in everything we do. We also work in partnership with community advocacy group Healthlinks to foster community participation in health decision making.

Understanding health needs in South Kaipara

Community and stakeholder engagement took place in the South Kaipara in late 2017 to explore the future health needs of the community during the development of a Health Needs Assessment. This was carried out on behalf of the Helensville District Health Trust with support from Waitemata DHB and ProCare PHO, and considered health service access, the main health issues for people living in South Kaipara and what extra health care services are needed in Helensville. While there was positive feedback, community and stakeholder enagement identified a need for more local mental health services, better communication and integration across health services and more mobile/community services.

Kōrero Mai (Talk to me)

Kōrero Mai (Talk to Me) is a co-designed patient/family/whānau-led escalation system for patients whose condition is deteriorating. When a patient or a loved one is unwell, it can be difficult to communicate to staff about what is happening, or staff may not understand how worried a patient or family member is about their health. An 'escalation system' is a process where patients, family or whānau can relay their concerns to another staff member, if they feel they are not getting the care they need.

Kōrero Mai is one of four work streams that form part of a Five Year National Adult Patient Deterioration Programme commissioned by the Health Quality and Safety Commission (HQSC).

A pilot for this programme of work was completed on two medical wards at Waitakere Hospital in May. The Waitakere Hospital pilot was very positive with some suggestions to enhance communication about the programme to ensure patients and their whānau are more aware of the process of escalating conerns about their care. Another pilot was conducted on four wards at North Shore Hospital before rolling the system out across all wards at both sites.

Youth designing smoke free campaigns

As part of the Secondary School Smoking Cessation Programme, a smokefree competition was held at Waitakere College. The student council led-competition, in partnership with Healthy Families Waitakere and Waitemata DHB, challenged students to design their own anti-smoking messages. Entries included a variety of sketches, memes, raps, dance routines and drama skits - all designed to keep kids smokefree.

The winner, Danika Hurman, has seen the detrimental effects of smoking in her family. "I have relatives who've had problems with smoking and I understand what it means. I do not believe smoking is at all a good thing and I want more people to think the same," she says.

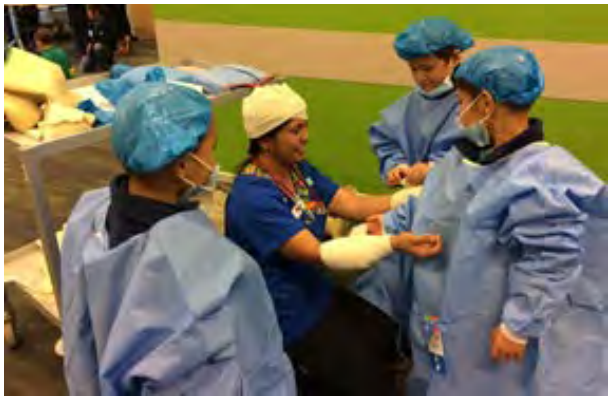
Danika Hurman's winning entry

Three further Waitakere schools will participate, with all entries available to use in delivering Quit Smoking messages.

Primary school visit – learning about the human body

In June 2017, around 60 five and six year old students from Henderson North Primary School visited Waitemata DHB to support their learning programme about the human body.

Staff from across the organisation delivered experience-based activities, including first aid, dental care, listening through a stethoscope and wearing hospital gowns and bandages. In an Empathy Zone, children engaged in activities designed to help understand and experience everyday tasks with an impairment, e.g. beading a necklace with gloves to understand the loss of sensation in hands.



Henderson North Primary School students learn about the role of doctors and nurses on a visit to Waitakere Hospital

INNOVATION AND IMPROVEMENT

Institute for Innovation and Improvement i3

Established in December 2015, the i3 Institute brings together clinicians with researchers, patients, whānau, our community and national and global leaders to design and apply innovative health care solutions. New ideas are accelerated and clinical teams are supported in the design and implementation of new models of care, to improve patient outcomes and experience.

Three principles underpin the i3's work:
Person centred design: we place people at the centre of everything we do
Data driven: we promote the continuous use of data to inform and improve
Community and clinician led: we support our community and clinicians to lead healthcare redesign and innovation

Two significant programmes of work led by the i3 are care redesign projects and the Leapfrog Programme.

Clinician-led Care Redesign Projects

The Criteria-led Discharge initiative is reducing unnecessary waiting time for surgical patients; doctors specify for each patient, conditions necessary for safe discharge from our hospitals, which enables nurses to complete the discharge process.

A new Chest Pain Pathway was implemented this year based on rigorous analysis of patient risk and diagnostic tests. Very low risk patients are identified early, discharged home from ED and managed through outpatient clinics, which allows doctors to focus on patients at higher risk.

Our Sepsis improvement project, the Survive Sepsis Improvement Collaborative, has improved our ability to recognise and treat sepsis early. Over 40 clincial staff have worked together to develop a range of improvements including a sepsis kit, systematic use of a standardised communication tool, and a sepsis screening tool and alert system in the new eVitals system.

The Early Discharge and Rehabilitation Service (EDARS) is now embedded as a a model of care delivering intensive rehabilitation in a patient's home environment. The service is delivered by a team of senior allied health and nursing clinicians, in collaboration with our geriatricians.

Leapfrog Programme

Leapfrog is our programme of large strategic projects that aim to improve health outcomes and patient/whānau experience.

In the past year, the programme has focused on the final stages of implementation of some of our major digital projects. These include the eVitals and Nursing Assessments system, with over 2500 clinicians using the system extending into paediatrics and maternity wards; eOrdering systems across radiology and laboratory tests; and internal eReferrals between services and DHBs.

The ability to be data driven has been revolutionised by our implementation of Qlik Sense, a responsive data exploration tool. We have a strong focus on ensuring this tool benefits clinicians, who have been heavily involved in developing data dashboards for their services. We even have senior doctors creating their own Qlik 'apps'. Thirty explorers and dashboards are now available for staff and are being used by them to improve the quality of care, clinical processes and patients' experience.

A big focus of the programme this year has been work redesigning Outpatient clinics. Our team has worked with many others to introduce a Qlik Outpatients Explorer and to move outpatient documentation to the point-of-care.

Surgical services are now using SOS cards to provide follow up visits only when requested by patients.

Telehealth – providing remote patient follow up visits by video conferencing – has started; we are testing a new platform and the potential for scaling up across the organisation.

In order to better communicate with patients about their appointments, we are introducing email validation and a digital postage/email system so email can be used where patients consent. There is further work planned to improve the flow of patients through Outpatients using innovative digital systems.

Improving outcomes

PERFORMANCE FRAMEWORK

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

Our performance framework (over page) reflects key national and local priorities, and demonstrates our commitment to an outcome-based approach to measuring performance. Overall 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 84.1 years

Our amenable mortality rate has reduced by 32% over the last 10 years, and is the lowest in New Zealand

Our children are staying out of hospital with ASH♦ rates for those aged 0-4 reduced by 5% over the last 3 years

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

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

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

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

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

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

Overall, the progress against our indicators suggests we are delivering on our promise of *best care for everyone* and are making a positive difference to the health of our population.

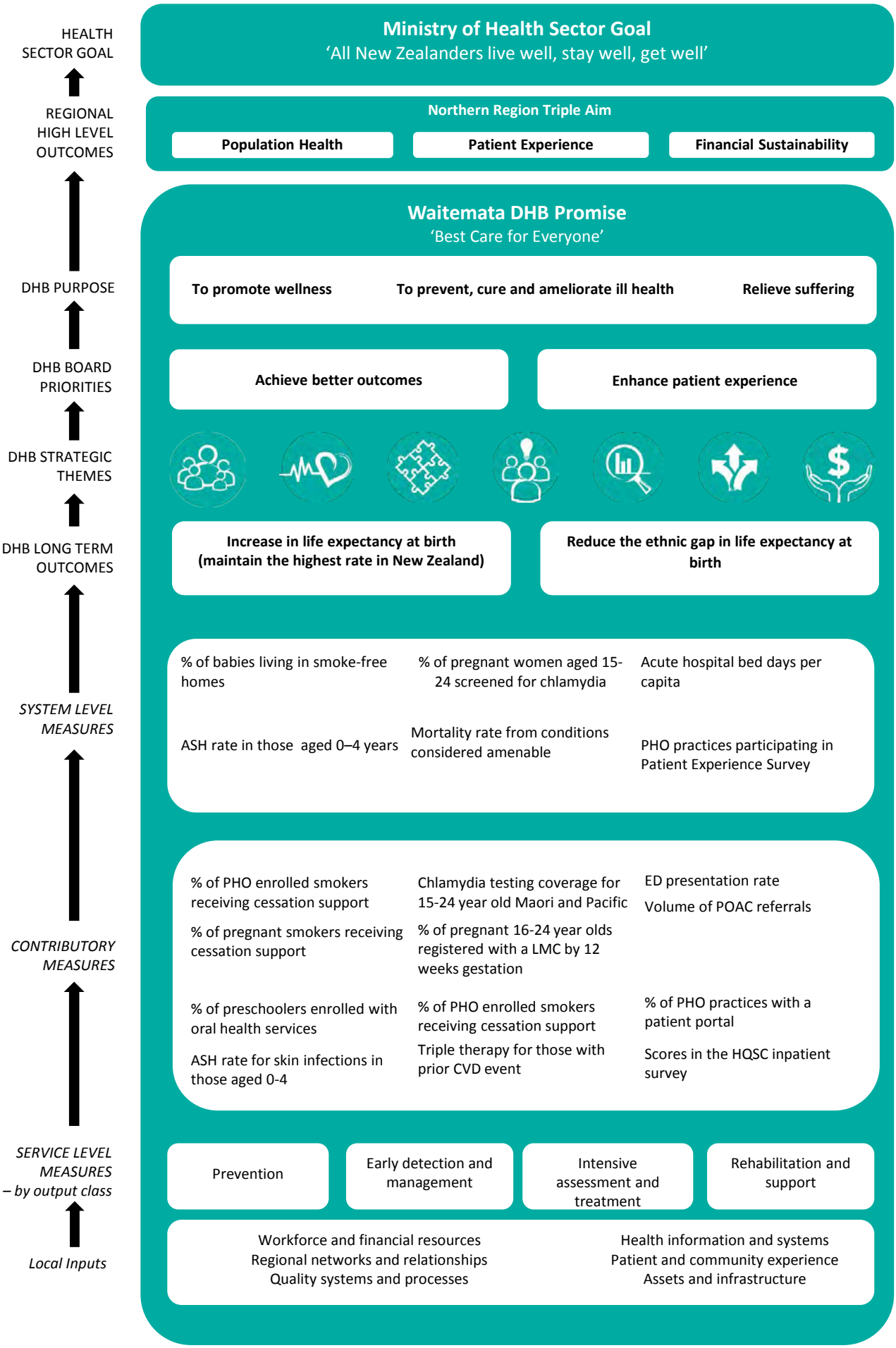
Life expectancy continues to improve, reaching 84.1 years (2015-17), the highest in the country and an increase of 1.3 years since 2008-11. Life expectancy has increased in our Māori (3.5 years) and Pacific (2.9 years) populations over the past decade and the gap in life expectancy continues to gradually close.

We have the lowest rate of amenable mortality - deaths potentially avoidable through healthcare intervention – in New Zealand. In 2015 (the latest available data), 63 deaths per 100,000 population were considered amenable, lower than the national rate of 91. We estimate that 472 deaths (45% of all deaths in those aged under 75 years) in Waitemata DHB were amenable in 2015.

Our children are receiving a great start to life. The number of preschool children admitted to hospital for conditions that are potentially avoidable (ASH♦), such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared to the rest of New Zealand, with our rate for Māori lower than the rate for New Zealand as a whole. However, rates for Pacific children are twice as high as those for other ethnicities in Waitemata.

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

Waitemata DHB Performance Framework



LONG-TERM OUTCOMES

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

WAITEMATA HAS THE LONGEST LIFE EXPECTANCY IN NEW ZEALAND, AT

84.1 YEARS

LIFE EXPECTANCY HAS INCREASED

3.5 YEARS

SINCE 2001

INEQUALITIES ARE DECREASING - LIFE EXPECTANCY OF OUR MĀORI AND PACIFIC POPULATIONS HAVE INCREASED MORE THAN

3 YEARS

OVER THE PAST DECADE

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

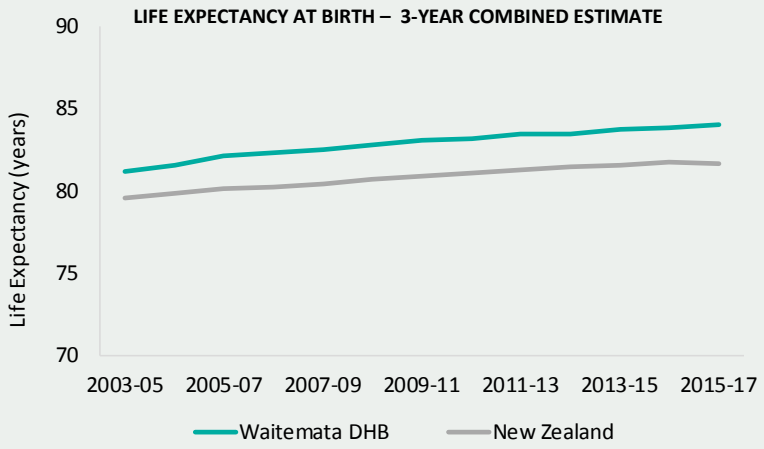
Improving life expectancy for everyone

Life expectancy at birth (LEB) is recognised as an overall measure of population health status. We have the highest life expectancy in New Zealand at 84.1 years (2015-17), which is 2.4 years higher than New Zealand as a whole. In Waitemata, life expectancy has increased by 3.5 years since 2001, a greater increase than that for New Zealand as a whole (2.7 years).

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 3.8 years for Māori and 6.8 years for Pacific. Life expectancy is increasing in our Māori (5.2 years since 2001) and Pacific (3.3 years) populations, and the gap between most ethnic groups is decreasing. Deaths from avoidable conditions account for around two thirds of the 3.8 year life expectancy gap between Māori and other populations and around half of the 6.8 year gap in Pacific.

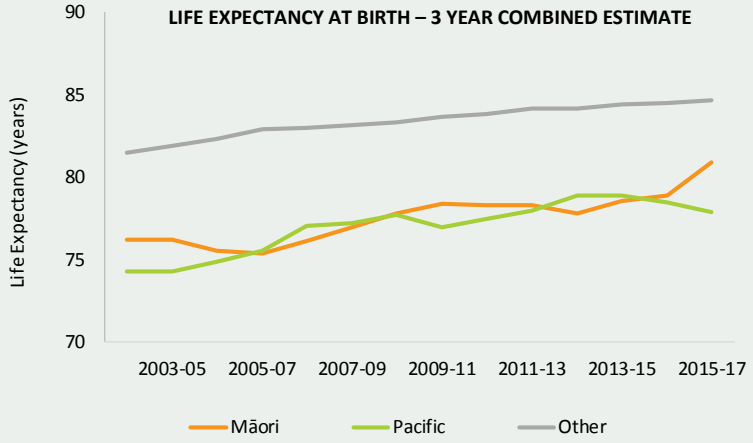
An increase in life expectancy

Our population has the highest life expectancy in the country at 84.1 years.



A reduction in the ethnic gap in life expectancy

The life expectancy gap for Māori has decreased by 3.8 years over the last decade, whilst the gap for Pacific people has only decreased 0.6 years.



SYSTEM LEVEL MEASURES

The system level measures (SLMs) and contributory measures in our performance framework support the achievement of our overall goals. Our SLMs provide an opportunity for us to work with our primary, secondary and community care providers to improve health outcomes for our local population and for the region as a whole.

6.8%
OF BABIES HAD NO SMOKEFREE HOME STATUS RECORDED (TARGET <10%)

82%
OF BABIES LIVE IN SMOKEFREE HOMES (TARGET EST. BASELINE)

14%
OR 30 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION SUPPORT (TARGET EST. BASELINE)

15,580
SMOKERS (32%) RECEIVED CESSATION SUPPORT (TARGET 36%)

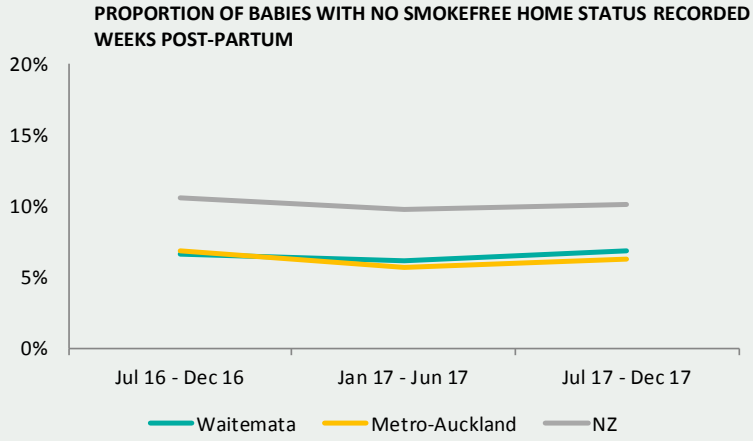
Healthy start

New Zealand has comprehensive tobacco control policies and programmes in place, yet smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the death of approximately 300 of our residents every year. Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. Smoking among our Māori and Pacific populations is reducing, but the prevalence remains at least twice that of other ethnicities. The rate of smoking in pregnancy, and worse pregnancy outcome for mothers and babies, is higher among Māori and Pacific women and those living in areas of high deprivation.

Proportion of babies living in smokefree homes

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

The focus for 2017/18 was to improve Well Child Tamariki Ora data quality for this measure. We worked with WCTO providers to ensure the smokefree home question was routinely asked and correctly recorded at the initial contact. By December 2017, only 6.8% of 6 week old babies had no information recorded about their smokefree home status.



The improvements in the Well Child Tamariki Ora data now give us a more accurate picture of the smokefree home status of babies born in our district. In the 6 months to December 2017, 82% of 6 week old babies lived in smokefree homes (no person ordinarily resident in the home is a current smoker).

Smoking in pregnancy increases the mother's risk of miscarriage, premature birth and low birth weight, as well as their children's risk of asthma and sudden unexplained death in infants (SUDI). Pregnancy is a time when women are likely to be motivated to stop smoking and to encourage their whānau to stop smoking. Ensuring that pregnant smokers are prescribed cessation medication and/or referred to cessation support services are crucial steps in the pathway to them becoming smoke-free. In 2017/18, 14% of pregnant women were offered cessation support, achieving our goal of establishing a baseline so we can monitor our improvements in the future.

At the end of 2017/18, 32% of identified smokers registered with primary care received cessation support in the previous 15 months, either through a referral to 'quit smoking' services or by being provided with smoking cessation medication.

Helping health professionals to help pregnant women quit

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

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

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

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

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

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

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

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

5,577
AMBULATORY SENSITIVE ADMISSIONS PER 100,000 (TARGET <5,409)

605
AMBULATORY SENSITIVE ADMISSIONS FOR SKIN INFECTIONS PER 100,000 (TARGET <760)

96%
ORAL HEALTH ENROMENT IN PRESCHOOLERS (TARGET 95%)

67%
OF CHILDREN WERE DENTAL CARIES FREE AT AGE 5 (CY 2017) (TARGET 68%)

92%
OF WAITEMATA CHILDREN WERE FULLY IMMUNISED BY EIGHT MONTHS OF AGE (TARGET 95%)

Keeping children out of hospital

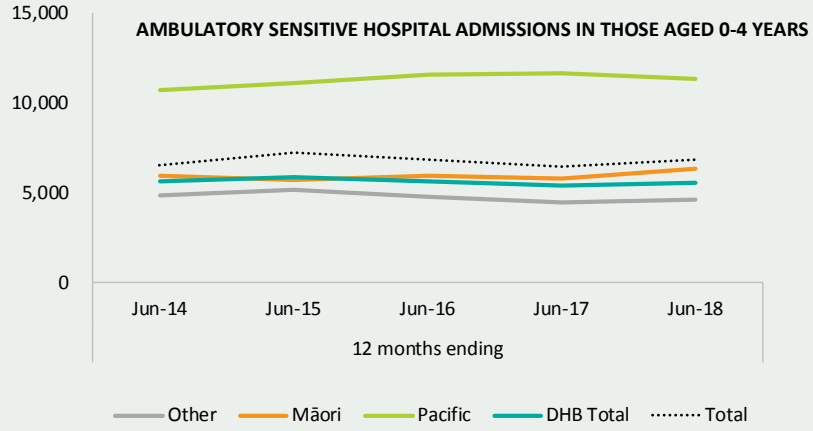
Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Well integrated, high quality primary and community services can prevent health problems and improve health outcomes.

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

Ambulatory sensitive hospital admissions in those aged 0-4

2017/18 improvement target: 5% reduction
(baseline = 5,694 per 100,000, Sep 2016)

In the 12 months to June 2018, there were 5,577 admissions per 100,000 in our 0–4 year old population (2,214 events) that were considered ambulatory sensitive, a slight increase on the previous two years. Rates in the Pacific population are twice as high as other ethnicities and in 2017/18 our efforts were focused on high need groups.



In 2017/18, 240 children were admitted to hospital with serious skin infections, including cellulitis, dermatitis and eczema. More than half of these children were Māori and Pacific. We worked with primary care, Well Child Tamariki Ora services, early childhood centres and community groups to promote key prevention messages to young families, with a particular focus on Pacific children. This has helped see a reduction in admissions for skin infections.

Hospitalisations due to dental conditions in the 0-4 age group make up nearly 10% of ASH admissions. Improving accessibility of oral health programmes will reduce the prevalence and severity of early childhood dental decay (caries), and reduce the numbers requiring treatment in hospital. By December 2017, we had achieved our target of enrolling 95% of all pre-schoolers with oral health services, although this figure was much lower for Māori and Pacific children.

Improving immunisation rates has remained a challenge for the DHB. Immunisation prevents serious childhood diseases, including rotavirus and pneumococcal pneumonia that can result in hospitalisation. During 2017/18 we fully immunised 92% of children by eight months of age. Immunisation rates in Māori children are lower than the total population, at 86%. The DHB collaborated with Plunket to provide an Outreach Immunisation Service (OIS) using their mobile clinics, particularly focused on Māori infants. The OIS also commenced Saturday home visiting to support working families to engage in immunisation. GPs have been encouraged to make follow up calls to whānau and improve processes for newborn enrolment and primary immunisations.

Kainga Ora service helping to make homes healthier

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

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

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

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

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

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

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

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

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

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

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

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

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

Youth are happy, healthy and supported

32.3%

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

12%

OF METRO AUCKLAND MĀORI AND PACIFIC YOUTH (15-24 YEARS) WERE SCREENED FOR CHLYAMYDIA (TARGET EST. BASELINE)

57%

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

60%

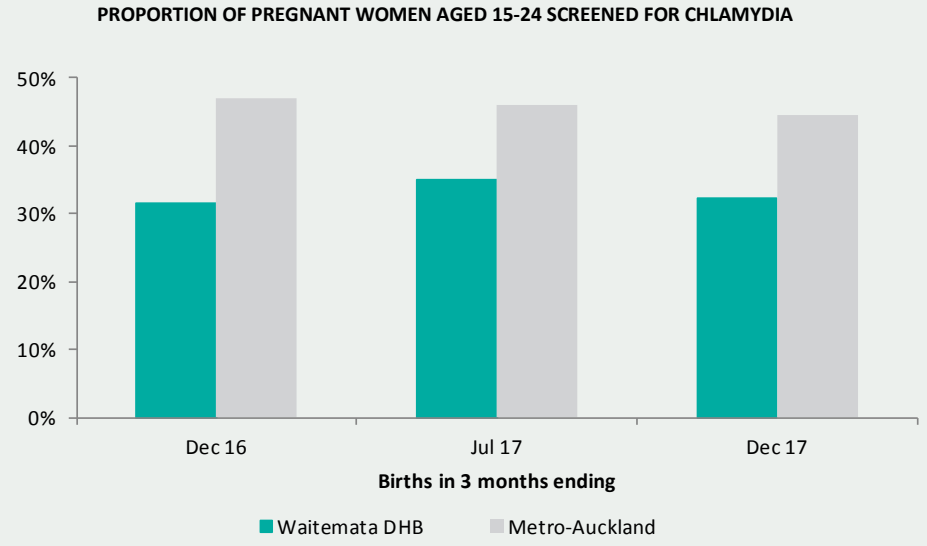
OF ELIGIBLE GIRLS HAVE RECEIVED DOSE THREE OF THE HPV VACCINE (TARGET 70%)

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

Proportion of pregnant women aged 15-24 screened for chlamydia

2017/18 improvement target: 80%

Of the 266 women aged 15-24 who gave birth between October and December 2017, 32% were screened for chlamydia (86 women), a slight decrease on the previous year and significantly below our target of 80% coverage. Data tools are being developed to help alert LMCs and primary care providers to women who have not yet been tested.



In 2017, 12.2% of all 15-24 year old Māori and Pacific youth living in metro-Auckland were tested for chlamydia (9,632 people). This was slightly higher than the total youth population rate of 11.6%. While our goal for 2017/18 was to establish a baseline to measure improvement against, international modelling suggests testing coverage needs to be between 30–40% to begin to reduce prevalence of infection. Testing rates for Waitemata DHB were slightly better than the Auckland region as a whole at 12%.

Early engagement with a Lead Maternity Carer (LMC) is associated with healthy births and better pregnancy outcomes. LMCs are encouraged to offer chlamydia testing to all pregnant women, in line with Ministry of Health recommendations. Testing can also be carried out in Primary Care. Diagnosis earlier in pregnancy allows an infection to be treated before delivery, reducing the risk to both mother and baby. Rates of registration with an LMC during the first trimester of pregnancy are lower in younger women. In 2015, 57% of pregnant women aged 16-24 years and registered with an LMC in the first trimester compared with 69% for all ages.

Our School Based Immunisation Programme (SBIP) continues to deliver HPV vaccines in school. There is currently a national shortage of the Gardasil vaccine. The Waitemata SBIP has been offering second HPV vaccine doses to students who had received dose 1 in primary care. Students not receiving HPV as part of the school programme are referred to their GP for completion when stock is available in primary care.

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

Waitemata DHB is leading the way with youth friendly, confidential and easy to access health services, based in high schools.

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

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

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

In 2019 this highly valued, youth friendly health service will expand to students in decile four schools, reflecting the on-going successful partnership between the DHB, non-government organisations (NGO) and secondary schools.

Identifying problems early

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

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

In 2017 we provided HEEADSSS assessments to 88% of the students in our school based programme.

Contributing to population health – MMR Immunisation Programme

In 2017 and 2018 the Auckland region suffered an outbreak of mumps, disproportionately affecting Pacific and Māori children and young people.

The DHB was able to activate School Based Health Service nurses to contribute to a catch-up MMR (measles, mumps, rubella) Immunisation Programme in SBHS schools, to date vaccinating 1,500 students aged 12-18 years. The Programme is ongoing and has been a success thanks to the existing relationships between the DHB, Primary Healthcare Organisations, NGOs and secondary schools.

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

A registered nurse swabs the throat of a student in an Auckland school based health service.

Fewer deaths from amenable conditions

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

63.2
AMENABLE MORTALITY DEATHS PER 100,000 (TARGET <63.6)

52%
OF PATIENTS WITH CVD ARE RECEIVING TRIPLE THERAPY MEDICATION (TARGET 57%)

15,580
SMOKERS (32%) RECEIVED CESSATION SUPPORT (TARGET 36%)

94%
RECEIVED THEIR FIRST CANCER TREATMENT WITHIN 62 DAYS (TARGET 90%)

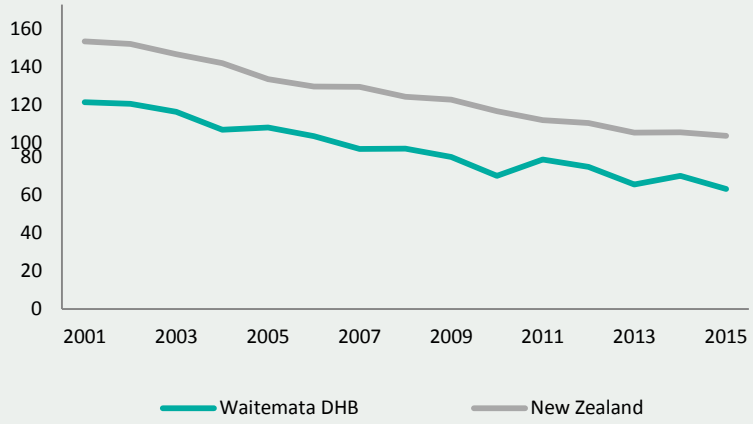
Note: The amenable mortality rates in this report have been calculated locally using 2015 mortality data and 2017 population projections.

A reduction in mortality from conditions considered amenable

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

The rate of amenable mortality has steadily decreased over the past decade and is the lowest in New Zealand at 63.2 per 100,000 population. In 2015, we estimate that 472 deaths (45% of all deaths in those aged under 75 years) in Waitemata DHB were amenable.

AGE-STANDARDISED MORTALITY FROM CONDITIONS CONSIDERED AMENABLE - DEATHS PER 100,000 POPULATION



Cardiovascular disease (CVD) is largely preventable and is associated with significant inequalities. There were 62 deaths from CVD in 2015 that were potentially avoidable through early detection and effective management.

The CVD burden weighs more heavily on Māori than other ethnicities. By identifying those at risk of CVD early, lifestyle and drug interventions can reduce the risk and severity of further disease. In 2017/18, 86% of eligible Māori had received a CVD risk assessment in the last 5 years (the coverage rate for the overall Waitemata population was 90%).

Good management of risk factors and prevention of further events can lead to a reduction in sickness and premature death. New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke should be treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta-blocker and a statin).

For the 12 months to March 2018, 51.5% of those Waitemata patients who had had a prior CVD event had been dispensed triple therapy medications.

Our five-year survival rates from cancer are among the highest in New Zealand. For individuals diagnosed with cancer in 2012/13, the five year survival rate was 68%, an increase from 64% in 2006/07.

We achieved the Faster Cancer Treatment Health Target in 2017/18. Ninety four percent of patients who received their first cancer treatment (or other management) in 2017/18 were treated within 62 days of being referred with a high suspicion of cancer, up from 90% in 2016/17.

Community-Based Cardiac Rehabilitation Prototype

Cardiac rehabilitation should be offered to patients following an acute coronary syndrome event (heart attack or unstable angina). It is a complex intervention which includes components of health education, advice on cardiovascular risk reduction, physical activity and stress management.

Evidence that cardiac rehabilitation reduces mortality, morbidity, and unplanned hospital admissions in addition to improvements in exercise capacity, quality of life and psychological well-being is increasing, and it is now recommended in international guidelines.

The Māori population, when compared with European New Zealanders, are:

- More than twice as likely to die from cardiovascular disease
- 1.5 times as likely to be hospitalised for cardiovascular disease
- Twice as likely to die from ischaemic heart disease
- 1.3 times as likely to be hospitalised for ischaemic heart disease. The disparity is even greater for females; Māori females are almost twice as likely to be hospitalised for ischaemic heart disease as non-Māori females[1].

However, Waitemata DHB was the only DHB in the northern region not meeting the regional standard for cardiac rehabilitation, which reflects international best practice. The existing model lacked a physical activity component, had much lower completion rates than the other northern region DHBs and under-representation of Māori and Pacific.

A Community-Based Approach

The Māori Health Gain Team, supported by the DHB's Cardiology Department, developed a community-based cardiac rehabilitation programme prototype, specifically for Māori, Pacific and quintile 5 patients within the Te Whānau O Waipareira Trust catchment area in west Auckland.

This collaborative model of care meets the agreed regional cardiac rehabilitation standards, with the aim to reduce current inequities in access and inform future service improvement requirements. Working in partnership with Te Whānau O Waipareira Trust to upskill its nursing workforce will ultimately improve patient care and wellbeing in the community, reducing the likelihood of subsequent coronary related hospital admissions.

[1] Ministry of Health (2014). New Zealand Health Survey, Tatau Kahukura: Māori health statistics, Cardiovascular Disease. Wellington.

Implementing the Cardiac Rehabilitation Prototype

The Cardiac Rehabilitation Prototype launched in June 2018, for 20 patients in west Auckland, with a specific focus on Māori and Pacific people. In partnership with Te Whānau o Waipareira Trust, a Māori health provider with an extensive track record of service provision in west Auckland, and Auckland University of Technology who are providing cutting edge clinical exercise expertise, the prototype also includes increased engagement with general practices and other community based providers whose involvement will depend on patient needs.

With these partners on board, we are now offering a broader range of cardiac rehabilitation care for patients who have been hospitalised following a cardiac event. Additional and free services that patients on the Prototype can expect are:

- Nurse-led clinics at Whānau House in Henderson that free up hospital-based resources while offering more accessible care closer to home
- An individualised 12 week fitness programme prescribed by a Clinical Exercise Physiologist (CEP) following a guided fitness assessment at Whānau House
- Individual and group fitness classes at a local fitness facility guided by a CEP
- Home visits by nurses from Te Whānau o Waipareira to monitor clinical markers and progress towards their individual and whānau wellbeing goals

To date, 16 people are either on or have completed the programme. The Prototype will be completed in December 2018. By this time we will understand each patient's experience of the Prototype, behaviour and knowledge changes accomplished, and any patient outcomes achieved by the service. Results of the Prototype will be presented to stakeholders who will determine the next steps for our cardiac rehabilitation service.

The team behind the development of the community-based cardiac rehabilitation programme prototype

THERE WERE

407

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

221

PEOPLE OUT OF EVERY 1,000 ATTENDED AN EMERGENCY DEPARTMENT (TARGET <222)

13,944

PEOPLE WERE REFERRED TO PRIMARY OPTIONS FOR ACUTE CARE (TARGET 10,811)

72%

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

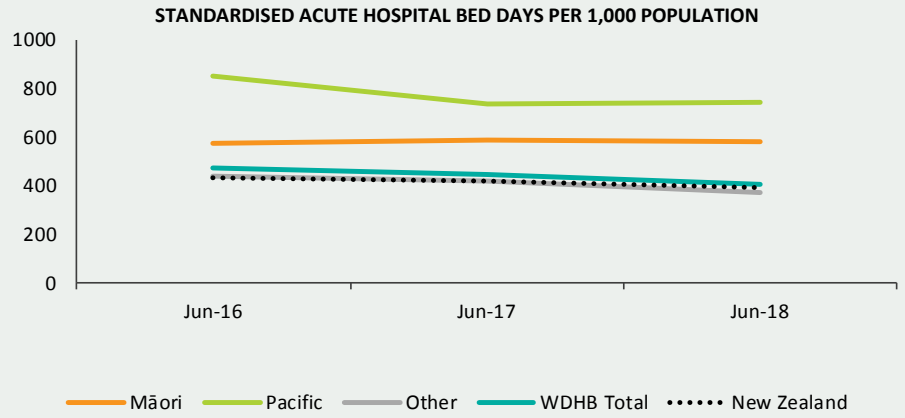
Using health resources effectively

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

A reduction in acute hospital bed days

2017/18 improvement target: 2% reduction – 428.9 standardised acute bed days/1,000 population (Metro Auckland DHBs combined rate)

Our standardised rate of acute bed days is slowly declining and is similar to the National rate at 407 per 1,000 population compared with 392 per 1,000 population nationally.



Emergency department attendances remained stable at 221 per 1,000 people in 2017/18, achieving our target. We have a number of programmes underway to reduce the volume of people presenting acutely to hospital, such as point-of-care testing in rural GPs, after-hours arrangements, and Primary Options for Acute Care (POAC).

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for patients in the community, preventing an ED attendance and possible hospital admission, and assisting earlier discharge. PHOs worked together with the POAC team to support GPs to better utilise POAC. In 2017/18, 13,944 patients were referred to POAC.

Alongside POAC, we have a number of programmes in place or under evaluation to reduce acute presentations, such as point-of-care testing in rural GPs, after-hours arrangements, and community falls prevention.

Optimising patient flow within our hospitals, including reducing delays to diagnostic and treatment procedures, improves patient outcomes and reduces wasted bed days. For those admitted to hospital with acute coronary syndrome (ACS) - sudden, reduced blood flow to the heart, e.g. unstable angina or heart attack – it is important to perform coronary angiography quickly to inform further treatment options and prevent additional cardiovascular events. In 2017/18, 1,082 ACS patients living in Waitemata received an angiogram, 72% within 72 hours, exceeding the 70% target.

Diagnostic testing in rural practices keeps patients out of hospital

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

Rural Point of Care Testing Service

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

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

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

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

The Waitemata DHB Laboratories POCT team oversees and manages the R-POCT service on behalf of both Auckland and Waitemata DHBs. This will ensure that all quality assurance and control measures are consistent across all general practices who are members of the Rural Alliance.

Feedback from practices has been very positive, with many patients benefitting from the new service.

Onsite testing allows patient to stay at home

Kumeu Village Medical was the first test site for Waitemata DHB, in December 2017. They reported that the POCT analyser was used to confirm a deep vein thrombosis (DVT) in a patient who had just had a total knee replacement. This enabled successful diagnosis and treatment of the patient in the community and avoided hospital admission.

Staff at Kumeu Village Medical training on the use of the QBC STAR analyser used to perform a Full Blood Count test

Rapid diagnosis saves a life

A ten year old child presented to Coast to Coast Healthcare in Wellsford with cold like symptoms. She was so lethargic her mum had to carry her into the clinic. After assessing her, it was clear to the GP that she was very unwell.

A Full Blood Count test was undertaken on the QBC Star Analyser which confirmed a diagnosis of bacterial sepsis. Sepsis is a life-threatnening reaction to infection, which can lead to organ failure and death. An ambulance was called immediately and the child was transferred to Starship. She suffered a cardiac arrest on the way to hospital and was in the intensive care unit for three days before transferring to Waitakere Hospital, but fortunately made a full recovery.

Ensuring patient-centred care

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

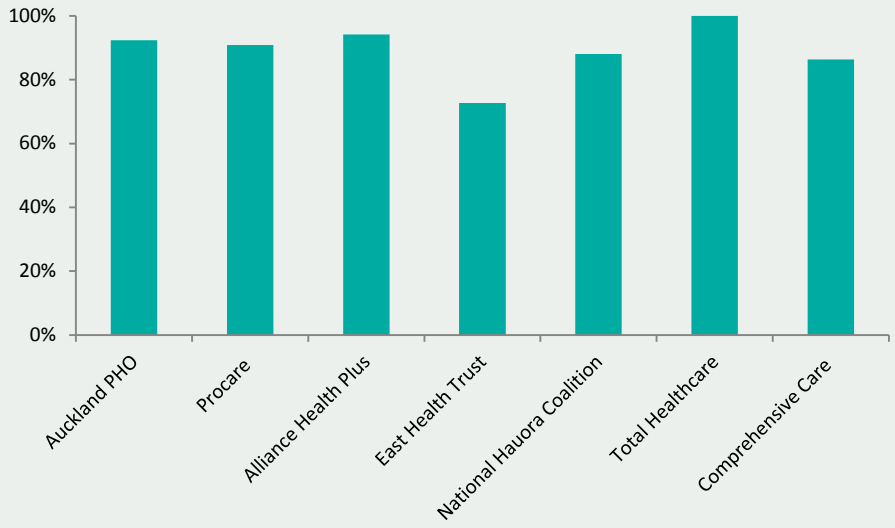
90%

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

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

2017/18 improvement target: 50%

The primary care patient experience survey was developed by HQSC to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety. By May 2018, 90% of practices in Metro Auckland were participating in the survey.



61%

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

Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a portal, people can better manage their own health care.

19%

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

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

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

8.2/10

AVERAGE SCORE IN HQSC INPATIENT SURVEY (TARGET 8.5)

Our average scores have improved since the survey was implemented and are similar to New Zealand as a whole. For patients treated in May 2018, our scores were: Communication 8.0: coordination 8.1; partnership 8.1; and physical and emotional needs 8.5, with an average score across all four domains of 8.2.

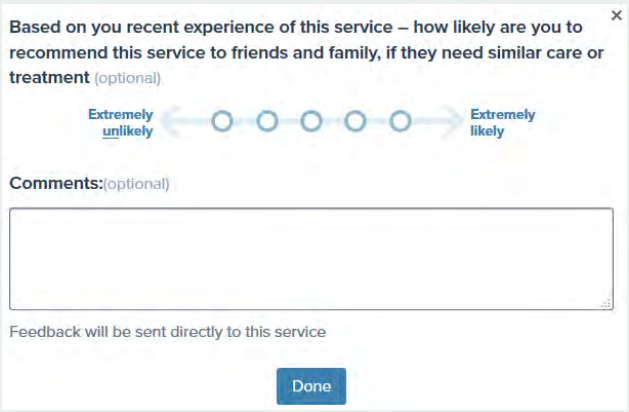
Social Listening through Healthpoint

Healthpoint is a website that provides up-to-date information about healthcare providers, referral expectations, services offered and common treatments – across the country. Over 300,000 people per month are looking at service information on Healthpoint and can provide feedback at this point.

Waitemata DHB provides information on Healthpoint about all GP, maternity, public hospital, mental health, specialist and pharmacy services. In total, 663 Waitemata DHB services have information available via Healthpoint.

Creating a Social Listening Platform

Healthpoint launched stage 1 of the Waitemata DHB social listening platform in early 2017. A question was created on each Waitemata DHB hospital, primary care and community service Healthpoint page: "Based on your recent experience of this service, how likely are you to recommend this service to friends and family if they need similar care or treatment?" (scale extremely likely to extremely unlikely). From launch until September 2017, there were 234 responses.



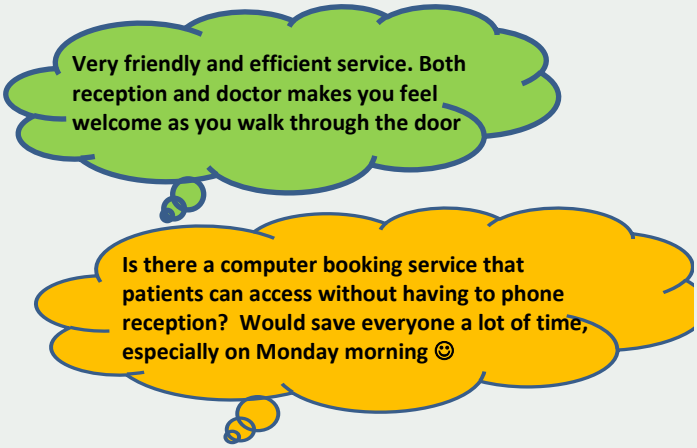
Findings

Of the 234 responses, 79% were thumbs up and 21% thumbs down. 39% of respondents made a comment. The majority of responses related to General Practice. Of the 84 comments left, 48 would recommend the services and 36 would not. Comments about service or staff were the most common themes and included compliments, suggestions and constructive feedback.

The feedback is emailed directly to services immediately and can be used to improve systems, interactions and information about their service. In addition, comments can be used to celebrate great work. Currently, this information is not made public on the Healthpoint website.

Stage 2 – Social Listening

Consumers are increasingly seeking information about services before they access them. We all use reviews to inform our choices in decisions about many aspects of our life. With Stage 2 of social listening, patient feedback will be published via service pages on Healthpoint. This is in line with the DHB's move towards greater transparency of feedback, as evidenced by the public sharing of patient story videos and the inclusion of social media feedback on the corporate website. Healthpoint can provide a platform for the community to communicate their satisfaction or experience. This platform will give power to the community to communicate their feedback and provide a direct link to services which will lead to improvements in the effectiveness of Waitemata DHB services.



Responding to feedback

To demonstrate how feedback is used a "You said this…… we did this…." section may be added to service information pages.

Staff at Waitemata manage and update the website content regularly. These staff members are well placed to receive feedback and direct it to the most appropriate local channels. Training will be provided to staff to help them manage feedback. Healthpoint can also support mediation of feedback by deleting feedback that is directed at a specific person. Links can also be added to direct users to feedback pages for complaints.

Our people, our performance

STATEMENT OF PERFORMANCE

Overview

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

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals set out in the Improving 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 84.1 years, an increase of 1.3 years over the last seven years. The life expectancy gap is 3.8 years for Māori and 6.8 years for Pacific, compared to all other ethnicities.

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 2017/18 Auckland and Waitemata DHBs' Māori Health Plan.

National Health Targets

2017/18 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 each quarter's and full year performance, where relevant. In quarter four, we achieved five of the seven Health Targets. according to Ministry of Health assessment criteria.

Health Targets	Health Target Description	2017/18				
		Q1	Q2	Q3	Q4	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	**96%**	**98%**	**96%**	**96%**	**97%**
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)[1], target = 22,073	**6,434 (113%)**	**12,264 (110%)**	**18,050 (110%)**	**24,027 (109%)**	**24,027 (109%)**
Faster Cancer Treatment	90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment[2]	**93%**	**94%**	**93%**	**94%**	**94%**
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time	**93%**	**93%**	**92%**	**92%**	**92%**
Better Help for Smokers to Quit	90% seen in primary care provided with advice to help quit	**88%**	**86%**	**88%**	**89%**	**89%**
	90% of newly registered pregnant women provided with advice to help quit	**90%**	**88%**	**93%**	**90%**	**90%**
Raising Healthy Kids	95% of obese children identified in the B4SC programme will be offered a referral to a health professional[3]	**100%**	**100%**	**99%**	**99%**	**99%**

[1] Waitemata DHB's targeted increase (share of the New Zealand total additional 4,000 discharges) is 490 additional discharges; quarterly results are year to date.
[2] This result does not include patients that have not yet received their first treatment. Patients still waiting longer than 62 days as at the reporting date, will not be reported as a breach because the first treatment has not yet occurred. Quarterly results are for checks completed in the rolling 6-month period to the end of the quarter.
[3] Quarterly results are for checks completed in the rolling 6-month period ending one month prior to the end of the quarter, as per MoH definition. The FY result is for the 12-month period Jun 2017 to May 2018 (thus the Q1 result is only partly represented in the FY result).

Health Quality and Safety Commission Markers

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, Open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred. During 2017/18, we improved or maintained our compliance across most of the HQSM markers:

Health Quality and Safety Markers	Q4 2016/17	Q4 2017/18
80% compliance with good hand hygiene practice	86%	90%
90% of older patients assessed for risk of falling	95%	95%
% of patients assessed at risk of falling who received an individualised care plan	97%	98%
100% of hip and knee arthroplasty primary procedures given antibiotic in right time	90%	98%
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	97%	96%
95% of audits of surgical safety checklist engagement score levels of 5 or higher	Sign in – 75% Sign out – 89% Sign out – n/a	Sign in – 85% Sign out – 92% Sign out – 95%

Output class measures

Outputs are goods or activities provided by the DHB and other entities and provide a snapshot of the services we deliver. Output measures are intended to reflect our performance for the year. The criteria against which we measure our output performance was revised in 2014/15 and we have continued with this grading system for 2017/18. This is applied to assess performance against each indicator in the Output Measures section. A rating is not applied to demand-driven indicators.

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

The following tables include our output measures from the 2017/18 Statement of Performance Expectations by Output Class. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, and these have been assigned the below symbols in the target column.

Symbol	Definition	Symbol	Definition
Measure type		Target Symbols	
Q	Measure of quality	Ω	Demand driven measure – not appropriate to set target or grade the result
V	Measure of volume	↓	A decreased number indicates improved performance
T	Measure of timeliness	↑	An increased number indicates improved performance
C	Measure of coverage		
N/A	Not Available		
♦	Measure not reported in previous year's annual report		

Output Class 1: Prevention Services

Prevention services help to protect and promote health in our population. Prevention services include health promotion to help prevent the development of disease, statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases, and population health protection services, such as immunisation and screening services. Outputs provided by general practice (including cervical screening and immunisation) are covered under Primary Care in Output Class 2. A significant portion of the work of Primary Care is preventative.

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Health promotion					
HT: % of PHO-enrolled patients who smoke have been offered help to quit in the last 15 months (C)	90.6%[1]	90.4%	88.5%	90.0%	
HT: % of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking (C)	90.6%	87.4%	90.2%	90.0%	
% of PHO-enrolled patients who smoke who received cessation support (Q)	32.9%[2]	31.8%	32.4%[3]	36.2%	
Raising Healthy Kids HT: % of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	41%[4]	100%	99.5%	95.0%	
Number of clients engaged with Green Prescriptions (V)	New indicator	New indicator	3,756 (76.3%)[5]	4,920	
Increased Immunisation HT (C): - % of eight months olds will have their primary course of immunisation on time (total population)	93%	92.5%	92.2%	95.0%	
- % of eight months olds will have their primary course of immunisation on time (Māori)	90%	86.3%	86.3%[6]	95.0%	
Rate of HPV immunisation coverage (2004 birth cohort) (C)	60.2%	60.1%	59.8%[7]	75.0%	
Population-based screening					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	67.2%	66.3%	65.2%[8]	70.0%	
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	75.7%	74.3%	71.0%[9]	80.0%	
Bowel Cancer Screening					
Percentage of people invited to participate who returned a correctly completed test kit (Q)	53.4%[10]	55%[11]	53.3%[12]	60%	
% of individuals referred for colonoscopy following positive iFOBT result who receive their procedure within 45 working days (T)	96%[13]	97%	93%	95%	
Children					
HEEADSS assessment coverage in DHB-funded school health services (C) ♦[14]	88%	88%	88%[15]	95%	
% of 4-year-olds receiving a B4 School Check (C)	93%	94%	90%	90%	

[1] Result incorrectly reported as 89% in our 2017/18 annual plan.
[2] Result for Q1 2016/17.
[3] Levels of cessation support provision have remained constant in recent years. Work to improve the referral process is underway.
[4] Result for the 6 months to 31 March 2016.
[5] Due to late contract signing, the establishment of new services were delayed so volumes were lower than anticipated.
[6] We have an active work programme with our Treaty partners and PHOs for initiatives to improve engagement and on-time immunisation for tamariki Māori.
[7] Our school-based immunisation programme reviewed the HPV service delivery model and introduced additional catch-up visits for absent students.
[8] We are working with providers and NSU to improve data matching processes to enable better invitation and recall for screening.
[9] We are working to increase access with opportunistic screening, broader clinic hours, support for high priority women, community outreach and the use of NSU data match lists to address the declining coverage rates; Māori and Pacific women remain a priority focus for screening promotion.
[10] Round 2 participation.
[11] Round 3 participation (results as at June 2017 for people invited Jan to Sep 2016).
[12] We expect the participation rate to increase over the next few months as some test kits are received much later than others. We continue to deliver a range of activities to increase awareness and engage with the community on the benefits of screening, including Samoan, Tongan and Māori populations.
[13] CY 2016 result.
[14] 2015/16 baseline and 2016/17 result = CY 2016 result; 2017/18 result = CY 2017 result.
[15] Responding to the large number of students affected by mumps in 2017 and the need to provide a catch-up immunisation programme is likely to have impacted the ability for schools to achieve the 95% target.

	Output measure	2016/17 result	2017/18 result	2017/18 target	Achievement
Auckland Regional Public Health Service (ARPHS)[16]					
Number of tobacco retailer compliance checks conducted (V)	342	316	372	300	●
Number of license applications and renewals (on, off club and special) received and are risk assessed (V)♦	4,208	3,870	2,112	Ω	N/A
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment (Q)	98%	94%	95%	95%	●
Number of assessments related to requirements of the Drinking-Water Standards (V)♦	45	57	57	57	●

Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals including general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services. These services are preventative and treatment services focus on individuals and smaller groups of individuals. Ensuring good access to early detection and management services for all population groups, we can support people to maintain good health, and through prompt diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes. These services also enable patients to maintain their functional independence and reduce complications or acute illness, reducing the need for specialist intervention.

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Primary health care					
Rate of primary care enrolment (Māori) (C)♦	82%	81%	83%	90%	●
Number of referrals to Primary Options for Acute Care (POAC) (V)	8,642	10,727	13,944	10,811	●
% of people with diabetes aged 15-74 years enrolled with Waitemata DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol (Q)	New indicator	New indicator	62.8%[17]	75.0%	●
% of the eligible population who have had their CVD risk assessed in the last five years (Māori) (C)♦	86.9%	86.7%	86.0%	90.0%	●
% of patients with CVD risk >20% on dual therapy (dispensed) (Q)[18]	41.4%	41.3%	41.5%	43.5%	●
% of patients with prior CVD who are prescribed triple therapy[18]	53.8%	53.1%	51.5%[19]	56.5%	●
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year olds - skin infections subset (Q)	800[20]	655	605	760	●
Pharmacy					
Number of prescription items subsidised (V)♦	7,067,601	7,310,184	7,382,041[21]	Ω	N/A
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	31,486	37,424	38,842	Ω	N/A
Number of community laboratory tests (V)♦	3,931,334	3,908,480	4,082,639	Ω	N/A
Oral health[22]					
% of preschool children enrolled in DHB-funded oral health services(C)♦	84%	93%	96%	95%	●
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q) - 2017 - 2018	0.74	0.67	0.61	0.68 0.68	●
% of children caries free at five years of age (Q) - 2017 - 2018	67%	66%	67%	68% 68%	●
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years (C)♦	67%	73%	68%[23]	85%	●

[16] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[17] We have a focus on high need populations, using a holistic system-wide targeted approach as part of the Diabetes Service Level Alliance flagship project.
[18] 2015/16 baseline = result for 12 months to Sep 2016; 2016/17 result = result for 12 months to Mar 2017; 2017/18 result = result for 12 months to Mar 2018.
[19] Shift in CVD funding model in Jan 2018 to include a focus on CVD risk management. Note: is not always clinically appropriate to prescribe these medications.
[20] Result for 12 months to Sep 2016.
[21] Result for 12 months to March 2018. June 2018 data not available at time of publication.
[22] Calendar year reporting: 2015/16 baseline = CY2015 data, 2016/17 =CY2016 data; 2017/18 = CY 2017 data.
[23] A number of activities are underway to improve utilisation of DHB-funded dental services by adolescents.

Output Class 3: Intensive Assessment and Treatment

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

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

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

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Acute services					
ED presentation rate per 1,000 population (V)	222.3[24]	224.6	220.6	217.9	●
Shorter stays in Emergency Departments HT: % of ED patients discharged admitted or transferred within six hours of arrival (T)	95.0%	96.8%	96.6%	95.0%	●
Faster Cancer Treatment HT: % of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks (T)	71.5%	90.2%	94.1%	90.0%	●
% of eligible stroke patients thrombolysed (C)	5.5%	7.7%	10.1%	8.0%	●
% of ACS inpatients receiving coronary angiography w/in 3 days (T)	80.8%	72.5%	72.4%	70.0%	●
Maternity					
Number of births in Waitemata DHB hospitals (V)	6,725	7,045	6,741	Ω	N/A
Proportion of women registering with LMCs ≤12 weeks (T)	72%	75%[25]	Not available	80%	N/A
Elective (inpatient/outpatient)					
Improved Access to Elective Surgery HT: number of elective surgical discharges (V)	21,994 (105.9%)	23,998 (111.2%)	24,027 (108.9%)	22,073	●
Surgical intervention rate (per 10,000 population) (C)[26]					
- Major joints	21.4	28.0	24.12	21.0	●
- Cataracts	33.2	39.7	43.91	27.0	●
- Cardiac surgery	6.8	6.1	5.71[27]	6.5	●
- Angioplasty (PCR)	14.6	16.5	15.79	12.5	●
- Angiogram	40.8	41.7	43.05	34.7	●
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	90%	92.0%	96.7%	90.0%	●
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	54%	77.5%	70.8%	70.0%	●
% of patients waiting longer than four months for their first specialist assessment (ESPI 2) (T)[28]	0.0%	0.0%	0.0%	0.0%	●
% of accepted referrals receiving their scan within 6 weeks (T)					
- CT	96%	96%	83.3%[29]	95.0%	●
- MRI	88%	91%	78.1%[30]	90.0%	●

[24] Data for year ending Sep 2016.
[25] CY2016 MOH Maternity Clinical Trends data. This is the most recent data available.
[26] 2015/16 baseline = Mar 2016 result.
[27] High transplant and complex volumes reduced capacity; we monitor patients closely and our overall wait times remain within MoH targets.
[28] Assessment of performance is based on Ministry of Health criteria.
[29] Increased demand for scans has impacted on waiting times; additional scanners are planned for both hospital sites in 2018/19, with outsourcing being considered in the short term. No CT patients wait more than 147 days.
[30] Work streams are underway to manage MRI wait times, including weekend sessions and outsourcing. No MRI patients wait over 147 days.

	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Quality and patient safety					
Aggregated score for the 4 domains of the HQSC inpatient survey (Q)♦	8.5[31]	8.3[31]	8.2[31]	8.5	
% of opportunities for hand hygiene taken (Q)	83%[32]	86%	89%[33]	80%	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.05	0.10	0.07	<0.12	
% of falls risk patients who received individualised care plan (Q)	98%[32]	96%	97%	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)♦	10.15	5.77	9.71[34]	<8.0	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	92%[32]	95%	97%[33]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	94%[32]	96%	97%[33]	95%	
Surgical site infections per 100 hip and knee operations (Q)	0.51	1.61	0.6[33]	<0.8	
Mental health					
Percentage of population who access mental health services (C):					
- Age 0–19 years	3.44%	3.65%	3.91%	3.10%	
- Age 20–64 years	3.55%	3.60%	3.57%	3.40%	
- Age 65+ years	2.05%	1.96%	2.07%	2.10%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental Health	60.5%	71.0%	76.5%	80%	
- Addictions	91.4%	88.8%	91.1%	80%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental Health	84.5%	94.7%	94.7%	95%	
- Addictions	98.5%	98.0%	98.7%	95%	

[31] All results for month of June in financial year
[32] April-June 2016 result
[33] YTD Q3 2017/18 result as Q4 not available at time of publication.
[34] Our Falls Injury Prevention Quality Improvement Group is conducting a root cause analysis to identify the reasons for a persistent number of falls with harm, despite implementing international best practice. While the review is in progress, we will continue our various falls prevention initiatives.

Output Class 4: Rehabilitation and Support Services

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

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

Output measure	2015/16 baseline	2016/17 result	2017/18 result	2017/18 target	Achievement
Home-based support					
% aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) in the last 24 months (Q)♦	89.5%[35]	75.2%	69.2%[36]	85.0%	
Palliative care					
Proportion of hospice patient deaths that occur at home (Q)	35%	33%	30%[37]	↑	
% of patients acutely referred who waited >48 hours for a hospice bed (T)	7.4%	4.5%	15.5%[38]	5%	
Number of Palliative Pathway Activations (PPAs) (V)	New indicator	New indicator	92[39]	250	
Number of Hospice Proactive Advisory conversations between the Hospice Service, Primary Care and ARC health professionals (V)	New indicator	New indicator	85[39]	250	
RESIDENTIAL CARE					
ARC bed days (V)♦	905,263	915,023	966,718	Ω	N/A
% of people in aged residential care (ARC) who have a subsequent interRAI long-term care facility (LTCF) assessment completed within 230 days of the previous assessment (Q)♦	74%	82%	84%	80%	

[35] Mar 2016 result.
[36] We met the Ministry target that 95% of HCSS clients have an interRAI assessment; the 24-month measure is a local target, which is currently under review.
[37] The target was set prior to a definition change, which excludes patient deaths occurring at high and low level residential aged care (22% and 2%, respectively).
[38] The result is primarily due to the closure of the overnight IPU at Hospice West Auckland in Q3 and Q4; patients are managed with a day stay, increased home care or transfer to another Waitemata DHB hospice.
[39] The new Regional Palliative Care Outcomes Initiative was launched in Nov 2017 to better support patients with a life-limiting illness and their whānau; while implementation of this new service has improved from Q3 to Q4, more time is needed to achieve target levels.

Cost of Service Statement – for year ended 30 June 2018

	Prevention Services		Early Detection & Management		Intensive Assessment & Treatment		Rehabilitation & Support		Total	
	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan
Total Revenue	**24,706**	**31,159**	**515,750**	**422,607**	**960,151**	**1,043,285**	**221,901**	**218,820**	**1,722,508**	**1,715,871**
Expenditure										
Personnel	7,614	7,766	75,011	77,058	529,283	522,197	29,878	30,360	641,786	637,382
Outsourced Services	968	965	10,923	11,454	57,084	50,551	5,191	5,284	74,166	68,253
Clinical Supplies	1,340	1,268	12,724	12,038	96,697	89,415	4,777	4,520	115,538	107,241
Infrastructure & Non-Clinical Supplies	1,411	1,092	11,991	6,754	112,109	104,376	3,620	992	129,132	113,213
Payments to Providers	13,186	19,649	397,699	306,102	196,326	292,222	171,703	171,810	778,913	789,782
Total Expenditure	**24,520**	**30,740**	**508,347**	**413,406**	**991,499**	**1,058,761**	**215,169**	**212,965**	**1,739,535**	**1,715,871**
Net Surplus/ (Deficit)	**186**	**419**	**7,402**	**9,201**	**(31,347)**	**(15,476)**	**6,733**	**5,855**	**(17,027)**	**(0)**

Note: Certain re-classifications of revenue and cost in the above actual columns have been made to improve interpretation of Intensive Assessment & Treatment, and Early Detection and Management. The DHB plans to review and further refine the methodology and reporting during the next twelve months

BEING A GOOD EMPLOYER

100%
COMPLIANCE WITH GOOD EMPLOYER PRINCIPLES (1ST EQUAL IN NEW ZEALAND)

7,203
EMPLOYEES AT WAITEMATA DHB (6,188 FTE)

23% MALE
77% FEMALE

At Waitemata DHB, our promise is the best care for everyone. We believe that our patients receive the best care from our people when our people receive the best care from us as their employer. 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 eight years and received the 2018 Diversity Award for 'celebration culture' due to our national cultural competency training programme.

Our Good and Equal Employment Programmes

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 on steering and working groups and are discussed at Board meetings and sub-committees, union/staff forums, workforce meetings and our staff health, safety and wellbeing committee.

Recruitment, Selection and Development

Waitemata DHB has a comprehensive training programme to equip new graduates with clinical and professional skills. In 2017, we introduced extensive coaching and teaching programmes to support the transition of post graduate medical staff from their student to intern year and into pre-registration training.

The DHB runs several sessions per year for practitioners returning to nursing after 5 years out of clinical work; as well as programmes to support clinical training for nurses new to acute care and mental health.

The DHB supports our Orderly, Cleaning, Therapy Assistants, Oral Health Assistants and Heath Care Assistant staff through NZQA accredited training via Careerforce with more than 200 staff through these programmes over the last 6 years.

The DHB has multi- campus learning facilities including video streaming, and uses modern on line and virtual reality technology to provide blended learning across multiple hospital and community sites.

Management and Leadership development

The Fellows Programme enables service redesign by matching high performing individuals to areas of organisational need. Fellowships are 12-month roles that require completion of a project and a publication in areas including medical education and anthropology; health care design, innovation and management; health informatics; patient safety and services (cancer care, stroke and midwifery). The Fellows programme was recognised in the 2018 IPANZ awards.

In 2015, the Northern region DHBs introduced a management graduate and management fellow programme with 75% of applicants confirmed into permanent management roles in 2017.

The DHB provides extensive management and leadership training including Clinical Leadership, Management Foundations, Leading Quality Care and Coaching programmes to short one off sessions that cater to specific skill development.

Health Equity

Our DHB has many activites in place to grow our Māori and Pacific workforces, helping us respond to strategic health equity outcomes for our patients. Evidence shows outcomes improve for patients when they are treated with a higher level of cultural understanding and awareness, and cared for by a skilled workforce that reflects our communities.

51% NEW ZEALAND/ EUROPEAN

6% MĀORI

5% PACIFIC

28% ASIAN

10% OTHER ETHNICITIES

ETHNIC PAY GAP

5% MĀORI

24% PACIFIC

1% ASIAN

THE AVERAGE WAITEMATA EMPLOYEE IS

45 YEARS OLD

16% AGED <30

46% AGED 30-50

38% AGED OVER 50

To support and commit our health equity efforts, the DHB has set employment growth targets to match Māori and Pacific working age district populations with levels of staff employment. Targets for 2017/18 were met, with work continuing into 2018/19 on recruitment, providing a great working environment and good ethnicity recording.

The Pacific Health Science Academies provide support to 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 are given summer work placements with Waitemata DHB.

Since 2009, the DHB has supported over 250 Māori and Pacific students through their tertiary study. Since 2017, 100% of scholarship graduates who applied for roles gained employment in the health sector.

In July 2017 the DHB joined Auckland City Council, Auckland and Counties-Manukau DHBs to sign a youth pledge so we can:

- Increase youth awareness and understanding of the many employment opportunities available to them in health.
- Remove barriers and strengthen enablers to increase the number of youth we employ.
- To become more youth ready and more youth friendly.

The DHB runs up to two 4-week programmes per year to support inexperienced candidates into Health Care Assistant (HCA) roles. The HCA programme was a finalist in the 2018 Human Resource Institute Awards.

Volunteers

There are approximately 400 volunteers currently involved with the DHB who work across both North Shore and Waitakere Hospitals. An extensive recruitment campaign commenced in 2017 has successfully recruited volunteers from a variety of ethnic backgrounds and age groups.

Organisational culture and values

Our 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.

Work in 2018 focuses on clinical leadership as well as spotlighting our 'with compassion' value through leadership visits to all parts of the DHB and development of new materials to support behaviours we love to see as well as guidance on bullying and harassment, providing feedback and healthy teamwork.

Remuneration and recognition

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

- Health Excellence awards – awards recognising innovation in patient outcomes or patient/staff experience

OCCUPATION TYPE

46% NURSING

23% ALLIED HEALTH

11% MEDICAL

20% OTHER

40%

OF OUR EMPLOYEES WORK PART TIME (2,162 FTE)

0.2%

OF OUR EMPLOYEES HAVE DECLARED A DISABILITY

4,212

EMPLOYEES RECEIVED A FLU VACCINATION IN 2017

- 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 or team who demonstrates outstanding achievement of 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 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 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 facility development programme is being planned across our sites, guided by the Auckland region DHB long term investment plan. Staff continue to be involved in planning discussions about construction and design to enable appropriate and future-proofed spaces that staff can work in, are safe and deliver contemporary patient care.

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.

Policies

In 2017/18 the DHB reviewed all our people based policies including contemporary changes to health and safety, security and safety, bullying and harassment, recruitment and leave management. Key employee policies are sent to union partners for their feedback and then endorsed by our Executive Leadership Team.

Health, Safety and Wellbeing

At Waitemata DHB, our health, safety and wellbeing aspiration is expressed in a promise to our staff:

"To have a safe environment for our people, patients and visitors, contractors, where our health and safety obligations, risk and harm is understood, regularly discussed, assessed, and addressed."

Our working environment is an important component of wellbeing for patients and staff, with the DHB focusing improvements on the following throughout 2017/18: construction management, orientation, hazardous substances, community workers, incident and risk management, security and governance.

A key work programme is our Healthy Workplaces Strategy which adopts the World Health Organisation Healthy Workplaces framework, and through 15 collaborative workstreams, supports an evidence base that staff wellbeing influences patient wellbeing. Through this strategy we have recently completed a series of mindfulness@work and wellbeing sessions; run wellbeing clinics for Senior Medical Staff and introduced online health and safety and security training and produced a 'good sleep' guideline for staff.

We remain committed to working with our regional and national DHB and union partners on employee participation, as well as commissioning deep dive internal audit reviews so we can collectively improve the health, safety and wellbeing of our teams.

SUSTAINABILITY

Waitemata DHB's targets are aimed at addressing sustainable procurement, energy and carbon management, water efficiency, waste management and the built environment.

Sustainability
Waitemata District Health Board

Waitemata DHB launched its first year of CEMARS (Certified Emissions Measurement and Reduction Scheme) certification, becoming the first and only DHB to be CEMARS and Enviro-Mark Gold certified, verifying that we are taking credible action for a better environment. The DHB is also a member of the Global Green and Healthy Hospitals, a worldwide network committed to reducing the health sector's environmental footprint and advocating for policies that promote environmental and public health.

Waitemata DHB has set annual targets to reduce our carbon footprint, and put in place initiatives to achieve the target. Significant improvements have been seen in the reduction of volatile medical gases.

Increasing patient numbers have resulted in greater demands for energy and water, and increased waste production, but we are working to be as efficient as possible. We have set ourselves targets for reductions in our use of energy and water, and for increases in the volume of waste that we recycle rather than sending to land fill. A report on progress goes to every meeting of the Hospital Advisory Committee (HAC) and the DHB has set measures to report to the Ministry of Health against high-priority agenda items of climate change mitigation and waste minimisation.

Our electricity use increased 1.8% over the year at North Shore and Waitakere Hospitals (while inpatients numbers grew 2%), to 27.3 Gwh. Gas use increased by 4.7% to 81.0 GJ.

Energy saving initiatives include low-energy LED lighting retrofits as part of general maintenance, and a PC sleep programme, which alone, reduces energy costs by $140K per year. The DHB installed 27 electricity meters across both hospital sites. This enables the identification of high use areas, processes and faults to improve energy efficiency. This work was subsided by EECA (Energy Efficiency and Conservation Authority), as part of the DHB's Collaboration Agreement.

In the context of increased inpatient events, general waste decreased by 5% to 1,365 tonnes in 2017/18, and recycling increased by 6% to 308 tonnes. Medical waste increased by 8% to 460 tonnes. Confidential paper decreased by 5% to 62 tonnes.

New waste reduction activities include recycling education, I.V. bag, metals (scissors and forceps) and battery recycling, as well as food waste composting, in association with Compass, who provide hospital meals and have shifted to compostable consumables, and the Packaging Forum who funded our new cafeteria waste station. Waste reduction can be challenging though, as the flow-on impact of China's recycling ban is reducing the types of recyclable materials due to a collapse in the recycled materials market.

Recycling and composting in action

Waitemata DHB worked with healthAlliance to update their procurement policy to include sustainability and embarked on large-scale sustainable procurement. The DHB uses 2.6m disposable polystyrene cups per year, which take hundreds of years to break down in landfill. Compostable alternatives were identified and integrated into our supply chain. This initiative has been offered to three other DHBs.

As part of the staff travel plan (supported by Auckland Transport), the DHB installed e-Bike charging points at North Shore Hospital and continued to host the Travelwise expos. We have also trialled e-bikes for staff to encourage low-emission, active travel to work. The DHB also received funding from a recent Electric Vehicle funding round with the Energy Efficiency and Conservation Authority (EECA). At North Shore and Waitakere Hospitals, Cityhop electric vehicles will replace 9 older hospital pool vehicles, and will also be available to the public after hours and at weekends.

ABOUT OUR ORGANISATION

Waitemata DHB Board members

Current Board members

Professor Judy McGregor, CNZM, Chair

Sandra Coney QSO

Brian Neeson

Kylie Clegg, Deputy Chair

Warren Flaunty QSM

Morris Pita

Prof Max Abbott, CNZM

Dr James Le Fevre

Allison Roe MBE

Edward Benson-Cooper

Dr Matire Harwood

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 waivers were given during the last year:

Meeting of the Waitemata DHB Board on 5 July 2017.

Warren Flaunty and Morris Pita both have disclosed pharmacy interests and were not provided with the item 'NGO contracts.' Warren Flaunty's disclosed interests were his Pharmacy Directorships. Morris Pita's disclosed interest was as a shareholder of Turuki Pharmacy Limited. However on the date of the meeting the NGO contracts were available in the public arena and the item 'NGO contracts' was then made available to both Warren Flaunty and Morris Pita. Having noted their interests, the Board were satisfied under Schedule 3, clause 36(4) that Warren Flaunty and Morris Pita could remain in the meeting for the discussion of the item but neither participated in the voting of the 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 2017/18 year, or that remain current are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May 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 2017/18 appropriations is detailed below:

Appropriations allocated and scope

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

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

What is intended to be achieved with this appropriation

The DHB provides services that align with:

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

How performance will be assessed and end of year reporting

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

	2016/17		2017/18		
	Budgeted $000	Estimated Actual $000	Final budgeted $000	Supplementary estimates $000	Estimated Actual $000
Total appropriations (revenue)	1,391,675	1,391,675	1,464,458	0	1,464,458

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.

ASSET PERFORMANCE

Introduction

Measuring the performance of assets, in particular critical assets, is an aspect of mature asset management as it provides visibility of risks to service delivery from under performance of these assets and allows actions or investment to be targeted accordingly.

The Waitemata DHB asset performance measures and targets define what is required of our critical assets to help achieve the DHB's organisational strategic objectives and regulatory requirements. The measurement of performance against target provides a mechanism for Waitemata DHB to determine and prioritise capital investments and operational improvements, under the direction of the DHB's Asset Management Leadership Group.

Waitemata DHB is required, by the Auditor General, to report on the technical performance of its three main asset portfolios (facilities, clinical equipment and Information Communications Technology (ICT)) to meet mandatory asset reporting requirements as set out in the Cabinet Office Circular CO (15) 5: Investment Management and Asset Performance in the State Services. The Circular gives effect to Cabinet's intention that there is active stewardship of government resources, and strong alignment between individual investments and the government's long-term priorities.

Waitemata DHB is required to provide asset performance information relating to the following asset performance indicators:

A. Condition
B. Utilisation
C. Functionality (fitness for purpose)

Waitemata DHB has defined asset performance measures across the three asset portfolios either at the portfolio level or for critical assets within that portfolio. These are set out in the tables below. The DHB's Asset Management Leadership Group is leading the development of asset management maturity of the organisation which includes refining the asset performance measures accordingly. Waitemata DHB has adopted a number of new measures that have taken effect from 1 July 2018 and will be reported in the next Annual Report.

Facilities Asset Portfolio

The asset performance measures for the facilities portfolio reflect the need to ensure the facilities are in acceptable condition, are well-utilised without being at or over capacity, and meet compliance requirements. Building condition is being maintained above poor and very poor condition by targeted refurbishment works. Targeted criticality assessments are underway and building stock will be re-surveyed over the next year to reassess the building element condition to inform future building and plant works.

	Measure	Indicator	2017/18 Target	2017/18 Actual
1.1	**Facility condition** Percentage of occupied buildings rated as "poor" or "very poor condition" *Assessment of facility condition based on visual inspection and reported as the percentage of overall buildings value in "poor" or "very poor condition" categories. Condition grading levels are very poor, poor, average, good and very good.*	Condition	<5%	5%
1.2	**Facility utilisation based on bed occupancy** Average Medical/Surgical Bed occupancy *Average occupation of inpatient beds throughout the year. (Excluding short stay and ICU beds). The occupation of beds provides an indication of total utilisation across wards and surgical theatres. The target reflects the variation between peak winter and low summer demand.*	Utilisation	≥85%	84.4%
1.3	**Theatre utilisation** Elective Surgery Ministry of Health Target (actual elective surgery discharges as a percentage of planned elective surgery discharges) *Performance against the Waitemata DHB annual target (as agreed with Ministry of Health) for elective surgery discharges. This measures actual elective surgery discharges against the target elective surgery for Waitemata DHB for the year.*	Utilisation	≥100%	100%
1.4	**Theatre utilisation** Elective Theatre Utilisation *Performance against annual production plan for elective theatre utilisation. This measures how well the theatre spaces are utilised (across all surgeries) based on the number of 4 hour lists completed.*	Utilisation	≥95%	95.4%

Measure		Indicator	2017/18 Target	2017/18 Actual
1.5	**Seismic compliance** Percentage of occupied buildings classed as greater than "Potentially Earthquake Prone" *Percentage of buildings housing patients that exceed the minimum "Potentially earthquake prone" seismic rating requirement (i.e. % of owned buildings (by building count) housing patients with seismic state based on NBS of greater than or equal to 34% (note <34% is classified as 'potentially earthquake prone'). The target reflects the importance of having patient facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	100%	100%
1.6	**Car parking compliance** Mobility car park spaces as a percentage of total car park spaces to be greater than NZ Guideline 4121 *Percentage of mobility spaces at Waitakere and North Shore Hospitals as percentage of total spaces. The target is based on the NZ Standards 4121 and was approved by the Waitemata DHB Disability Advisory Committee as part of delivering the NZ Disability Strategy.*	Functionality (Fitness for Purpose)	>100%	177%

Clinical Equipment Asset Portfolio

The asset performance measures for the clinical equipment portfolio reflect the need to ensure the clinical equipment meets compliance/testing requirements, and that equipment is available to meet the service delivery needs of the clinical services. Waitemata DHB is currently completing a criticality assessment of clinical equipment across the DHB and new asset performance measures have been implemented from 1 July 2018 to improve the ability to monitor and prioritise investment proposals across this portfolio in the future.

Measure		Indicator	2017/18 Target	2017/18 Actual
2.1	**CT Scanners Condition** Compliance with six monthly physics testing *Assessment of CT integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%
2.2	**MRI Condition** Compliance with annual physics testing *Assessment of MRI integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%
2.3	**CT Scanners Utilisation** Annual CT screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available and staffing resources within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	113%
2.4	**MRI Utilisation** Annual MRI screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	105%
2.5	**Clinical Equipment Functionality** Critical clinical equipment passing monthly "Functionality test" *Percentage of critical clinical equipment that is inspected and passes functionality test against schedule. The target reflects the importance of having high criticality equipment fit for purpose and available when required. Critical clinical equipment are those that are classed as having high patient risk associated with failure (ECRI score 1).*	Functionality (Fitness for Purpose)	100%	100%

ICT Asset Portfolio

Waitemata DHB's ICT asset portfolio is owned, managed and maintained by healthAlliance, the shared service company owned by the DHBs in the Northern Region. The asset performance measures for 2017/18 are as agreed in the Service Level Agreement (SLA) between healthAlliance and the DHBs. Waitemata DHB has been working with healthAlliance to improve the level of reporting for critical ICT assets. An additional 12 asset performance measures have been implemented from 1 July 2018 and will be reported in the next Annual Report.

Measure		Indicator	2017/18 Target	2017/18 Actual
3.1	**ICT Tier 1 and 2 Applications Utilisation** Average monthly service outage duration in minutes. *Measures the duration of unplanned service interruptions as reported in the monthly performance reporting.*	Utilisation	≤90 minutes	62
3.2	**ICT Tier 1 Applications Functionality** Availability of IT Services (Tier 1 Apps) *This measures the operational integrity, performance and stability of Tier 1 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/ Number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.99%
3.3	**ICT Tier 2 Applications Functionality** Availability of IT Services (Tier 2 Apps) *This measures the operational integrity, performance and stability of Tier 2 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/ Number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.99%

Financial statements

FINANCIAL STATEMENTS

Statement of Responsibility

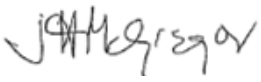
We are responsible for the preparation of the Waitemata District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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 2018.

Signed on behalf of the Board:



Professor Judy McGregor, CNZM

Chair

Dated: 31 October 2018

Kylie Clegg

Deputy Chair

Dated: 31 October 2018

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

	Notes	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Group and Parent Budget 2018 $000	Parent Actual 2017 $000
Revenue						
Patient care revenue	2	1,688,957	1,597,087	1,688,957	1,678,812	1,597,087
Interest revenue		2,417	3,088	2,063	2,810	2,747
Other revenue	3	33,441	28,174	31,488	34,249	26,800
Total revenue	30	1,724,815	1,628,349	1,722,508	1,715,871	1,626,634
Expenditure						
Personnel costs	4	641,786	604,008	641,786	637,382	604,008
Depreciation and amortisation expense	12,13	29,608	28,007	29,608	29,674	28,007
Outsourced services		74,166	76,280	74,166	68,253	76,280
Clinical supplies		115,538	109,936	115,538	107,241	109,936
Infrastructure and non-clinical expenses		52,228	39,713	52,228	36,277	39,713
Other district health boards		299,498	274,356	299,498	299,916	274,356
Non-health board provider expenses		479,415	452,872	479,415	489,866	452,872
Capital charge	5	36,679	21,560	36,679	36,927	21,560
Interest expense		0	6,532	0	0	6,532
Other expenses	6	10,682	11,793	10,617	10,335	11,452
Total expenditure	30	1,739,600	1,625,057	1,739,535	1,715,871	1,624,716
Surplus / (deficit)		**(14,785)**	**3,292**	**(17,027)**	**0**	**1,918**
Other comprehensive revenue and expense						
Gain /(Loss) on property revaluations	18	15,938	(379)	15,938	0	(379)
Total other comprehensive revenue and expense		15,938	(379)	15,938	0	(379)
Total comprehensive revenue and expense		**1,153**	**2,913**	**(1,089)**	**0**	**1,539**

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 2018

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Balance at 1 July		625,696	346,077	614,215	615,588	335,970
Owner debt conversion to equity		0	276,706	0	0	276,706
		625,696	622,783	614,215	615,588	612,676
Comprehensive Income						
Surplus / (Deficit)		(14,785)	3,292	(17,027)	0	1,918
Other comprehensive revenue and expense						
Gain / (Loss) on property revaluations		15,938	(379)	15,938	0	(379)
Total comprehensive revenue and expense for the year		**1,153**	**2,913**	**(1,089)**	**0**	**1,539**
Balance at 30 June	18	**626,849**	**625,696**	**613,126**	**615,588**	**614,215**

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 2018

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Assets						
Current assets						
Cash and cash equivalents	7	32,534	19,629	29,077	18,399	17,812
Receivables	8	55,362	55,939	55,179	58,000	55,291
Investments	9	1,126	1,163	0	1,200	0
Inventories	10	7,933	7,552	7,933	8,053	7,552
Prepayments		759	5,201	759	5,201	5,201
Total current assets		97,714	89,484	92,948	90,853	85,856
Non-current assets						
Investments	9	8,922	7,924	0	7,924	0
Investments in associates and joint ventures	11	39,782	36,830	39,782	36,830	36,830
Property, plant and equipment	12	751,150	742,488	751,150	743,492	742,488
Intangible assets	13	3,730	5,071	3,730	8,666	5,071
Total non-current assets		803,584	792,313	794,662	796,912	784,389
Total assets		**901,298**	**881,797**	**887,610**	**887,765**	**870,245**
Liabilities						
Current liabilities						
Payables	14	105,795	108,942	105,830	109,683	108,871
Borrowings	15	256	256	256	173	256
Employee entitlements	16	130,560	108,175	130,560	110,767	108,175
Provisions	17	4,653	1,051	4,653	1,051	1,051
Total current liabilities		241,264	218,424	241,299	221,674	218,353
Non-current liabilities						
Borrowings	15	86	342	86	342	342
Employee entitlements	16	33,099	37,335	33,099	50,161	37,335
Total non-current liabilities		33,185	37,677	33,185	50,503	37,677
Total liabilities		**274,449**	**256,101**	**274,484**	**272,177**	**256,030**
Net assets		**626,849**	**625,696**	**613,126**	**615,588**	**614,215**
Equity						
Contributed Capital	18	379,721	379,721	379,721	379,721	379,721
Accumulated surpluses / (deficits)	18	(56,045)	(39,018)	(56,045)	(37,645)	(39,018)
Property Revaluation Reserves	18	289,450	273,512	289,450	273,512	273,512
Trust funds	18	13,723	11,481	0	0	0
Total equity		**626,849**	**625,696**	**613,126**	**615,588**	**614,215**

Budgeted current and non-current assets have been restated from the 2018 Annual plan to be consistent with the classification of assets as reported in the 2018 Financial Statements. There are no differences between the budget figures reported here and the Annual Plan budget at a total asset level.

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 2018

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Budget 2018 $000	Actual 2017 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,675,846	1,582,348	1,675,846	1,685,799	1,582,348
Other		39,490	48,321	37,850	27,262	48,587
Interest received		2,076	4,196	2,076	2,810	4,166
Payments to suppliers		(1,017,136)	(994,171)	(1,017,136)	(1,012,007)	(994,173)
Payments to employees		(624,385)	(608,107)	(624,385)	(637,270)	(608,107)
Payments for capital charge		(36,679)	(21,762)	(36,679)	(36,924)	(21,762)
Interest paid		0	(8,349)	0	0	(8,349)
GST (net)		1,523	749	1,523	0	749
Net cash flow from operating activities	19	40,735	3,225	39,095	29,670	3,459
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		(24,878)	(63,718)	(24,878)	(30,901)	(63,718)
Purchase of intangible assets		0	0	0	0	0
Acquisition of investments		(2,952)	24,440	(2,952)	0	24,440
Net cash flow from investing activities		(27,830)	(39,278)	(27,830)	(30,901)	(39,278)
Cash flows from financing activities						
Capital contributions from the Crown		0	0	0	0	0
Proceeds from loans		0	0	0	0	0
Repayment of loans		0	0	0	0	0
Net cash flow from financing activities		0	0	0	0	0
Net (decrease) / increase in cash and cash equivalents		**12,905**	**(36,053)**	**11,265**	**(1,231)**	**(35,819)**
Cash and cash equivalents at the start of the year		19,629	55,682	17,812	19,630	53,631
Cash and cash equivalents at the end of the year	7	**32,534**	**19,629**	**29,077**	**18,399**	**17,812**

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 2018

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 relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate 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. The group does not operate to make a financial return. 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 2018 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 2018, and were approved for issue by the Board on 31 October 2018.

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).

Standards issued and not yet effective, and early adopted

Impairment of Revalued Assets

In April 2017, the XRB issued *Impairment of Revalued Assets*, which now scopes in revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant and the equipment assets measured at cost were scoped into the impairment accounting standards. There is no effect in applying these amendments.

Standards issued and not yet effective, and not early adopted

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 *Financial Instruments*. PBE IFRS 9 replaces PBE IPSAS 29 *Financial Instruments: Recognition and Measurement.* PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses
- Revised hedge accounting requirements to better reflect the management of risks.

Waitemata DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The effects of this new standard have not been assessed.

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.

Joint ventures
A joint venture is a binding arrangement whereby two or more parties committed to undertake an economic activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. Where the joint venture's results are material, the DHB includes the interest in the joint venture in the consolidated financial statements, using the equity method, from the date that joint control commences until the date that joint control ceases. The investments in joint ventures are accounted for in the parent entity financial statements at cost.

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 associate is recognised at cost. The DHB's interest in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) is not accounted for in the group financial statements as it is not material to the group.

The 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 population-based revenue
The DHB receives annual funding from the MoH, which is based on population levels within the Waitemata DHB region. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MoH contract revenue
The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

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 district. The Ministry credits Waitemata DHB with a monthly amount based on estimated patient treatment for non-domiciled Waitemata residents within the Waitemata district. An annual wash up occurs at year end to reflect the actual revenue for non Waitemata-domiciled patients treated within the Waitemata district.

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.

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) 2 to 80 years (1.25%-50%)
- 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.

National Oracle Solution
The National Oracle System Project ('NOS') (previously part of the Finance Procurement Supply Chain programme), is a national initiative, funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitemata DHB holds an asset at cost of capital invested by the DHB in NOS. This investment represents the right to access the NOS assets and is considered to have an indefinite life. 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 and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets' standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be 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.

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 ongoing 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:
- crown equity;
- 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 restricted 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 Inland Revenue Department 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.

The DHB has entered into a contract for services with providers for laboratory services. Services are provided across several DHB districts. 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.

2 Patient care revenue

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Health and disability services (MOH contracted revenue)	1,585,840	1,496,896	1,585,840	1,496,896
ACC contract revenue	10,775	9,755	10,775	9,755
Inter district patient inflows	80,691	79,486	80,691	79,486
Revenue from other district health boards	5,852	5,773	5,852	5,773
Other patient sourced revenue	5,799	5,177	5,799	5,177
Total patient care revenue	**1,688,957**	**1,597,087**	**1,688,957**	**1,597,087**

3 Other revenue

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Clinical Training Agency	9,674	9,762	9,674	9,762
Donations and bequests received	753	1,192	746	1,192
Rental revenue	915	585	915	585
Professional, training and research	4,565	3,752	3,464	3,752
Other revenue	17,534	12,883	16,689	11,509
Total other revenue	**33,441**	**28,174**	**31,488**	**26,800**

4 Personnel costs

	Notes	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Salaries and wages		604,263	593,290	604,263	593,290
Contributions to defined contribution schemes		19,374	18,487	19,374	18,487
Increase/(decrease) in liability for employee entitlements		18,149	(7,769)	18,149	(7,769)
Total personnel costs		**641,786**	**604,008**	**641,786**	**604,008**

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 period of first six months to 31 December 2017 was 6% (2017 :7%). The rate for the period of second six months to 30 June 2018 was 6% (2017 : 6%).

6 Other expenses

	Notes	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Audit fees for Waitemata DHB financial statement audit		219	204	219	204
Audit fees (for subsidiary financial statements)		0	10	0	10
Operating lease expense		8,480	9,402	8,477	9,262
Impairment of debtors		1,578	1,611	1,578	1,611
Board members fees	23	343	365	343	365
Other expenses		62	201	0	0
Total other expenses		**10,682**	**11,793**	**10,617**	**11,452**

7 Cash and cash equivalents

	Group Actual 2018 $000	Group Actual 2017 $000	Parent Actual 2018 $000	Parent Actual 2017 $000
Cash at bank and on hand	1,707	67	0	0
Call deposits	1,750	1,750	0	0
NZ Health Partnerships Limited	29,077	17,812	29,077	17,812
Total cash and cash equivalents for the purposes of the statement of cash flows	**32,534**	**19,629**	**29,077**	**17,812**

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 $3.457m (2017 : $1.817m) generated for specific purposes such as research. 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.

7 Cash and cash equivalents (continued)

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 $79.963m (2017 : $73.730m).

8 Receivables

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Ministry of Health	27,239	29,101	27,239	29,101
Other receivables	9,857	11,946	9,674	11,298
Other accrued revenue	20,539	17,181	20,539	17,181
Less: Provision for impairment	(2,273)	(2,289)	(2,273)	(2,289)
Total receivables	**55,362**	**55,939**	**55,179**	**55,291**

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 2018			Group 2017		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	48,132	0	48,132	50,897	(76)	50,821
Past due 1-30 days	5,394	(395)	4,999	1,093	(244)	849
Past due 31-60 days	985	(217)	768	1,223	(169)	1,054
Past due 61-90 days	274	(93)	181	236	(94)	142
Past due > 90 days	2,850	(1,568)	1,282	4,779	(1,706)	3,073
Total	**57,635**	**(2,273)**	**55,362**	**58,228**	**(2,289)**	**55,939**

	Parent 2018			Parent 2017		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	47,949	0	47,949	50,249	(76)	50,173
Past due 1-30 days	5,394	(395)	4,999	1,093	(244)	849
Past due 31-60 days	985	(217)	768	1,223	(169)	1,054
Past due 61-90 days	274	(93)	181	236	(94)	142
Past due > 90 days	2,850	(1,568)	1,282	4,779	(1,706)	3,073
Total	**57,452**	**(2,273)**	**55,179**	**57,580**	**(2,289)**	**55,291**

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.

8 Receivables (continued)

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

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Balance at 1 July	2,289	2,781	2,289	2,781
Additional provisions made	1,578	1,611	1,578	1,611
Receivables written off	(1,594)	(2,103)	(1,594)	(2,103)
Balance at 30 June	**(2,273)**	**(2,289)**	**(2,273)**	**(2,289)**

9 Investments

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,126	1,163	0	0
Total current portion	1,126	1,163	0	0
Non-current portion				
Portfolio investments	8,922	7,924	0	0
Total non-current portion	8,922	7,924	0	0
Total investments	**10,048**	**9,087**	**0**	**0**

The carrying value of the current portion of investments approximates their fair value.
The fair value of term deposits with a remaining duration greater than 12 months is $8.922m (2017: $7.924m). 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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Pharmaceuticals	630	625	630	625
Surgical and medical supplies	7,303	6,927	7,303	6,927
Total inventories	**7,933**	**7,552**	**7,933**	**7,552**

The write-down of inventories held for distribution amounted to $nil (2017: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2017: $nil). However, some inventories are subject to retention of title clauses.

11 Investments in associates and joint ventures

	Interest held 30 Jun 2018	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
New Zealand Health Partnerships Limited	5%	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. The agreement expired in 2016 and was renewed 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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
healthAlliance N.Z. Limited	39,470	36,568	39,470	36,568
South Kaipara Medical Centre	88	88	88	88
McCrae Research	224	174	224	174
Total investments	**39,782**	**36,830**	**39,782**	**36,830**

There were no impairment losses in the value of associates and joint ventures assessed for 2018 (2017: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $39.470m (2016: $36.568m).

Summary of financial information of joint ventures and associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2018					
New Zealand Health Partnerships Limited	373,341	315,924	57,417	37,577	(4,263)
healthAlliance N.Z. Limited	191,996	31,337	160,659	136,513	(492)
New Zealand Health Innovation Hub Limited Partnership	573	47	526	56	(191)
Northern Regional Alliance Ltd	12,660	11,224	1,436	14,289	(107)
South Kaipara Medical Centre	484	261	223	2,216	(91)
Total	**579,054**	**358,793**	**220,261**	**190,651**	**(5,144)**
2017					
New Zealand Health Partnerships Limited	349,139	287,459	61,680	50,541	862
healthAlliance N.Z. Limited	172,978	27,394	145,584	135,152	1,334
New Zealand Health Innovation Hub Limited Partnership	755	(2)	757	0	(303)
Northern Regional Alliance Ltd	10,923	9,380	1,543	14,469	28
South Kaipara Medical Centre	588	264	324	2,307	57
Total	**534,383**	**324,495**	**209,888**	**202,469**	**1,978**

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

	2018 $000	2017 $000
Share of surplus / (deficit) before tax:	(438)	282
Less: Tax expense	0	0
Share of surplus / (deficit)	**(438)**	**282**

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	Total $000
Cost or valuation							
Balance at 1 July 2016	224,310	414,515	115,950	30,371	4,079	50,957	840,182
Additions from WIP	0	46,745	5,741	2,517	100	(55,103)	0
Revaluation increase/(decrease)	0	0	0	0	0	0	0
Additions to WIP	0	0	0	0	0	60,513	60,513
Disposals	0	0	0	(1,083)	0	(376)	(1,459)
Balance at 30 June 2017	224,310	461,260	121,691	31,805	4,179	55,991	899,236
Balance at 1 July 2017	224,310	461,260	121,691	31,805	4,179	55,991	899,236
Additions from WIP	0	32,907	6,580	1,807	246	(41,540)	0
Revaluation increase/(decrease)	37,817	(75,251)	0	0	0	0	(37,434)
Additions to WIP	0	0	0	0	0	24,878	24,878
Disposals	0	0	0	0	0	(3,379)	(3,379)
Balance at 30 June 2018	262,127	418,916	128,271	33,612	4,425	35,950	883,301
Accumulated depreciation and impairment losses							
Balance at 1 July 2016	0	22,417	81,110	22,463	4,003	0	129,993
Depreciation expense	0	18,241	7,370	2,200	36	0	27,847
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	(1,083)	0	0	(1,083)
Elimination on revaluation	0	(9)	0	0	0	0	(9)
Balance at 30 June 2017	0	40,649	88,480	23,580	4,039	0	156,748
Balance at 1 July 2017	0	40,649	88,480	23,580	4,039	0	156,748
Depreciation expense	0	19,675	7,342	2,338	82	0	29,437
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	(54,034)	0	0	0	0	(54,034)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2018	0	6,290	95,822	25,918	4,121	0	132,151
Carrying amounts							
At 1 July 2016	224,310	392,098	34,840	7,908	76	50,957	710,189
At 30 June and 1 July 2017	224,310	420,611	33,211	8,225	140	55,991	742,488
At 30 June 2018	**262,127**	**412,626**	**32,449**	**7,694**	**304**	**35,950**	**751,150**

The net carrying amount of assets held under finance leases is $342k (2017: $598k) for clinical equipment.
IT assets in Work In Progress of $12.073m (2017: $9.434m) 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.

The most recent valuation of land and buildings was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2018 and the land and buildings values were adjusted accordingly.

12 Property, plant, and equipment (continued)

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 and is adjusted where relevant for the condition of the asset, management's best estimates of future maintenance and replacement plans, and experiences with similar buildings;
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset;
- Judgments have been made on the extent to which infrastructure value is compromised based on the information available;
- Adjustments have been made for the estimated capital costs to be incurred to maintain the continued function of buildings, as a deduction from the asset values.

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

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

	2018 $000	2017 $000
Buildings	17,198	38,874
Clinical equipment	5,348	6,538
Other equipment	1,331	1,145
IT equipment	12,073	9,434
Total work in progress	**35,950**	**55,991**

Impairment
No impairment loss has been identified in property, plant and equipment in 2018 (2017 : 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	NOS Rights $000	Acquired Software $000	Total $000
Cost			
Balance at 30 June 2016	4,819	3,449	8,268
Additions from WIP	0	0	0
Additions to WIP	0	219	219
Balance at 30 June 2017	4,819	3,668	8,487
Additions from WIP	0	152	152
Impairment	(1,323)	0	(1,323)
Balance at 30 June 2018	3,496	3,820	7,316
Accumulated amortisation and impairment losses			
Balance at 30 June 2016	0	3,257	3,257
Amortisation expense	0	159	159
Balance at 30 June 2017	0	3,416	3,416
Amortisation expense	0	170	170
Balance at 30 June 2018	0	3,586	3,586
Carrying amounts			
At 1 July 2016	4,819	192	5,011
At 30 June 2017	4,819	252	5,071
At 30 June 2018	**3,496**	**234**	**3,730**

The National Oracle Solution (NOS) is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL). During the year to 30 June 2018, Waitemata DHB had capitalised payments in respect of the NOS totalling $nil (2017: $nil). The total value of payments made by Waitemata DHB since the inception of the NOS to 30 June 2017 was $4.819m (2017: $4.819m).

In return for these payments, Waitemata DHB gained rights to access the NOS asset. In the event of liquidation or dissolution of NZHPL, Waitemata DHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total NOS rights that have been issued.

The NOS rights have been tested for impairment at 30 June 2018, by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Waitemata DHB's share of the DRC of the underlying NOS assets. Impairment charge has been estimated to be in the range of $0.5m to $1.3m in 2017/18 (2017: Nil).

14 Payables

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Creditors and accrued expenses	93,045	93,820	93,080	93,749
Revenue in advance	3,837	7,733	3,837	7,733
GST payable	8,913	7,389	8,913	7,389
Capital charge payable	0	0	0	0
Total payables	**105,795**	**108,942**	**105,830**	**108,871**

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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Current portion				
Finance leases	256	256	256	256
Non-current portion				
Finance leases	86	342	86	342
Total borrowings	**342**	**598**	**342**	**598**
Borrowing facility limits				
Overdraft facility	0	0	0	0
Total borrowing facility limits	**0**	**0**	**0**	**0**

Finance leases

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Minimum lease payments payable:				
No later than one year	315	315	315	315
Later than one year and not later than five years	105	419	105	419
Later than five years	0	0	0	0
Total minimum lease payments	420	734	420	734
Future finance charges	(78)	(136)	(78)	(136)
Present value of minimum lease payments	**342**	**598**	**342**	**598**
Present value of minimum lease payments				
No later than one year	256	256	256	256
Later than one year and not later than five years	86	342	86	342
Later than five years	0	0	0	0
Total present value of minimum lease payments	**342**	**598**	**342**	**598**

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.

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	
	2018	2017	2018	2017
	$000	$000	$000	$000
Current portion				
Accrued salaries and wages	5,228	4,704	5,228	4,704
Annual leave	74,740	70,923	74,740	70,923
Sick leave	942	1,042	942	1,042
Sabbatical leave	138	3,855	138	3,855
Continuing medical education	8,197	6,418	8,197	6,418
Work related entitlements	21	153	21	153
Unpaid payroll	6,266	6,209	6,266	6,209
Payroll provisions	20,705	5,293	20,705	5,293
Unsettled CEAs	6,781	1,609	6,781	1,609
Accrued long service awards	0	3,305	0	3,305
Long service leave	2,675	671	2,675	671
Retirement gratuities	4,867	3,993	4,867	3,993
Total current portion	130,560	108,175	130,560	108,175
Non-current portion				
Continuing medical education	5,036	8,169	5,036	8,169
Long service leave	6,972	8,276	6,972	8,276
Sabbatical leave	2,507	0	2,507	0
Retirement gratuities	16,276	18,205	16,276	18,205
Sick leave	2,308	2,685	2,308	2,685
Total non-current portion	33,099	37,335	33,099	37,335
Total employee entitlements	**163,659**	**145,510**	**163,659**	**145,510**

The present value of sick leave, long service leave, sabbatical 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.

The private and public sector have experienced widespread payroll issues relating to the Holidays Act and employment agreements. This is particularly the case for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management in conjunction with other DHBs to identify risk areas focusing on systems, reporting and analytics, people and processes.

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements.

For employers such as the DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

In the meantime, a number of DHBs have made preliminary assessments of their liability.

Waitemata DHB has estimated its liability as at 30 June 2018 to be $10.0m (2017: $nil)

17 Provisions

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Current portion				
ACC Partnership Programme	2,363	1,051	2,363	1,051
Make good provision	2,290	0	2,290	0
Total current portion	4,653	1,051	4,653	1,051

Movements for each class of provision are as follows:

	Group		Parent	
	2018 $000	2017 $000	2018 $000	2017 $000
Balance at 1 July	1,051	704	1,051	704
Movement in provisions	3,602	347	3,602	347
Amounts used	0	0	0	0
Balance at 30 June	**4,653**	**1,051**	**4,653**	**1,051**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2018. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 11% (2017: 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% (2017: 1.7%);
- a weighted average discount factor of 2.3% (2017: 2.5%) has been applied.

Insurance risk

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

The DHB is responsible for managing claims for a period of up to 24 months following the lodgement date. At the end of 24 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

18 Equity

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Crown equity				
Balance at 1 July	379,721	103,015	379,721	103,015
Capital contributions from the Crown	0	276,706	0	276,706
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	379,721	379,721	379,721	379,721
Accumulated surpluses/(deficits)				
Balance at 1 July	(39,018)	(40,936)	(39,018)	(40,936)
Prior year adjustments	0	0	0	0
	(39,018)	(40,936)	(39,018)	(40,936)
Surplus/(deficit) for the year	(14,785)	3,292	(17,027)	1,918
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(2,242)	(1,374)	0	0
Balance at 30 June	(56,045)	(39,018)	(56,045)	(39,018)
Revaluation reserves				
Balance at 1 July	273,512	273,891	273,512	273,891
Impairment loss	0	0	0	0
Revaluations	15,938	(379)	15,938	(379)
Balance at 30 June	289,450	273,512	289,450	273,512
Revaluation reserves consist of:				
Land	247,275	209,414	247,275	209,414
Buildings	42,175	64,098	42,175	64,098
Total revaluation reserves	289,450	273,512	289,450	273,512
Balance at 1 July	11,481	10,107	0	0
Movement	2,242	1,374	0	0
Balance at 30 June	13,723	11,481	0	0
Total equity	**626,849**	**625,696**	**613,126**	**614,215**

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

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Net surplus/(deficit)	(14,785)	3,292	(17,027)	1,918
Add/(less) non-cash items				
Depreciation and amortisation expense	29,608	28,007	29,608	28,007
Total non-cash items	29,608	28,007	29,608	28,007
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/ loss investments	1,323	0	1,323	0
Investments in associates – healthAlliance	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	0	0	0	0
	1,323	0	1,323	0
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(5,761)	(1,289)	(5,159)	(1,289)
Inventories	(380)	(939)	(380)	(939)
Creditors and other payables	9,728	(21,747)	9,728	(20,139)
Provisions	3,602	0	3,602	0
Employee entitlements	17,400	(4,099)	17,400	(4,099)
Net movements in working capital items	24,589	(28,074)	25,191	(26,466)
Net cash flow from operating activities	**40,735**	**3,225**	**39,095**	**3,459**

20 Capital commitments and operating leases

	Group		Parent	
	Actual 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Capital commitments				
Property	655	2,793	655	2,793
Equipment	2,095	4,996	2,095	4,996
Total capital commitments	**2,750**	**7,789**	**2,750**	**7,789**

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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Not later than one year	3,970	5,169	3,970	5,169
Later than one year and not later than five years	2,142	3,878	2,142	3,878
Later than five years	0	107	0	107
Total non-cancellable operating leases as lessee	**6,112**	**9,154**	**6,112**	**9,154**

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 2018 which creates a contingent liability totalling approximately $40k (2017: approximately $670k).

At balance date, Unitec Institute of Technology have granted $261k (2017: $348k) 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 $1.597b (2017: $1.507b) to provide health services in the Waitemata area for the year ended 30 June 2018.

Transactions with key management personnel

Key management personnel compensation

Board members:	Actual 2018 $000	Actual 2017 $000
Remuneration	343	337
Full-time equivalent members	11	11
Salaries and other employee benefits of Executive Leadership Team	3,399	3,964
Full-time equivalent members	11	13
Total key management personnel remuneration	**3,742**	**4,301**
Total full-time equivalent personnel	**22**	**24**

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 (2017: twelve members).

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2017: $nil).

23 Board member remuneration

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

	Actual 2018 $000	Actual 2017 $000
Prof Judy McGregor (Chair from Jun 2018)	3	0
Dr Lester Levy (Chair)	45	72
Prof Max Abbott	28	31
Edward Benson-Cooper	27	16
Sandra Coney	28	29
Kylie Clegg	43	32
Warren Flaunty	28	29
James Le Fevre	28	28
Anthony Norman	0	16
Morris Pita	29	29
Christine Rankin	0	13
Allison Roe	28	27
Gwen Tepania–Palmer	0	11
Matire Harwood	27	15
Brian Neeson	29	17
Total board member remuneration	**343**	**365**

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $ 2k (2017 : $2k) - 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 (2017 : $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 2018	Actual 2017		Actual 2018	Actual 2017
$100,000 – 109,999	217	214	$340,000 – 349,999	11	12
$110,000 – 119,999	157	123	$350,000 – 359,999	11	8
$120,000 – 129,999	93	83	$360,000 – 369,999	12	8
$130,000 – 139,999	62	52	$370,000 – 379,999	6	8
$140,000 – 149,999	33	29	$380,000 – 389,999	7	7
$150,000 – 159,999	37	23	$390,000 – 399,999	9	1
$160,000 – 169,999	21	20	$400,000 – 409,999	4	4
$170,000 – 179,999	25	22	$410,000 – 419,999	4	3
$180,000 – 189,999	26	20	$420,000 – 429,999	3	1
$190,000 – 199,999	25	33	$430,000 – 439,999	2	3
$200,000 – 209,999	25	24	$440,000 – 449,999	1	3
$210,000 – 219,999	24	23	$450,000 – 459,999	2	2
$220,000 – 229,999	25	25	$460,000 – 469,999	0	0
$230,000 – 239,999	19	26	$470,000 – 479,999	0	0
$240,000 – 249,999	25	21	$480,000 – 489,999	0	2
$250,000 – 259,999	17	21	$490,000 – 499,999	2	0
$260,000 – 269,999	23	13	$500,000 – 509,999	1	0
$270,000 – 279,999	9	14	$510,000 – 519,999	0	0
$280,000 – 289,999	16	12	$520,000 – 529,999	0	0
$290,000 – 299,999	24	23	$530,000 – 539,999	0	0
$300,000 – 309,999	8	15	$540,000 – 549,999	0	0
$310,000 – 319,999	13	8	$550,000 – 559,999	1	1
$320,000 – 329,999	16	22	$580,000 – 589,999	0	1
$330,000 – 339,999	11	10	$630,000 – 639,999	1	0
			$1,020,000 – 1,029,999	0	1
			Grand Total	**1,028**	**941**

During the year ended 30 June 2018 there were 116 (2017 : 106) employees who received compensation and other benefits in relation to cessation totalling $1.420m (2017 : $2.012m).

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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
	32,534	19,629	29,077	17,812
Debtors and other receivables	55,362	55,939	55,179	55,291
Investments	10,048	9,087	0	0
Total loans and receivables	97,944	84,655	84,256	73,103
Financial liabilities measured at amortised cost				
Creditors and other payables (excl revenue in advance & GST)	95,335	93,820	95,370	93,749
Finance leases	342	598	342	598
Total financial liabilities measured at amortised cost	**95,677**	**94,418**	**95,712**	**94,347**

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 (2017 : nil).

Sensitivity analysis

As at 30 June 2018, if the New Zealand 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 NZ Health Partnerships 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.

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 33%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

26b Financial instrument risks (continued)

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 2018 $000	Actual 2017 $000	Actual 2018 $000	Actual 2017 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	0	151	0	0
AA -	4,515	3,081	0	0
A	445	0		
A+	0	343	0	0
A	198	343	0	0
A-	338	218	0	0
BBB+	254	92	0	0
BB+	204	199	0	0
Total counterparties with credit ratings	5,954	4,427	0	0
Cash, cash equivalents	29,077	17,812	29,077	17,812
Investments	7,551	6,477	0	0
Total counterparties without credit ratings	36,628	24,289	29,077	17,812
Total cash, cash equivalents and investments	**42,582**	**28,716**	**29,077**	**17,812**
Debtors and other receivables				
Existing counterparty with no defaults in the past	55,362	53,939	55,179	55,291
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**55,362**	**53,939**	**55,179**	**55,291**

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.

26b Financial instrument risks (continued)

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. 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
2017						
Cash on hand	17,879	17,879	17,879	0	0	0
On call deposits	1,750	1,750	1,750	0	0	0
Debtors and other receivables	55,939	55,939	55,939	0	0	0
Investments	9,087	9,087	1,266	6,368	1,453	0
Total	**84,655**	**84,655**	**76,834**	**6,368**	**1,453**	**0**

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
2018						
Cash on hand	30,784	30,784	30,784	0	0	0
On call deposits	1,750	1,750	1,750	0	0	0
Debtors and other receivables	55,362	55,362	55,362	0	0	0
Investments	10,048	10,048	1,126	6,711	2,079	132
Total	**97,944**	**97,944**	**89,022**	**6,711**	**2,079**	**132**

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
2017						
Cash on hand	17,812	17,812	17,812	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,291	55,291	55,291	0	0	0
Investments	0	0	0	0	0	0
Total	**73,103**	**73,103**	**73,103**	**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
2018						
Cash on hand	29,077	29,077	29,077	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,179	55,179	55,179	0	0	0
Investments	0	0	0	0	0	0
Total	**84,256**	**84,256**	**84,256**	**0**	**0**	**0**

Contractual maturity analysis of financial liabilities

The table following 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.

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
2017						
Creditors and other payables	93,820	93,820	93,820	0	0	0
Finance leases	598	598	315	283	0	0
Total	**94,418**	**94,418**	**94,135**	**283**	**0**	**0**
2018						
Creditors and other payables	93,045	93,045	93,045	0	0	0
Finance leases	342	342	256	86	0	0
Total	**93,387**	**93,387**	**93,301**	**86**	**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
2017						
Creditors and other payables	93,749	93,749	93,749	0	0	0
Finance leases	598	598	315	283	0	0
Total	**94,347**	**94,347**	**94,064**	**283**	**0**	**0**
2018						
Creditors and other payables	93,080	93,080	93,080	0	0	0
Finance leases	342	342	256	86	0	0
Total	**93,422**	**93,422**	**93,336**	**86**	**0**	**0**

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 (2017 : $nil).

Summary of financial information of Three Harbours Health Foundation.

	Assets $000	Liabilities $000	Equity $000	Revenue $000
2017	11,614	133	1,462	1,374
2018	13,886	163	2,307	2,242

29 Patient trust monies and restricted funds

	Actual 2018 $000	Actual 2017 $000
Balance at 1 July 2017	85	73
Monies received	663	680
Payments made	(650)	(668)
Balance at 30 June 2018	**98**	**85**

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

30 Explanation of major variances against budget

The major variances in the Statement of Comprehensive revenue and expenses are due to:

- Total revenue for the year was $7.0m greater than the budget largely due to additional funding received for services from the Crown after the finalisation of the budget.

- Expenditure for the year was $23.6m higher than budget which is mostly due to:
    - Personnel costs being $4.4m higher due to additional provisions made on employee entitlements
    - Outsourced services costs $5.9m higher due to unbudgeted outsourced radiology, gastroscopy and colonoscopy services
    - Clinical supplies were $8.3m higher due to unbudgeted costs for clinical supplies, inpatient pharmaceuticals, unbudgeted repairs and maintenance as a consequence of increased volumes
    - Infrastructure and non-clinical costs were higher than budget by $16.0m mainly due to additional make good provisions of $2.2m on leased properties and increased outsourced maintenance costs of $8.8m, reflecting the costs of maintaining older buildings
    - Non-healthboard provider expenses were lower by $ 10.5m due to lower demand community costs.

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

- Receivables being $2.6m lower than planned due to lower than anticipated levels of accrued revenue
- Prepayments were $4.4m lower due to a prepaid pay equity settlement made in advance in prior year but no such occurrence in current year
- Revaluation of land and buildings led to a higher than budgeted value on PPE
- Payables were $3.9m lower than planned due to lower than anticipated levels of accrued expenses
- Employee entitlements were $2.7m higher due to additional provisions made on Holiday pay and MECA settlements.

The major variances in the Statement of Cash flow are attributed to:

- Increased operating cash flow of $9.4m mainly due to lower than budgeted employee payments
- Decreased investing cash flow of $3.1m on capital expenditure.

31 Compliance with Crown Entities Act 2004

The Waitemata DHB Board approved a draft Statement of Performance Expectation (SPE), excluding forecast financial information on 27 April 2018 and this was submitted to the Ministry of Health on 30 April 2018. The forecast financial information was not complete in time due to the delay in receiving funding advice. The DHB did not comply with the requirements of the Crown Entities Act 2004 to have a complete SPE before 1 July each year. The Board completed its SPE on 29 October 2018.

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 2018

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

Opinion

We have audited:

- the financial statements of the Health Board and group on pages 45 to 76 that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity, and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and group on pages 10 to 33 and on page 39.

In our opinion:

- the financial statements of the Health Board and group on pages 45 to 76:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2018; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and group on pages 10 to 33 and on page 39:
  - presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2018, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 31 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw attention to a matter in relation to compliance with the Holidays Act 2003. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 16 on page 65. Our opinion is not modified in respect of this matter.

Basis for our opinion

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

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

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

Responsibilities of the Board for the financial statements and the performance information

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

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board and group for assessing the Health Board and group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board and group or there is no realistic alternative but to do so.

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board and group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board and group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Health Board and group's audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 9, 34 to 38 and 40-44 but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

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

Other than the audit, we have no relationship with, or interests in, the Health Board or group.

Athol Graham
Audit New Zealand
On behalf of the Auditor-General Auckland, New Zealand


St John
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KAINGA ORA
HEALTHY HOMES


VOLUNTEER

“best care for everyone

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

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

“everyone matters

Every single person matters, whether a patient/client, family member or staff member.”

“with compassion

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

“connected

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

“better, best, brilliant...

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

Waitemata
District Health Board

Best Care for Everyone

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