Waitematā
District Health Board

Best Care for Everyone

ANNUAL REPORT

Waitematā DHB 2020|2021

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

Contents

Who we are and what we do

Waitematā DHB is the Government's funder and provider of health services to an estimated 643,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and one of the fastest growing DHBs in the Aotearoa New Zealand, and expect an extra 72,000 people by 2030.

We have an ethnically diverse population, with over one third of our population born overseas. We are relatively affluent, with a large proportion living in areas of low deprivation. However, one in ten of our population live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those who reside in more affluent areas.

We employ more than 8,700 people.

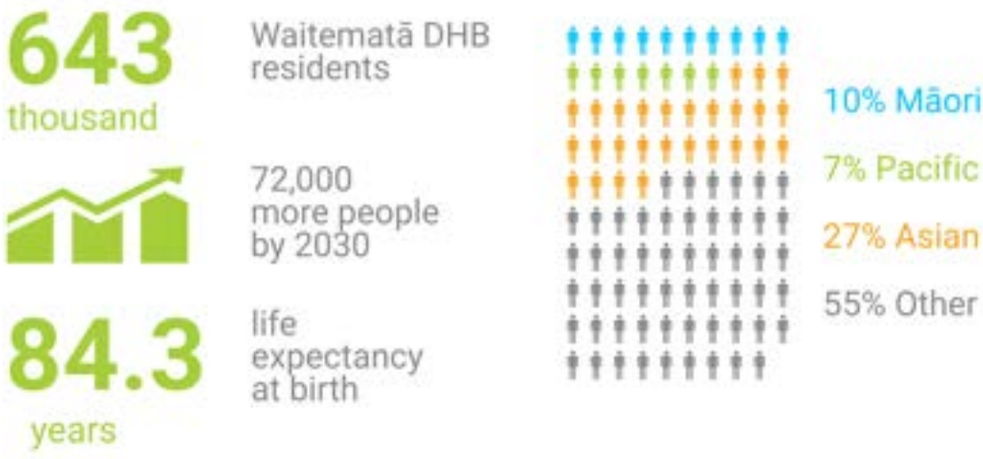
Waitematā DHB provides hospital and community services from 31 sites, including North Shore Hospital, Waitakere Hospital and the Mason Clinic.

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 two other Metro Auckland 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 2020/21 was $2.2 billion.

Our population in 2020/21



Working together to achieve Māori health gain

E ngā iwi, e ngā karangatanga maha, tēnā koutou

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

Ka huri mātou ki te hunga ora, tēnā koutou katoa

Ngā mihi maha hoki ki a koutou, mānawatia a Matariki

Tēnā koutou, tēnā koutou, tēnā koutou katoa

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

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

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

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

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

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

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

(Our partnership will endure and our work will continue)

Gwen Tepania-Palmer
Chair, Kōtui Hauora

Meeting the challenge

We begin this foreword by acknowledging and thanking every single member of our staff. The deft response to each alert level and through the rollout of a comprehensive vaccination campaign has been nothing short of extraordinary. Kia ora koutou katoa – we thank you all for your hard mahi.

Their professionalism, skill and resilience in these unprecedented times has helped our DHB face each phase of the COVID-19 pandemic and enabled us to keep delivering the highest-possible standard of health care, despite the most challenging of circumstances.

Everyone matters

Our DHB has worked closely in the community alongside primary health providers to maintain and develop COVID-19 supports for all those entrusted to our care - in keeping with our core promise of 'best care for everyone'.

We have, in particular, partnered with Māori and Pacific health providers to engage with some of our most-vulnerable communities – making sure equity is of primary consideration every step-of-the-way in our continual efforts to relieve suffering; promote wellness; prevent, cure and ameliorate ill-health.

Similarly, we have built and fostered relationships within our fast-growing Asian community - now accounting for 28 per cent of our district's 650,000-strong population, providing cultural and linguistic support to encourage best-practice in our fight against COVID-19.

The fast stand-up and staffing of multiple community-based vaccination options has been a highlight of our DHB's response to-date and we extend special thanks to all those who have worked incredibly long hours to make them user-friendly, effective and accessible to all.

Thanks also to those staff who have supported the community-based testing centres.

Better, best, brilliant

Other major milestones during the 2020/21 year include:

- major on going earth and infrastructure works, paving the way for construction of Tōtara Haumaru - the new $300 million state-of-the-art hospital building scheduled for completion on our North Shore campus in late 2023
- the announcement of a $40 million funding package to build a new 30-bed inpatient ward at Waitakere Hospital. The work is planned to begin at the end of 2022 in alignment with the Northern Region Long Term Investment Plan, which forecasts that 320 additional inpatient beds will be needed at Waitakere Hospital by 2037
- the opening of E Tū Tanekaha - our new state-of-the-art, 15-bed medium secure unit at Mason Clinic

CEO Dale Bramley, Rt Hon Jacinda Adern and Board Chair Judy McGregor at the opening of E Tū Tanekaha

- the continuation of work on an upgraded $6 million Special Care Baby Unit at Waitakere Hospital
- the opening of a new regional interventional radiology (IR) service at North Shore Hospital – offering an expanded service that reduces the need for patients to travel to Auckland City Hospital (ACH) for treatment during the week
- the opening of Kia Ū Ora – Waitematā Breast Service - bringing multiple procedures and clinics together under one roof at North Shore Hospital to improve access and health outcomes for patients. This was complemented by the opening of our Kia Ū Ora BreastScreen NorthWest Clinic at Westgate - welcome news for those who previously travelled to the North Shore for follow-up assessments after their initial mammogram results.
- the prioritisation of $20 million by the Minister of Health to develop an Intensive Care Unit (ICU) at Waitakere Hospital, pending Government approval of a business case. This is of particular significance because the opening of an ICU will also enable the development of other clinical services at the hospital which would otherwise not be possible.
- the rollout of COVID-19 vaccination options across the Waitematā DHB catchment – including static centres in Henderson, Birkenhead, Albany and Orewa, as well as pop-up options and mobile clinics to service the Hibiscus Coast, Warkworth and more rural areas of our DHB. Organisers worked closely with our Māori, Pacific and Asian health teams to ensure cultural appropriateness and equity were key considerations.

Connected

Waitematā DHB continues to sit at the forefront of technological advancement, thanks to the work of our Institute for Innovation and Improvement (i3).

The i3 development of a national dashboard and app for vaccinations has assisted greatly in managing and monitoring the rollout of New Zealand's vaccination programme.

Multiple other initiatives continue to bring us a step closer to a paperless sector, where key patient information is readily accessible to our clinicians in the safest and most time-efficient way possible.

The ongoing development and use of telehealth has proved invaluable in a COVID-19 environment – offering safe continuity of non-urgent care and a level of convenience that heightens patient experience. A total of 32,000 telehealth consultations took place in 2020/21 and the convenience factor also makes it a viable option for many of our patients to use in the future.

The Medinz primary communications platform pioneered by Waitematā DHB – and now in-use across metropolitan Auckland, has played a pivotal role in keeping GPs, community pharmacies, urgent care, aged care and Māori health providers abreast of the rapidly evolving COVID situation, with almost 5000 healthcare professionals receiving our free updates.

Our work with Kōtui Hauora, a partnership board between the Northern Region DHBs and iwi, has proved invaluable during the COVID-19 pandemic - as has our relationship with the Waitematā DHB Consumer Council. Both alliances help connect us directly with the various communities we are here to serve.

Best care for everyone

Waitematā has one of the highest Māori life expectancies in the country at 79.6 years and a number of key developments during 2020/21 are designed to improve that number even further.

These include plans to trial a lung cancer screening programme among Māori, whose mortality rates from the disease are up to four-times-higher than other ethnic groups.

We've also launched a human papillomaviruses virus (HPV) self-testing research programme, aimed at boosting the number of Māori and Pacific women who are screened for cervical cancer. Both groups are currently the most underserved in the country and this initiative will remove some of the cultural barriers that otherwise contribute to disproportionate mortality rates.

With compassion

Compassion is the cornerstone of healthcare and one of the organisational values that guide our staff in their day-to-day dealings with the communities that we serve.

We see it demonstrated right across our organisation every day – whether it be in our general hospitals, mental health facilities, Wilson Home or out in the community.

With that in mind, we thank them for the exemplary care and professionalism they consistently deliver to our patients and service-users – irrespective of whether we are in a pandemic or not.

Health NZ, the Government's planned new single national health service, is scheduled to replace the country's 20 District Health Boards in 2022 and will work alongside the new Māori Health Authority to meet the future health needs of New Zealanders.

With change comes reflection, and we take this opportunity to acknowledge our DHB's solid service to the community over nearly 21 years. At the same time, we express our sincerest gratitude to the thousands of people who made it all possible.

They were united in their drive to relieve suffering, promote wellness and prevent, cure and ameliorate ill health. Each one of them helped our DHB to make a difference in countless lives and we thank them all.

Dr Dale Bramley

Chief Executive
Waitematā District Health Board

Dr Judy McGregor

Board Chair
Waitematā District Health Board

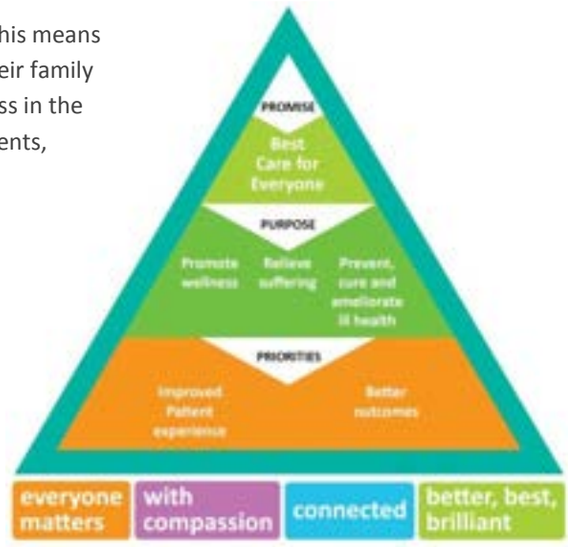
Best care for everyone

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 each 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, which is to:
  - promote wellness
  - prevent, cure and ameliorate ill health
  - relieve suffering of those entrusted to our care.

- We have two **priorities**:
  - better outcomes
  - patient experience.



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

Equity

Waitematā DHB is committed to achieving health equity for all those in our community, in particular for Māori, who make up 10% of our population. Māori are guaranteed rights under Te Tiriti o Waitangi, which means attention to our Tiriti obligations as a Crown entity is paramount to securing Māori health gain.

The health status of the majority of our residents is very good and we are a relatively affluent population. However, some of our population experience inequalities in health outcomes, with ethnicity as the strongest equity parameter. Nearly one in five (17%) of our total population are Māori or Pacific, but 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. Individuals living in these areas tend to experience poorer health outcomes than those living elsewhere.

We are proud of our progress towards health equity, demonstrated by the increase in life expectancy observed for all population groups. Waitematā has one of the highest Māori life expectancies in the motu, at 79.6 years and the rate of increase in Māori life expectancy is similar to that of non-Māori.

We established a Te Tiriti o Waitangi-based partnership board, Kōtui Hauora, with iwi from Tāmaki and Te Tai Tokerau to lead work to improve local and regional Māori health outcomes for Northland, Waitematā and Auckland DHBs. The current focus is on regional initiatives and major system change projects across the priority areas of child and youth health, mental health, and primary health care (prevention and screening).

We want our patients to be cared for by a culturally aware workforce that reflects our communities. Our Māori workforce development strategy has helped increase our total Māori workforce to a current total of 582 permanent Māori employees (7.3% of our workforce). By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population.

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

Key achievements

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

Our achievements in the last year include:

- The life expectancy of our population is the highest in New Zealand, and is increasing for all ethnic groups
- Our smoking rate is among the lowest in New Zealand (2018 Census), with only one in ten in our population regularly smoking; we continue to help more smokers to quit. 92% of pregnant women and 77% of PHO-registered smokers were given advice and help to quit smoking
- Amenable mortality has steadily declined over the past decade, and our rate is the lowest in New Zealand at 64.4 per 100,000 population
- Waitematā DHB has one of the highest 5-year cancer survival rates in New Zealand, and we achieved the Faster Cancer Treatment 90% target
- Our childhood immunisation rates are among the highest in New Zealand, and almost all preschool children are enrolled with oral health services
- We delivered 36,167 elective surgical procedures, exceeding our target by 11%
- Our patients are cared for by a culturally aware workforce that reflects our communities. Our Māori workforce has increased to a current total of 582 permanent Māori employees (7.3% of our workforce). We are on track to reach parity with the proportion of Māori and Pacific people in our working age population by 2025
- We are working hard to manage COVID-19. By the end of June 2021, our residents had been tested for COVID-19 more than 335,000 times and nearly 86,000 people had received at least one dose of the COVID-19 vaccine.

84.3

Our life expectancy is higher than NZ as a whole

64.4 DEATHS PER 100,000

Our amenable mortality rates are among the lowest in the country

10%

Our smoking rate is among the lowest in NZ

437 BEDDAYS PER 1000

Our population is spending less time in hospital

We are working hard to vaccinate our population against COVID-19

Avoidable hospital admissions for children are decreasing and rates for Māori are no higher than those for non-Māori

Our COVID-19 response

A region-wide effort

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

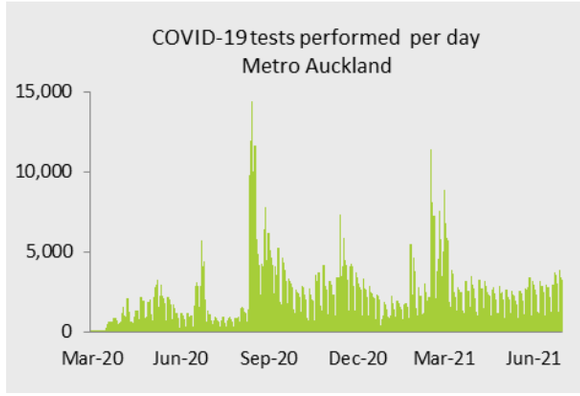
Working with Counties Manukau, Auckland and Northland DHBs, the region is delivering a whole-of-health-system response to COVID-19 through the Northern Regional Health Coordination Centre (NRHCC). The NRHCC is responsible for community COVID-19 testing and outbreak control, surveillance testing of all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

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

A pop-up COVID-19 community testing centre in Albany, run by Whanāu Ora

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

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



Testing capacity across Metro Auckland rapidly increased to meet demand

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

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

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

Working with our Māori and Pacific partners, flexible services are provided to support vulnerable populations. During periods where there is no additional need for increased COVID-19 testing, the mobile units support whānau to access primary care, welfare and other social services support. Te Puna Manawa HealthWEST delivers this kaupapa Māori, nurse-led service in Waitematā DHB, seeing 1,382 patients in 2020/21.

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

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

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

Preparing our hospitals

Services across Waitematā DHB continue to develop and improve systems to ensure our services are prepared for the resurgence of COVID-19 in our communities. This means that we maintain a high level of readiness and were able to respond quickly and effectively to the Delta variant outbreak discovered in Auckland in August 2021.

We have robust Operational and Readiness Plans, which are regularly reviewed and amended to reflect learnings from previous outbreaks and the changes that different variants bring.

Additional emergency department (ED) staff have been brought on board to enable screening of patients who present to ED, to assess their COVID-19 risk and then stream them into care pathways. At all alert levels, patients arriving at ED are triaged and suspected COVID-19 patients (blue stream) are cared for in COVID-19 designated areas (blue zones) with staff using appropriate personal protective equipment (PPE). This increase in ED staffing allowed us to allocate dedicated staff members to work in the Blue or White stream in the emergency department at North Shore Hospital, which lowers the risk of cross infection.

There have been additional full time positions allocated on ward 11 and other medical wards to help manage COVID-19 patient pathways, and 3.5 FTE of additional cleaning positions have been added to ensure we have 24/7 cleaning services across both our hospitals.

Blue Zone staff have weekly COVID-19 safety huddles to embed and ensure safety protocols are correctly followed. N95 masks are now mandated in Blue Zones and PPE use is checked and audited.

Staff across all of our services received training in the correct use of PPE, including mental health and community teams, such as district nurses. N95 mask fit-testing is a priority, and we monitor the proportion of staff who complete fit testing. In our mental health services, trained N95 fit-testers ensure that fit testing can be done within the service; nurses in our inpatient mental health units are being trained to perform COVID-19 swab tests.

Our Readiness Plan has a phased response, based on the volumes of cases in the community and the demand for inpatient beds. Initially patients will be directed to specified wards with negative pressure single rooms, and designated HDU beds. These are known as our COVID ready beds or Blue Zones.

If demand exceeds the number of beds available in the Tower Block, our Elective Surgery Centre (ESC) can be quickly converted into a dedicated facility for COVID-19 patients. Given ESC is our elective surgical centre and the heart of our planned care programme, we are currently redeveloping Ward 11, to be commissioned as COVID-19 Ready. This will mean the whole ward will be redesigned into 3 pods, with a total of 16 separate rooms all providing negative pressure as required. This work will see this ward as our primary COVID-19 ready unit.

The ESC can be re-configured to provide ward-level care for initially 12 COVID patients in negative pressure rooms, and numerous COVID-19 patients were admitted over the August 2021 outbreak. A dedicated medical team (Respiratory and Infectious Diseases physicians) has been developed to manage any COVID-19 patients. An on-call team of anaesthetic technicians has also been established to help manage patients requiring breathing support. Training has been provided to perioperative nurses and anaesthetic technicians to provide them with ICU skills if required. This team will be available to provide these skills in Ward 11, once the redevelopment and commissioning is complete.

The Elective Surgery Centre can be transformed into a dedicated COVID-19 facility if required

Dedicated Blue Zones have been developed across both our hospitals, with physical barriers, signage and additional doors to create boundaries and reduce air flow between zones.

Air handling functions (air exchange rates and negative pressure capability) were improved in ESC and Blue Zone wards. More than 50 HEPA filters are now located at the fringes of the Blue and White Zones and in large circulation areas, such as foyers to absorb unwanted microbes, improving air quality in these areas.

A new ventilation system has been installed to improve air quality

Portable cabins outside our emergency departments were used during the original Alert Level 4 lockdown in 2020 to provide safe screening areas and were an effective tool in our on-going efforts to reduce risk of community spread. These were reinstalled in August 2021 with the emergence of the Delta outbreak. They will be retained into the future with plans to activate and staff them should there be a significant surge of COVID in the community.

We are able to continue to safely care for all patients during a COVID-19 outbreak. Plumbing for dialysis patients has been installed in the Blue zone of ward 10, and a six bedded blue zone has been stood up at He Puna Waiora (inpatient mental health unit) if required.

Facilities upgrades are also underway in our Specialist Mental Health and Addiction Services to improve infection control, with blue zone areas identified for urgent Mental Health community assessments. Additional staffing capacity can be added to increase security and operate blue stream models of care.

We have developed a Maternity COVID-19 plan should a COVID-19 positive patient arrive in labour, with further work being undertaken in our Birthing unit to improve the air handling units to create an appropriate labour assessment and birthing “Blue Zone” for our expecting mothers.

A community services response framework has been developed to guide services in delivering care and community services continue to go in to people’s homes, with appropriate PPE, to provide on-going care. Breast screening have run assessment clinics for high risk women so their care is not disrupted and Auckland Regional Dental Service dental clinic upgrades are occurring to meet infection prevention and control (IPC) and dental council guidance.

The threat of COVID-19 will be with us for some time but we are prepared and ready to scale up our response to keep our patients, staff and the community safe, should we need to.

Our COVID-19 vaccination roll-out

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

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

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

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

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

The Albany vaccination centre opened in June 2021 and can vaccinate up to 500 people per day

Many general practices and urgent care facilities are now delivering vaccines. The Waiheke Island Medical Centre was the first GP clinic to begin vaccinating its patients against COVID-19 in May 2021, with more than 150 doing so by September 2021, and more vaccinating practices planned. Delivery of vaccines by community pharmacies is also ramping up in 2021.

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

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

The Waitematā DHB staff vaccination clinic opened in March 2021, in line with the Government's COVID-19 vaccination plan, and as at the end of June 2021, 86% of staff had received at least one vaccination, and 81% were fully vaccinated.

By the end of June 2021, Ministry of Health data shows 9.7% of those in our population aged 12 years and over living in our DHB area (nearly 48,000 people) were fully vaccinated.[1] At this time only those aged 16 and over were eligible for vaccination.[1]

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

By 7th December 2021, 95% of eligible people (aged 12+) residing in the Waitematā DHB area had received at least one dose and 91% were fully vaccinated.[1]

[1] The data presented here has been provided by Ministry of Health and is based on the Health Service User eligible population. These volumes show vaccination of those living in our catchment; the volumes presented on p47 report vaccinations provided by our DHB.

Delivering the best care for everyone

'Best care for everyone' is our promise to the Waitematā community and the standard for how we work. 2020/21 saw some great examples of how we deliver the best care for everyone in line with our values.

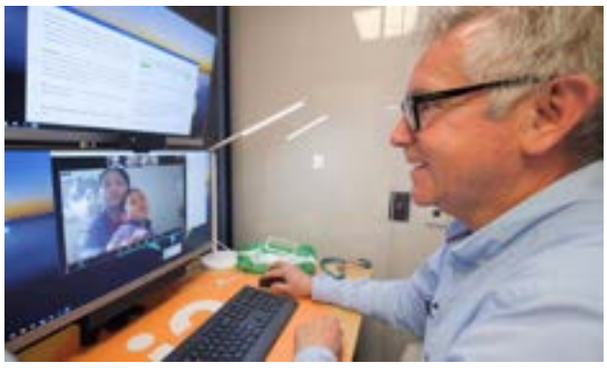
Keeping people connected

"connected"

COVID-19 has changed the way we work and continue to deliver healthcare to our communities.

Telehealth appointments have become crucial to continuing patient care and keeping our people connected with health services. With digital health appointments becoming our new normal, a telehealth pod was installed at North Shore Hospital. The soundproof pod includes a computer, phone and online toolkit so that doctors can call (via video or phone) patients at their home or workplace. An entire telehealth toolkit was developed to assist with the delivery of virtual clinics.

During Alert Level 4 in 2020, nearly 10,000 appointments were conducted by phone or video each month. Many patients continue to choose the convenience of telehealth consultations outside of lockdown periods, with 32,000 taking place in 2020/21.



Dr David Grayson, Clinical Director ENT, in the new telehealth pod

Laboratory team excels

"better, best, brilliant"

During the COVID-19 resurgence in August/September 2020, our laboratory team played a critical role in the metro Auckland testing programme.

The introduction of molecular testing for COVID-19 in our laboratories shortened the regional turnaround time of results, from up to two days to 12-18 hours. At the peak of the response, our laboratory processed 1,800 swabs a day.

Laboratories Manager, Lee-Ann Weiss, won the 2021 Health Excellence award for Leadership for her contribution to driving these changes and commitment to her staff during such a busy and challenging time.

Safe care in an improved environment

"with compassion"

E Tū Tanekaha, Waitematā DHB's new inpatient facility at the Mason Clinic for forensic psychiatry, was opened in April 2021 in Point Chevalier.

The 15-bed, medium secure unit is part of an extensive programme of facility upgrades and expansion for the regional forensic psychiatry service. E Tū Tanekaha, which means stand strong Tanekaha, was designed to flexibly accommodate different patient populations requiring secure care in a clinically and culturally appropriate environment. There are multiple therapy spaces, including an occupational therapy kitchen, which allows the development of vital life skills, and a sensory modulation room. Two outdoor areas allow for sport and relaxation.

Prime Minister Jacinda Adern with members of our Mental Health and Pacific Health teams at the opening of E Tū Tanekaha

500 wāhine Māori

"everyone matters"

An initiative to find 500 wāhine Māori in the Northern Region, who are overdue for a breast screen, won the Waitematā Health Excellence award for Equity in 2021.

The project is a Māori Health Pipeline initiative aimed at improving equity in breast screening for Māori wāhine who, as a population, have the lowest coverage and poorest outcomes for breast cancer.

BreastScreen Aotearoa (BSA) and Primary Health Organisations worked together to find eligible Māori wāhine. The project identified and contacted nearly 1,600 wāhine in the Northern Region who were not enrolled with breast screening providers; 730 of these wāhine are now enrolled and 460 have gone on to have a mammogram.

Innovation and improvement

Informing the COVID-19 response

The Waitematā DHB Institute for Innovation and Improvement (i3) analytics team contribute significantly to the COVID-19 response.

Head of Analytics, Delwyn Armstrong, and the team initially developed the Northern Region COVID-19 dashboard, which displays information on positive test results and inpatients across the Northern Region, as well as the sector's ED and ICU capacity during surges. The next step was the development of a national dashboard and app for vaccinations. The dashboard is used by local, regional and national leaders in managing and monitoring the progress of the vaccination roll-out.

The COVID-19 vaccination dashboard gives a live picture of vaccination coverage across the Auckland region

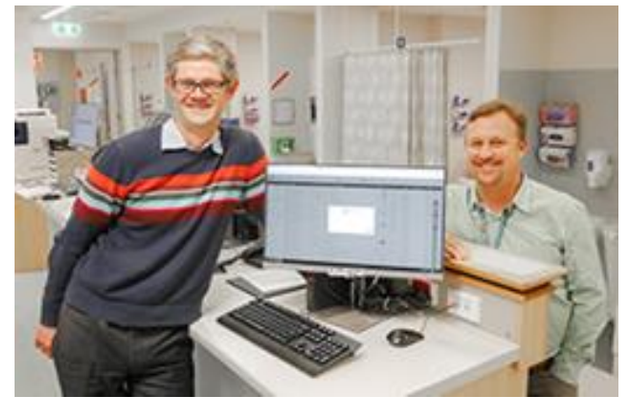
Dr Lara Hopley, Clinical Advisor of Digital Innovations, leads Waitematā DHB's developments in electronic ordering systems. Dr Hopley is also the clinical lead on the national eOrders system for the COVID-19 swab testing in Managed Isolation and Quarantine facilities and Community Testing Centres around New Zealand.

Launched in 2020, the Éclair Touch COVID-19 app uses barcode scanning to link the COVID-19 swab with the individual's unique National Health Index (NHI) number, removing the need for paper orders to be sent to laboratories. This reduces the time needed to process tests in the laboratory by around three minutes per swab, as well as labelling errors at the point of swabbing or transcribing errors at the laboratory.

Recently the Digital Innovations team developed and launched the 'phinter' - a phone and printer combined in a three-dimensional printed chassis - along with a barcode wristband to support paperless blood collections in the Acute Day Unit. This reduces any possible duplication or error, and streamlines processes for patients and clinicians.

ED system designed for clinicians

Waitematā DHB's two Emergency Departments (EDs) are now using an electronic whiteboard solution designed around clinicians' user experience. The Centric whiteboard lists all the patients in the ED, allows clinicians to view, at a glance, the status of laboratory or radiology requests and newly prescribed medications, and provides an easy, faster link into almost every other clinical system. It can also be viewed as a map of the ED beds with direct links to the patients in each bed.



Waitematā DHB information systems clinical change manager David Ryan and Dr Willem Landman with the Centric Whiteboard software at North Shore Hospital ED

Dr Willem Landman, Head of Division, Speciality Medicine and Health of Older People, says the system saves time and has improved the running of the ED.

"The biggest benefit is tying in a whole load of different systems into something the user can access from a single place. It also allows us to look at where spaces are in the department and how to direct traffic through the department."

Outpatients coming online

A large amount of work has gone into improving information systems for outpatient clinics over the past few years. The use of email validation and digital postage systems means that we have validated over 500,000 email addresses and now send around 50,000 letters per month through digital post, rather than traditional paper-based post. The Breast Screening service went live with digital post in December 2020. Together, this saves around $50,000 per month, and frees up many hours of labour to perform higher value tasks.

Recently, the outpatients project focused on the design and build of an online booking system which will allow patients to view and manage (i.e. change or cancel) their appointments online. We plan to go live with online booking for our first specialty in October 2021.

Sustainability

At Waitematā DHB, we work collectively for all life, with an aim to create positive value for our people and planet.

The challenges over the last 12 months reinforced our efforts to reduce our environmental footprint and achieve long-term health outcomes for our staff and communities.

A key element is how we approach sustainability in our organisation. We established a Sustainability Steering Group to help shape and guide our refreshed strategies and framework through the next phase of our sustainability journey. We reconvened our Sustainability Champions group to support initiatives at all levels. Our key target areas are sustainable procurement, energy and carbon management, waste and water management, and designing the built environment.

Decarbonising our DHB

The past year saw significant developments in carbon management and reduction. Waitematā DHB measures our greenhouse gas (GHG) emissions through Envirocare Toitū carbonreduce and successfully achieved re-certification in October 2020.

To lead the country towards our net zero goal by 2050, the Carbon Neutral Government Programme (CNGP) was launched in December 2020 and set a target of carbon neutrality by 2025 for public sector organisations. We are working with other DHBs, the Energy Efficiency and Conservation Authority (EECA) and government Ministries to meet the programme requirements.

We are increasing our emissions reporting boundaries within Toitu carbonreduce in line with government requirements. We added an Energy Efficiency Officer to our sustainability team and commenced an Energy Transition Accelerator programme, both supported by EECA, to identify opportunities to decarbonise our operations and future investments.

Work is underway to assess our fleet of vehicles, reduce where appropriate and transition to battery electric vehicles (BEVs) where possible.

Decarbonising our DHB requires everyone; we are reviewing our messaging and communication on the drivers for change and the intrinsic link between planetary and human health. While recognising and reducing our carbon emissions, we must also be prepared to provide our services in a world impacted by climate change. Assessing climate-related risk (e.g. extreme weather events, sea level rises, increasing temperatures) and developing a framework for adaptation is a large piece of work that we developed this year with other DHBs.

Sustainability within the community

Over the last two years, our Sustainability Coordinator worked closely with Asian health and cultural health services to promote sustainable living practices that can enhance health and wellbeing and access to health services for these communities.

English is often a second language for members of the Asian community and can lead to barriers to accessing appropriate health care. In particular, the use of public transport or connecting with community support can be difficult. The Sustainability Coordinator, with Asian Health services, provided translations of public transport timetables and valuable sustainability information to facilitate affordable, accessible services and healthy sustainable living practices.

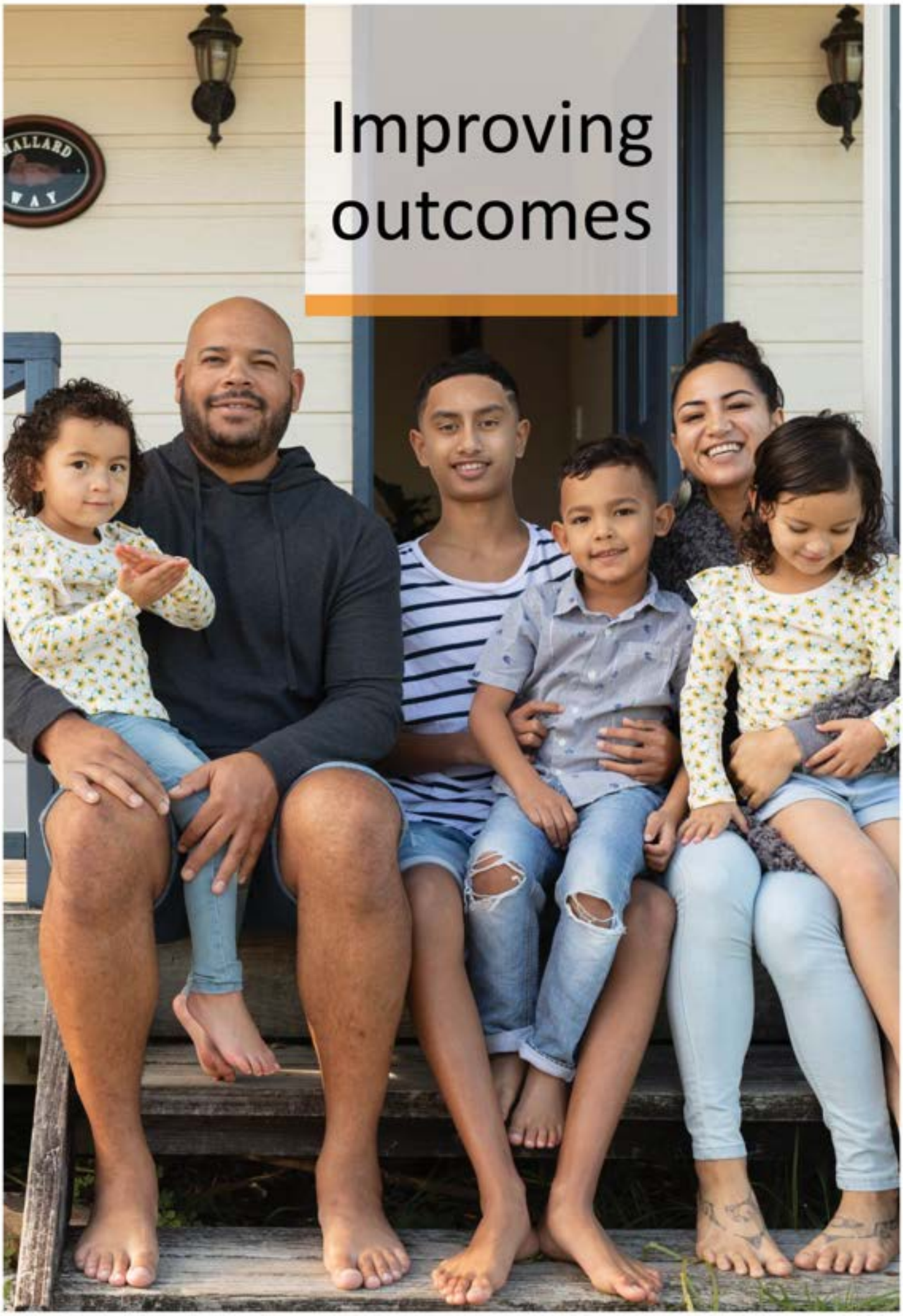
Cutting waste

Over the past year, our waste management programmes were affected by the COVID-19 response. PPE use created an increase in waste sent to landfill, and recycling programmes were impacted by lockdown restrictions. Despite the challenges, we achieved some positive results. Our medical waste volumes were reduced by 10t (tonnes) over the period and our recycling volumes increased by nearly 60t.

Over the last two years, battery and single-use scissor recycling was successfully rolled out across the organization. The scissors are collected by Interwaste, sterilised and recycled into new objects, such as chair legs and handles. The batteries are also collected for recovery and recycling of key elements.

Efforts continue to ensure that consumables, equipment or furniture that can no longer be used in Waitematā DHB are kept out of landfill. Over 44t of items were directed to community groups and charities last year. In addition, these items were diverted from landfill: 135t of waste for recycling, 10t of paper, cardboard and compostables, and 7t of electrical equipment for material recovery and recycling.

Improving outcomes



Making a difference to the health of our population

Our performance framework demonstrates how the services we fund or provide contribute to the health of our population and to achieving our longer-term outcomes and the expectations of the Government. Our progress against these indicators suggests we are a high performing DHB and are improving the health of our population.

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

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

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

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

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

Overall, the progress against our performance measures shows we are delivering on our promise of 'best care for everyone' and are making a positive difference to the health of our population.

WAITEMATĀ DHB RESIDENTS HAVE THE HIGHEST LIFE EXPECTANCY IN THE MOTU, AT 84.3 YEARS

Our life expectancy continues to improve, reaching 84.3 years (2018-20), the highest in the motu and an increase of 1.6 years over the last decade. Life expectancy for our Māori population increased by 1.8 years over the past decade and the gap in life expectancy continues to gradually close. Life expectancy for our Māori (79.6 years) and Pacific (78.2 years) populations remains significantly lower than other ethnicities. The life expectancy gap between Pacific and other (non-Māori, non-Pacific) groups has increased 1.3 years since 2010.

OUR AMENABLE MORTALITY RATE REDUCED BY 21% OVER THE LAST 10 YEARS AND IS THE LOWEST IN NEW ZEALAND

Waitematā DHB has the lowest rate of amenable mortality (deaths potentially avoidable through healthcare intervention) in New Zealand. In 2018 (the latest available data), 64.4 deaths per 100,000 population were considered amenable, which is lower than the national rate of 88.9 per 100,000. An estimated 506 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were amenable in 2018.

OUR CHILDREN STAY OUT OF HOSPITAL WITH LOW ASH RATES FOR THOSE AGED 0-4 YEARS

Our children receive a great start to life, resulting in fewer hospitalisations. The number of preschool children admitted to hospital for conditions that are considered ambulatory sensitive (i.e. potentially avoidable though primary healthcare) such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall. Our ASH rate for Māori children is similar to that of non-Māori, and our overall ASH rate is significantly lower than the national rate. Although it is decreasing rapidly, the rate of ASH admissions for our Pacific children is twice as high as that for other ethnicities in Waitematā DHB.

Understanding our performance

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

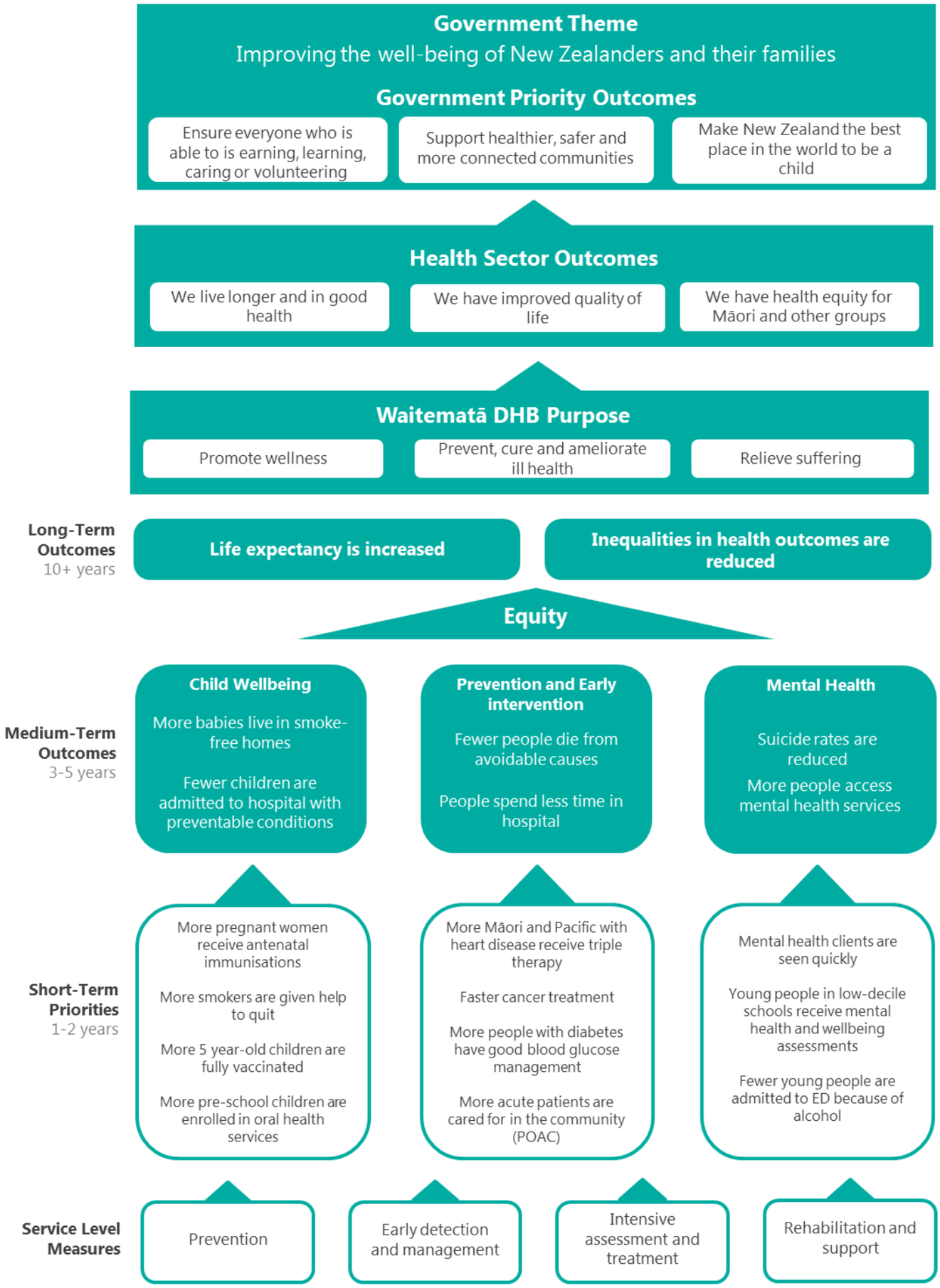

performance has improved


performance has worsened


no change in performance.

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

Performance and intervention framework



Improving population health

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).

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

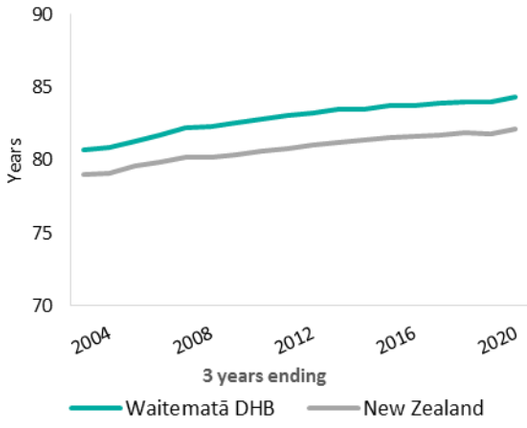
PEOPLE IN WAITEMATĀ DHB LIVE 2.2 YEARS LONGER THAN NEW ZEALAND OVERALL

We have the highest life expectancy in New Zealand at 84.3 years (2018-20[2]), which is 2.2 years higher than New Zealand as a whole.

LIFE EXPECTANCY INCREASED BY 3.6 YEARS SINCE 2001

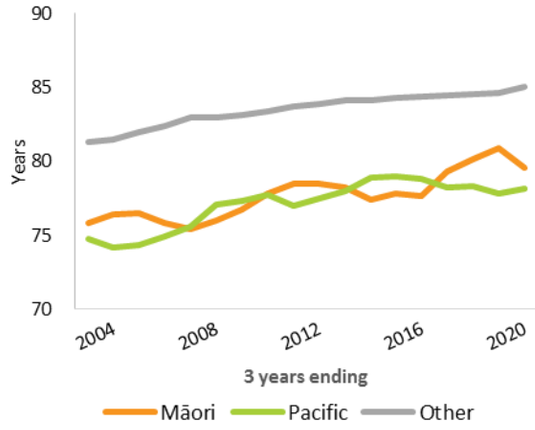
In Waitematā DHB, life expectancy increased by 3.6 years since 2001, a greater increase than that for New Zealand as a whole (3.1 years).

LIFE EXPECTANCY AT BIRTH:
3-YEAR COMBINED ESTIMATE



Life expectancy differs significantly between ethnic groups in our district. Māori and Pacific people have a lower life expectancy than other ethnic groups, with a gap of 5.5 years for Māori and 6.9 years for Pacific.

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



Māori have a life expectancy of 79.6 years, and Pacific 78.2 years, significantly shorter than the 85.1 years experienced by other ethnicities.

INEQUALITIES EXIST: LIFE EXPECTANCY OF OUR MĀORI AND PACIFIC POPULATIONS IS 5-7 YEARS SHORTER THAN OTHER ETHNIC GROUPS

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

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

The life expectancy gap between Māori and other populations is largely due to mortality from cancers, in particular lung cancer, and chronic conditions, including cardiovascular disease. Smoking is a major contributory factor to these conditions, and the Māori smoking rate is more than double that of the total DHB rate (22% vs. 10%).

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

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

Child Wellbeing

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

Children grow up smoke free

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

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

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

Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities, with 22% of Māori living in Waitematā DHB reporting daily smoking in the 2018 Census, compared with 9% of non-Māori. The rate of smoking in pregnancy and likelihood of worse pregnancy outcome for mothers and babies is higher among Māori women and those living in areas of high deprivation. Census data shows that younger Māori women (aged 20-34 years) are a group of particular concern, with nearly 40% of this group reporting regular (daily) smoking. In 2020/21, 173 women in our community smoked when first pregnant, and 62% (108) of these were Māori.

Our focus is on reducing equity gaps for Māori.

More babies living in smokefree homes

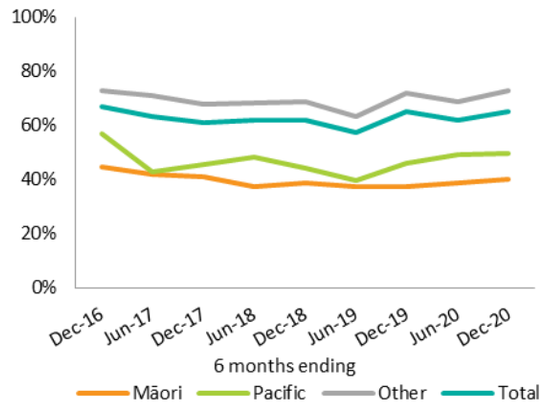
64% of babies live in smokefree homes ↑ 2%

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

In the 12 months to December 2020 (the latest available data), 64% of all 6-week-old babies born in our district lived in smokefree homes. This is a 2% improvement from the December 2017 result.

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

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



More Māori and Pacific babies are exposed to smoking in their homes, with only 39% of Māori and 50% of Pacific babies living in smokefree homes. Programmes like the maternal incentives smoking cessation programme aim to improve performance against this indicator and reduce the inequities for our Māori and Pacific populations.

Child Wellbeing

Keeping children out of hospital

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

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

ASH rates are much higher for Māori and Pacific children. Primary health care access and quality, as well as underlying determinants of health (e.g. housing quality and crowding, exposure to second-hand cigarette smoke, poverty) may influence the incidence of ASH.

Fewer young children are admitted to hospital with preventable conditions

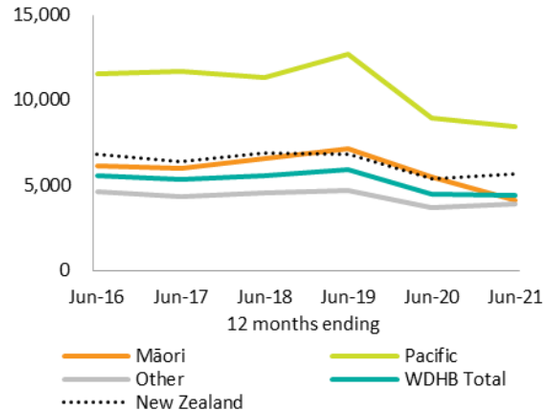
4,392 PER 100,000 ambulatory sensitive admissions ⇩ 21%

In the 12 months to June 2021, there were 4,392 admissions per 100,000 children in our 0-4 year-old population (1,764 events) that were considered to be ambulatory sensitive.

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

	Māori	Pacific	Other	Total
Asthma and respiratory infections	153	204	609	966
Gastroenteritis	44	52	283	379
Skin conditions	36	43	82	161
Dental conditions	35	35	92	162
Other	14	15	67	96

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



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

It is pleasing to note that ASH rates in 2020/21 have not returned to pre-COVID-19 levels, and for Māori the decline (i.e. improvement) has continued, so there is no longer a gap between Māori and other ethnicities. ASH rates for our total population are now 21% lower than in June 2018 and rates have reduced even further for our Māori (38%) and Pacific (26%) children. Even with this significant reduction, Pacific ASH rates are nearly twice as high as those for other ethnicities.

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

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

27% of smokers were helped to quit

8%

54% of pregnant vaccinated against pertussis

44% of pregnant women were vaccinated against influenza

87% of five year olds were fully vaccinated

2%

98% of pre-schoolers were enrolled with oral health services

Delivering on our priorities

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

Support to quit offered by primary care includes referral to a smoking cessation programme and prescribing nicotine replacement therapy, other medicines or behavioural support. In the 15 months to June 2021, 27% of smokers received cessation support in primary care, which is an 8% reduction from the 29% recorded in 2019/20.

More than half (52%) of all avoidable hospital admissions for Waitematā DHB children in 2020/21 were for respiratory conditions. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine-preventable conditions and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Vaccination rates are increasing. For babies born in 2021, 54% of mothers received a pertussis vaccination during pregnancy and 44% received an influenza vaccination; however, the rates are much lower for Māori and Pacific.

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

In the year ending June 2021, 87% of all five-year-old children were fully vaccinated. This is higher than the national rate, but a decrease on the previous year. COVID-19 meant some families were reluctant to attend GPs or receive home visits for vaccinations. Immunisation rates are also significantly lower for Māori children. We are implementing a targeted action plan to improve immunisation in Māori and Pacific children.

Dental conditions account for nearly 10% of preventable hospital admissions in pre-school children. Engagement with oral health services facilitates prevention and early treatment of dental problems. Our data reports high levels of enrolment overall*, but Māori children in particular miss out on dental care, with only 74% estimated to be enrolled.

* The numerator is the actual number of children enrolled with oral health services and the denominator is an estimated population projection (from Stats NZ). The projected population is likely to be less accurate at ethnicity level.

Knowing every child – Uri Ririki Child Health Connection Centre

Opened in 2019, Uri Ririki - Child Health Connection Centre is a coordination hub focused on ensuring that babies and children receive their free health checks and immunisations on time.

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

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

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

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

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

Healthier homes for healthier children

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

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

This service is delivered by social workers who complete housing assessment and provide broader bio-psychosocial supports to whānau. Many Māori and Pacific whānau experience varied and complex housing needs. Pacific whānau make up 46% of the referrals received by Noho Āhuru - Healthy Home service to date.

The use of social workers allows for individualised support plans to be developed with whānau to address their housing, health and social barriers.

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

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

Prevention and early intervention

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

People live longer, healthier lives

Amenable mortality rates measure the number of deaths in people aged under 75 years that could be avoided through effective health prevention, detection and management interventions at an individual or population level.

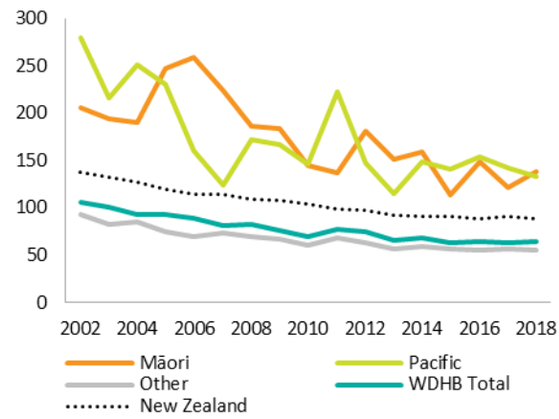
Fewer people die from avoidable causes

64
DEATHS PER 100,000

amenable mortality rate

2%

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



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

In 2018* (the latest available data), an estimated 506 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were amenable; this is a rate of 64 deaths per 100,000 population. The rate has increased slightly since recording an all-time low in 2015, but the overall trend shows the proportion of amenable deaths is in decline.

The biggest contributors to amenable mortality are heart diseases (30% of all amenable deaths) and those cancers considered to be amenable (26%). Cerebrovascular disease (e.g. stroke), diabetes and respiratory conditions are also significant contributors.

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

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

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

Prevention and early intervention

Reducing the demand for acute care

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

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

The demand for acute care can be reduced by effective management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between healthcare providers.

People spend less time in hospital

437 acute hospital bed days

PER 1,000 POP

2%

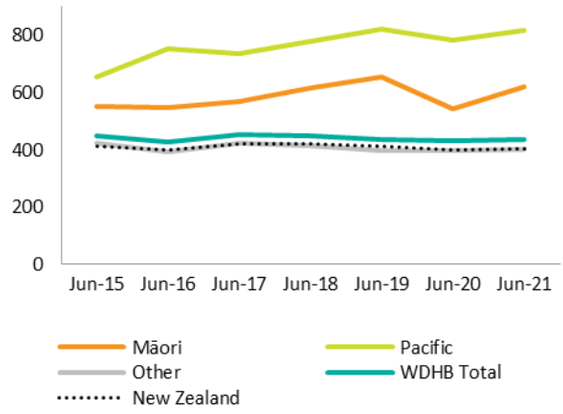
Acute hospital bed days per capita is a measure of the demand for unplanned care in hospitals.

In the 12 months to June 2021, Waitematā residents spent more than 280,000 days in hospital receiving acute care, with nearly 78,000 acute admissions. This equates to 437 days in hospital for every 1,000 people in our population (standardised for age).

Although our overall standardised rate of acute bed days is slowly declining (i.e. improving), it remains higher than the national rate (402 per 1,000 population). The rate of acute bed day use is significantly higher for Māori (622 per 1,000) and Pacific people (818 per 1,000).

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

STANDARDISED ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



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

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

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

64% (M)
71% (P)
of Māori and Pacific people received triple therapy


8%

90%
of cancer patients were treated quickly


1%

63%
of people with diabetes have good blood sugar management

11,797
acute patients were cared for in the community


30%

Delivering on our priorities

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

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

As at June 2021, 63% of all those with a previous CVD event were dispensed triple therapy medication. The rate for Pacific was higher, at 71%. The use of triple therapy increased by 8% for Māori and 6% for Pacific compared with the previous year.

Diabetes is also a major and increasing cause of disability and premature death. Poorly controlled diabetes can lead to serious damage to the heart, kidneys, eyes and nerves.

The management of diabetes is multi-faceted and includes patient education, lifestyle intervention and pharmacological treatments. Managing blood sugar (HbA1c levels) can reduce a patient's risk of complications associated with diabetes. As at June 2021, 63% of patients with diabetes had an HbA1c level of less than 64mmol/mol, indicating their diabetes is well managed. Diabetes is less well managed in our Māori and Pacific communities, with only 51% of Māori and 50% of Pacific people with diabetes recording ideal blood sugar levels. In 2020/21, Pacific-focused diabetes self-management programmes were held with church, community and family groups where whānau could talk to a registered nurse about their condition and receive general health information, including about COVID-19 vaccination.

Prompt investigation, diagnosis and treatment of cancer increases the likelihood of better outcomes. Care of cancer patients continued as usual throughout Alert Level 3 in Auckland in August-September 2020 and February-March 2021. In 2020/21, 90% of cancer patients received their first treatment within 62 days of referral, achieving the 90% target improving slightly on the previous year's result.

Primary Options for Acute Care (POAC) provides access to investigations, care or treatment in the community so that patients can be safely managed by primary care at home, avoiding or shortening hospital stays. Service provision was restricted in 2019/20 due to COVID-19, but has since returned to normal levels. 11,797 patients benefitted from POAC-funded community care in 2020/21.

Te Oranga Pūkahukahu – Māori-led lung cancer screening

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving mental health and wellbeing

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

Improving mental health outcomes

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

Fewer deaths from suicide

8.6 deaths from suicide

PER 100,000

4%

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

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

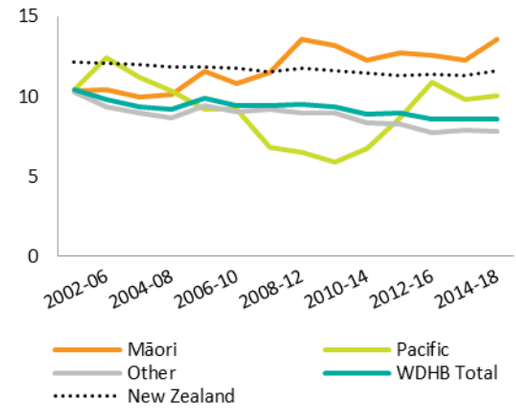
In the five years to December 2018, an average of 53 lives were lost to suicide each year in our district, a rate of 8.6 deaths per 100,000 population. This is lower than the national rate and is declining. Māori are disproportionally affected by suicide, and their rate is increasing.

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

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

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

SUICIDE RATE
DEATHS FROM SUICIDE, PER 100,000 POPULATION



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

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

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

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

Improving mental health and wellbeing

Better access to mental health support

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

More people are helped by mental health services

3.6% of people accessed mental health services ⇧ 6%

In the 12 months to June 2021, 3.6% of the total Waitematā DHB population (23,000 people) were seen by DHB and NGO specialist mental health services.

The prevalence of mental distress is much higher in Māori than other ethnicities, and 7.1% of our Māori population accessed mental health services in 2020/21. The proportion of all people accessing mental health services has increased by 6% over the last three years.

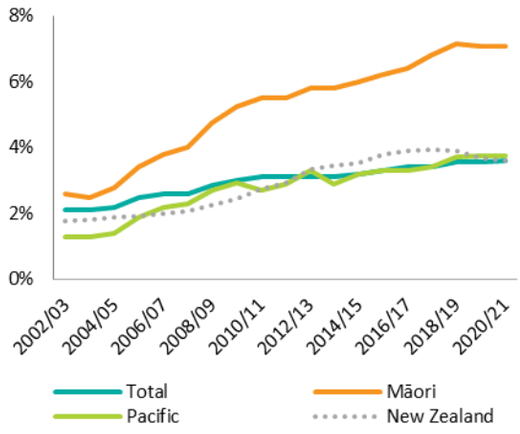
Our Specialist Mental Health and Addiction Services comprise community hubs, acute inpatient units, a Liaison Psychiatry team, Whītiki Maurea (Māori services); Takanga a Fohe (Pacific services); Child Youth and Family Mental Health Services; Regional Forensic Psychiatry Services and Community Alcohol and Drug Services (CADS). Our addictions services operate across Metro-Auckland and our forensic services cover the Northern Region.

We contract around 20 community mental health service providers, who saw close to 5,500 clients in 2020/21. In addition, Waitematā DHB works with primary care to deliver mental health support programmes through general practice and other community support services.

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

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

PROPORTION OF POPULATION ACCESSING MENTAL HEALTH SERVICES



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

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

An improvement programme is underway at our adult mental health inpatient units, He Puna Waiora and Waiatarau, to ensure that all clients receive high-quality care in a safe environment. A cultural welcome is now available for people entering the units and family/whānau participation and engagement is improved. We are implementing a new model of nursing care and improving access to clinical supervision for nursing staff and health care assistants. Leadership coaching is underway to strengthen the leadership and culture of our teams. The clinical psychology framework and model of care is being reviewed. A new assessment and treatment pathway has been developed for people needing specialist rehabilitation services and we are improving our skills and knowledge in working with alcohol and substance misuse.

96% of mental health clients were seen quickly

5%

82% of young people received wellbeing assessments at school

9%

4.7% of youth ED presentations were alcohol related

5%

Delivering on our priorities

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

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

In 2020/21, 96% of clients referred non-urgently to DHB-provided mental health services were seen within 8 weeks, and 73% were seen within 3 weeks.

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

In the 2020 school year, 82% of eligible Year 9 students in decile 1-5 schools received a HEEADSSS wellbeing assessment. This is lower than previous years due to school closures during COVID-19 lockdowns. School nurses continue to complete assessments for all Māori, Pacific and high risk students who missed out on HEEADSSS in 2020.

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

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. Our hospitals have implemented alcohol data collection in ED. All 12,511 young people aged 15-24 years old and admitted to our EDs were screened for alcohol in 2020/21, with 582 (4.7%) admissions a result of excessive alcohol consumption. This is a decrease on the 4.9% reported in the previous year.

New support service helping people get back to work

Getting into work is a goal for many people coping with mental health issues. Not only does employment contribute to their income, it can support people to build self-esteem and confidence, and give a sense of purpose. Finding a job can be difficult and support is needed.

Individual placement and support (IPS) is an evidence-based integrated approach to employment support for people with serious mental illness or those experiencing drug and alcohol dependence to gain and maintain employment. IPS integrates employment support with mental health care.

After the success of a prototype trial, the programme was expanded across the Auckland region, with 500 clients receiving help by June 2021.

In 2016, Waitematā DHB's Planning, Funding and Outcomes team developed a proposal for a four-year project to set up an employment support service aligned with IPS principles and practices. The project aimed to increase employment and enhance financial independence, improve mental and physical health, and reduce socio-economic, physical and mental health disparities for Māori.

The employment team for the IPS prototype comprised two experienced employment consultants and one part-time IPS supervisor from an established employment support service provider with experience in implementing IPS programmes. This team was integrated with two Waitematā DHB mental health teams, the West Auckland Adult Community Mental Health Service and the Henderson site of the Moko (Māori Mental Health) Service. Relationships were established with the local Work and Income service centre and regional staff.

The employment team began accepting referrals from the mental health teams in June 2018. The initial prototype targeted people aged 18-35 years who wanted to work but were unemployed, were at risk of losing their employment, or were receiving a benefit. Two-thirds of the first 50 participants were out of work for a year or more, and just over half had a diagnosis associated with psychosis (schizophrenia, psychotic disorder or drug-induced psychosis).

The prototype was formally evaluated after 3 months and, despite being early in the programme, the pilot was considered a success. It had achieved a high degree of integration between employment services and clinical support services. Importantly, it achieved an impressive level of fidelity to IPS practices and principles in a short time frame. The high calibre of leadership, positive attitude of clinical staff and high quality of service delivery were all considered key factors of the success.

The prototype was extended into a full trial in July 2019. The initial target for the trial was for Waitematā DHB to deliver IPS to at least 500 clients over two years (ending on 30 June 2021). Based on recommendations from the prototype evaluation, the programme was expanded into more community mental health teams in July 2019 and the initial target age of 18-35 years was widened to include all adults.

Currently, eight employment consultants are contracted from three NGO providers, Workwise, Emerge Aotearoa, and Ember, located in nine community teams. A Pacific (Isa Lei) and Māori (Moko) team operate across two sites.

Employment consultants help clients with:

- developing an up-to-date CV, completing job applications, and interview confidence
- job preparation, e.g. clothing, glasses, driver licence
- working towards their recovery goals and developing their career plans
- accessing support from WINZ, IRD, health agencies
- building relationships with employers and job retention.

The successful implementation of IPS in Waitematā DHB resulted in additional funding being secured to extend this trial for an additional 2 years, and to expand the pilot to Auckland and Counties Manakau DHB. This new investment provides funding for 16 additional FTE (8 in each DHB) and further expands the evaluation to demonstrate the efficacy of IPS in a large metropolitan city. The RFP for the expansion is currently being advertised and successful applicants are expected to be appointed in late 2021, with a start date in January 2022, depending on recruitment.


Our people,
our performance
RLY USE ONLY
HOWARD WRIGHT

Our people, their stories

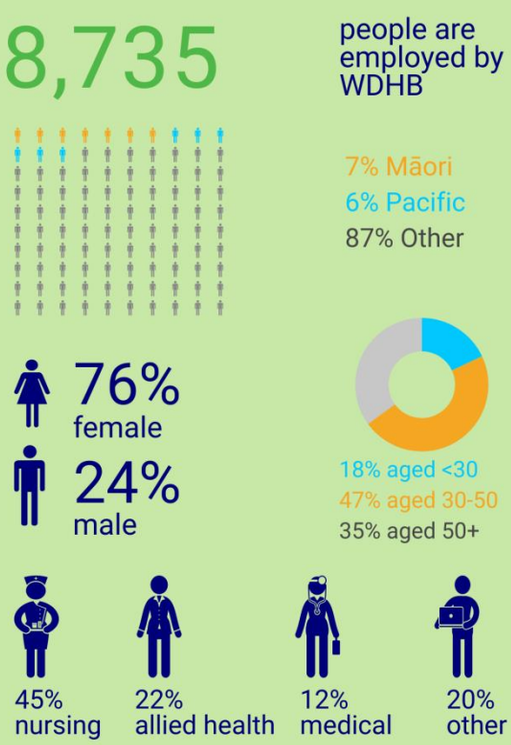
At Waitematā DHB, we take great pride in all of our employees. Here are just a few of the amazing people on our team.

A passion for change

Waitematā DHB Māori Nurse of the Year 2021 Angela Perawiti turned a personal tragedy into a 30-year career full of passion and a drive to create change in the system.

Her son, who would have turned 40 years old in 2021, died at nine months of age after complications related to an ear infection that was never diagnosed, despite her repeated efforts to seek care for him.

Our Workforce



"I didn't use my voice in that situation because I didn't realise that I even had one. I trusted the doctor, even though he was treating me with prejudice. That experience started a fire in me; it gave me a drive to see change."

As an ear, nose and throat (ENT) nurse specialist in 1993, Angela set up one of Auckland's first mobile ENT services that focuses on reaching Māori and Pacific communities.

"I believe change happens in the homes and on the ground. I'm passionate about closing that disconnect between the hospital and community services. I want whānau to have access to services that are culturally appropriate, accessible and affordable."

In her role as a Māori gerontology nurse specialist, Angela works specifically with kaumātua and is involved in physical, cognitive and whānau assessments. She also works to make connections and build relationships between the hospital and community health providers.

Although happy to have received the award, it was never about the recognition for Angela.

"My work has always been about fulfilling this drive I have to make things better and figure out who I am in the process. But I'm trying to embrace it and I love the korowai I received at the ceremony, it's very special."

Connecting with patients

Wesley Pigg was in his second year of physiotherapy study when he became paralysed from the waist down due to a spinal condition. Two years and many surgeries and hospital stays later, he returned to AUT and graduated.

“Rather than holding me back, I realised it could be powerful if I brought my experiences of being a patient and the fact that I'm in a chair to my patient interactions. It allows me to connect with patients in a different way. I just use my situation as best I can and it’s opened up so many opportunities I otherwise wouldn’t have had.

I’m grateful that as a health professional, I get to give to the health system that has given so much to me.”

Settling in to a new life

Eliene Zhu understands the challenges migrants face. Moving to New Zealand from China 7 years ago, Eliene was unable to continue her career as a psychiatrist, her husband struggled to find a job that matched his skills, and her son experienced difficulties at school.

When Eliene got a part-time job with Asian Health Services as a cultural support worker, she began to feel more comfortable working in the health sector here. Her family settled in and now enjoy New Zealand life.

“I know what migration looks like; I know how stressful it can be and I want to support people to live a better life and overcome the mental and physical challenges they might face in a new country. My experience boosted my ambition to support our Asian patients and community.”

Making a difference

Dwaine Faletanoai, Team Manager for Takanga A Fohe (Pacific Mental Health and Addiction Services), always wanted a career that gives back to others.

“I remember real humble beginnings, growing up in a state home, just my mum and my sister and I. I was watching how mum sacrificed and I just really wanted to do something for other people because I saw how many people wanted to help us and did help us.

Somewhere along the line, I was going to do a job that made a meaningful difference in someone’s life, because we had that. I have found that opportunity in mental health and addictions.”

He Kāmaka Waiora

He Kāmaka Waiora is our Māori Health Service working across Auckland and Waitematā DHBs to maximise health outcomes for Māori. The service focuses on accelerating Māori health gains, implementing tikanga Māori, recruiting and retaining Māori workforce, developing Māori leadership and continuing to improve the quality of care in the delivery of services across both DHBs.

The He Kāmaka Waiora provider team works with Māori patients and their whānau when they need to access hospital services. This includes coordinating whānau accommodation, providing social, cultural and advocacy services and working with DHB clinicians and other staff to ensure that services are responsive to the needs of Māori health gain.

Dame Rangimarie Naida Glavish is our Chief Advisor Tikanga. The Chief Advisor Tikanga role maintains a strong Ngāti Whātua Tikanga lens and leadership across both Waitematā and Auckland DHBs, and provides cultural expertise to the executive team, staff, patients and their whānau. Dame Naida is supported by Te Kaunihera Kaumātua (Council of Elders), Kaumātua, the Directors of Māori Research and Māori Clinical Nursing, and the General Manager of the Māori Provider Service.

Dame Naida maintains strong relationships with the Coroner, Police and Te Arai Kapua (Auckland City Hospital, the mortuary whānau room), and leads the two DHBs in managing relationships with Mana Whenua, Iwi Māori and agencies from a tikanga perspective. She also assists in upholding the DHBs obligations to Te Tiriti o Waitangi and its four articles.

Te Kaunihera Kaumātua

Reporting to the Chief Advisor Tikanga, this select group of esteemed elders oversees matters of Māori cultural significance across Waitematā DHB and Auckland DHB.

While COVID-19 continues to challenge our hearts, minds and resources, our Kaumātua continue their commitment to providing the best care for everyone. Our Kaumātua have experienced self-isolation when required, and provide support, such as blessings and mihi whakatau via zoom or phone when appropriate.

One of our Kaumātua, Matua Fraser Toi, turned 80 years old this year. Matua Fraser provides invaluable cultural support, as well as a friendly ear and wise counsel for both patients and staff. We held a celebration to help mark this significant milestone for Matua Fraser.

Matua Fraser Toi and Dame Rangimarie Naida Glavish at Matua Fraser's birthday celebration

Tikanga in action

He Kāmaka Waiora is an integral part of many key work programmes, including: the design and development of the Waitematā DHB COVID-19 vaccination plan (pages 9-10); the establishment of Kōtui Hauora, our Iwi-DHB Partnership Board (page 2); the development of our DHB's equity plan; the development of our Māori-led lung cancer screening study (page 25); and the design, development and building of new DHB facilities to ensure that they embrace Te Ao Māori, including site works at Waitakere Hospital, Whānau Ora accommodation and the new Tōtara Haumaru hospital facility. As part of our work to improve communications and engagement with Māori, Auckland and Waitematā DHBs and Te Whare Wananga o Awanuiārangi are in our 3rd year delivering Te Reo Māori learning classes across the two DHBs.

Matua Fraser Toi blesses the new garden area next to the Whenua Pupuke Centre at North Shore Hospital

Waitematā DHB Consumer Council

Waitematā District Health Board works hard to provide the best possible patient experience to the many people who use our services.

Our Consumer Council was set-up in 2019 to assist us in our on-going drive for excellence – helping us focus on a patient and whānau-centred approach to everything that we do. The Consumer Council recognises the discrete areas of Waitakere, North Shore and Rodney and reflects our MOU partnership with both Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira.

The Consumer Council works collaboratively with the Waitematā DHB Chief Executive, and the Board, to develop effective partnerships in the design, planning and delivery of high quality, safe and accessible health care services for the Waitematā community.

The members of the Consumer Council have a huge variety of backgrounds and areas of interest within the community. These include women's health, men's health, child health, older persons health, disability & impairment, chronic conditions, mental health and addictions, LGBTIQ, Māori health, Pacific peoples' health and Asian health. The addition of two Year 13 high school students, one from west Auckland and one from the North Shore, has brought an enormously valued youth voice to the Council.

Consumer Council meetings are held six weekly and alternate between west and north Auckland.

During 2020/21 there has been a focus on three key areas - Improving patient, Whānau and family experience, Informing decision making about equity, safety & quality, design and redesign of health services, and Ensuring the patient & community voice is heard by the DHB.

The founding members of the Waitematā DHB Consumer Council

Waitematā DHB Board members

Dr Judy McGregor, CNZM
Chair

Sandra Coney, QSO

Allison Roe, MBE

Kylie Clegg
Deputy Chair

Warren Flaunty, QSM

Renata Watene

Edward Benson-Cooper

John Bottomley

Hon. Chris Carter

David Lui

Eru Lyndon

Meeting attendance

	Board (9 meetings)	Board (2 special meetings)	Hospital Advisory Committee (8 meetings)	Audit and Finance Committee (8 meetings)	Community and Public Health Advisory Committee (4 meetings)	Disability Support Advisory Committee (4 meetings)
Board						
Judy McGregor, Board Chair	9	2	8	8	4	4
Chris Carter	9	2	8	-	2	-
Edward Benson-Cooper	8	2	8	8	-	4
John Bottomley	9	2	8	-	4	-
Kylie Clegg, Deputy Chair	9	2	-	8	4	-
Sandra Coney	9	2	8	-	2	2
Warren Flaunty	9	2	8	8	4	-
David Lui*	2 (of 2)	n/a	1 (of 1)	1 (of 1)	-	-
Eru Lyndon*	2 (of 2)	n/a	1 (of 1)	-	-	-
Allison Roe	9	2	6	-	4	4
Renata Watene	9	2	8	8	3 (of 3)	4
Independent committee						
Norman Wong, Chair	-	-	-	8	-	-
Tony Howe	-	-	-	-	-	2 (of 2)
Kaeti Rigarlsford	-	-	-	-	-	2 (of 2)
Jade Farrar	-	-	-	-	-	2 (of 2)

* Appointed in April 2021

Being a good employer

At Waitematā 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. We have been an employer member of Diversity Works for the last ten years and were awarded the Accessibility Tick in December 2019. Our values programme won a 2015 Institute of Public Administration New Zealand (IPANZ) award and the 2016 Human Resources Institute of New Zealand Talent Development and Management award.

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.

Staff experience, wellbeing and culture

Waitematā DHB is committed to fostering a positive culture and living our values every day. We acknowledge that our healthcare systems are facing huge challenges and that our people work hard to advocate for and provide excellent patient care. The need to look after our staff has never been greater. We acknowledge the importance of ensuring that our intention (our talk) matches the lived experience of our staff (our walk).

Our work in 2020/21 staff experience, wellbeing and culture builds upon a strong foundation of shared values and dedicated work by individuals and teams. The focus is on working with our staff to learn, tap into our collective strengths and co-create system-level changes as well as teams and individual supports. This work is always evolving, ever striving for learning, improvement and mana enhancement for our staff.

In mid-2020, we launched our staff experience programme 'Better, Together'. The programme was primarily a response to COVID-19. Our work has extended into a broader staff experience programme encompassing Leadership Development, support for staff Rainbow and Disability networks, digital enablement of previous manual forms and processes, a wellbeing strategy, and staff listening and appreciative inquiry sessions.

We had a significant response to COVID-19-related activities that saw an increase in wellbeing activities and support, including: on-site Employee Assistance, mindfulness sessions (which are always booked to capacity), locally donated treats distributed to staff, and our popular wellbeing check-ins (which have run almost weekly in 2021). A winter wellbeing plan was commenced in 2021, which focuses on support for inpatient areas, shared lunches and our appreciation for each member of the team.

Diversity and inclusion

Our DHB has many activities in place to grow our Māori and Pacific workforces, through which we respond to strategic health equity outcomes for our patients. Evidence shows improved outcomes for patients when they receive a higher level of cultural understanding and awareness, and are cared for by a skilled workforce that reflects our communities.

To support our health equity efforts, we set and aligned employment growth targets to match Māori and Pacific working-age district populations with levels of staff employment. Targets for 2020/21 were met through good ethnicity reporting, targeted recruitment and growing our responsive recruitment practises. We are also building Te Reo skills through our popular night class education sessions.

The Pacific Health Science Academies have grown to 10 schools and support selected students to gain additional science courses and mentoring, enabling them to move into health-related tertiary training prior to taking up a health-related career in the Auckland region.

70 West Auckland secondary students from Waitakere, Kelston Boys and Kelston Girls Colleges spent the day experiencing work at Waitakere Hospital

Since 2009, we supported over 350 Māori and Pacific students through their tertiary study. Since 2017, 97% of scholarship graduates who applied for roles gained employment in the health sector. Waitematā DHB runs a paid programme to support Māori and Pacific candidates into Health Care Assistant (HCA) roles. The 'New to HCA' programme was a finalist in the 2018 Diversity Awards NZ.

Our award winning eCALD programme continues to build capability in cultural awareness and development across the DHB.

Recruitment, selection and development

We continue to improve the recruitment experience for our candidates and hiring managers, with a specific focus on identifying and addressing cultural awareness and competency within services. We aim to strengthen both the recruitment experience for Māori applicants and our promise of best care for everyone, by keeping safe mana motuhake for existing staff.

We have a new strategy to be an employer of choice for disabled healthcare professionals and those looking to work in healthcare. We actively attract, place and support disabled candidates, and ensure that our recruitment advertising and application processes are fully accessible.

Building capability

Waitematā DHB is committed to growing our digital capability. In 2019, we launched our first digital academy to develop clinical staff to design people-centred digital solutions. The success of the programme saw an increase in internally developed digital technologies that benefit our staff and patients.

We have a comprehensive training programme to equip new graduates with clinical and professional skills. Extensive coaching and teaching programmes support the transition of post-graduate allied health, nursing and medical staff from their student to intern year, and into pre-registration training.

We run several sessions each year for practitioners returning to nursing after 5 years away from clinical work, as well as programmes to support clinical training for nurses new to acute care and mental health.

We support our staff through NZQA accredited training via Careerforce, with more than 358 Cleaning and Orderly staff and 178 Health Care Assistants progressing through these programmes in the last 8 years.

Waitematā DHB provides extensive management and leadership training, launching a new programme called Growing Authentic Leadership in 2021, which pairs staff peer groups with a leadership coach in a 10-month programme.

We have multi-campus learning facilities, including video streaming, and use modern digital technology to provide webinar, meeting and remote learning opportunities across multiple hospital and community sites.

Volunteers

We are assisted by approximately 350 volunteers who support our patients and their whānau. Volunteer groups include Volunteer Stroke Service, St Johns – Friends of Emergency and Ward 2, Hospital Auxiliary, Volunteer Chaplain Assistants, Front of House (Green Coats), ward volunteers, outpatient volunteers, Justice of the Peace, Radio Lollipop volunteers and Westlake Girls and Boys Schools. Our volunteers are highly valued by the organisation, patients and visitors. They provide a friendly face to assist with way finding as visitors enter our hospitals, help with patient feedback data collection and provide support to ward patients in conversation and attending to their needs.

Other organisations volunteer their time to our gardens, including City Impact Church and the North Harbour Rose Society.

Remuneration and recognition

Living within our means is central to our success as an organisation. We actively participate in national bargaining, establishing parameters to ensure bargaining will deliver organisational and sector expectations. Any agreements negotiated nationally or locally are approved by the Ministry of Health.

We are involved in finalising gender pay equity claims for a number of our staffing groups, and recently agreed to actions that will help us to reduce the gap between high and low income earners. Work on understanding the ethnic pay gap is ongoing.

Waitematā DHB recognises the valuable contribution that our staff make to patient care, through recognition programmes and/or awards, including:

- Health Excellence awards. These recognise innovation in patient outcomes or patient/staff experience.
- Chief Executive awards. These recognise staff for a specified activity or action that demonstrates a DHB goal, priority or value.
- Health Heroes awards. A bi-monthly award to a staff member or team who demonstrates outstanding achievement of DHB values, standards and behaviours.
- Long service awards. These recognise staff who have 15 years or more of service with the DHB.

The Waitakere Hospital cleaning team won a Health Heroes award in November 2020, for their hard work during COVID-19 outbreaks.

In partnership with unions

We value our relationships with our union partners, establishing partnership agreements for health and safety and engaging in regular bipartite committees, both nationally and locally. Programmes of work discussed in the last 12 months include: COVID-19 work, staff experience, occupational health and safety, wellbeing, facility development and change, and new workforce pilots for paramedics and bullying and harassment prevention.

Policies

In 2020/21, we reviewed key people-based policies, including introducing new occupational health and safety policies and guidance to respond to COVID-19. Key employee policies are sent to union partners for their feedback and endorsed by our Executive Leadership Team.

Workplace flexibility and design

A large facility development programme is underway across our sites, guided by the Northern Region Health Services Plan. Staff are involved in planning discussions on construction and design to enable accessible workplaces and future-proofed spaces that are safe and deliver contemporary patient care.

We offer our staff flexible hours, as demonstrated by our large part-time workforce, and we work with our staff and unions on remote working arrangements, with a key aim for safe and effective systems that enable working anywhere in the motu.

Health, safety and wellbeing

At Waitematā 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, and we focus improvements on construction management, orientation, hazardous substances, community workers, incident and risk management, security and governance.

Waitematā DHB is working towards ISO 45001 standards and our work plans and self-audits are oriented to achieving these milestones.

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 to collectively improve the health, safety and wellbeing of our teams.

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.

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals, set out in the Improving Health Outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitematā DHB population is now 84.3 years, an increase of 1.6 years over the last decade. The life expectancy gap is 5.5 years for Māori and 6.9 years for Pacific, compared with 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 Waitematā residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population.

Output class measures

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

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

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

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

Population Projections

Every year, Statistics NZ releases revised population estimates and projections, based on the most recent census. In February 2020, the first data to use 2018 Census counts was released. This resulted in a 3% reduction in the projected population for Waitematā DHB, and changes between ethnic groups. The 2021 release was an update on 2020 projects, but the numbers are not significantly different. The changes in 2020 had a substantial impact on measures that use DHB population as the denominator. In 2019/20, we re-calculated many of our prior year's results using the revised population estimates to provide a more accurate comparator. Therefore, some 2018/19 baseline results will differ to those published in our 2018/19 Annual Report.

Output Class 1: Prevention Services

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

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Health promotion					
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months (C)	88%	79%	77%[3]	90%	🔴
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking (C)	91%	90%	92%	90%	🟢
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	168	193	199[4]	231	🔴
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	100%	100%	99%	95%	🟢
Number of clients engaged with Green Prescriptions (V)	5,340	4,900	5,080	4,861	🟢
% of clients engaged with Green Prescriptions (C)					
- Māori	16%	13%	15%	13%	🟢
- Pacific	19%	15%	15%	12%	🟢
- South Asian	8%	6%	8%	9%	🔵
Immunisation					
% of pregnant women receiving pertussis vaccination (C)	52%	54%	54%	50%	🟢
- Māori	32%	32%	30%[5]	50%	🔴
- Pacific	33%	39%	37%[5]	50%	🔴
- Asian	65%	66%	66%	50%	🟢
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness[6] (C)	12%	18%	30%	30%	🟢
- Māori	8%	10%	20%[7]	30%	🔴
- Pacific	11%	9%	19%[7]	30%	🔴
% of eight months olds will have their primary course of immunisation on time[8] (C)	92%	93%	90%	95%	🔵
- Māori	86%	87%	78%[9]	95%	🔴
- Pacific	96%	92%	91%	95%	🔵
% of five year olds will have their primary course of immunisation on time (C)	87%	89%	87%[9]	95%	🔴
- Māori	84%	86%	82%[9]	95%	🔴
- Pacific	85%	88%	87%[9]	95%	🔴
- Asian	92%	93%	92%	95%	🔵
Rate of HPV immunisation coverage (C)	56%	68%	71%[10]	75%	🔵

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

[4] This target was based on the 2017 pregnancy smoking rate, which declined in subsequent years. The latest target, based on the 2019 pregnancy smoking rate, is 190, which we exceeded.

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

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

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

[8] Eligible population data sourced from National Immunisation Register; babies added to this at birth through the NHI system.

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

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

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Population-based screening					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	66%	65%[11]	64%[12]	70%	🔴
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	72%	69%[11]	70%[13]	80%	🔴
HEEADSSS assessment coverage in DHB-funded school health services[6] (C)	90%	90%	82%[14]	95%	🔴
% of four year olds receiving a B4 School Check (C)	90%	68%	78%[15]	90%	🔴
Bowel cancer screening					
% of people aged 60-74 years invited to participate who returned a correctly completed kit (Q)	63%	61%	59%	60%	🔵
- Māori	62%	63%	61%	60%	🟢
- Pacific	47%	49%	47%[16]	60%	🔴
- Asian	55%	55%	52%[16]	60%	🔴
- Other	66%	64%	63%	60%	🟢
% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system (T)	97%	95%	99%	95%	🟢
Auckland Regional Public Health Service (ARPHS)[17]					
Number of tobacco retailer compliance checks conducted (V)	432	184	5[18]	300	🔴
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into (V)	3,010	3,625	2,921[19]	Ω	n/a
% of smear-positive pulmonary tuberculosis cases contacted by the public health nurse within 3 days of clinical notification (Q)	83%	95%	98%	90%	🟢
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	89%	96%	100%	95%	🟢
% of compliance assessments conducted of large and medium networked drinking water supplies (Q)	100%	100%	n/a[20]	100%	n/a

[11] Result updated in 2020 using revised 2019 population projections, therefore may differ from result published in 2018/19 Annual Reports.

[12] Screening continues to be affected by COVID-19 restrictions. Initiatives to promote screening continue, targeting those at highest risk; improvements from a Māori campaign will be reviewed for other ethnicities.

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

[14] Performance was affected by extended school closures and increase in school roll. School nurses continue to complete assessments for all Māori, Pacific and high risk students who missed out on HEEADSSS in 2020.

[15] Performance was affected by COVID-19 lockdowns, staff shortage, and client and staff sickness; recruitment is underway.

[16] Participation declined due to COVID-19, and our messages compete for attention with COVID-19 and influenza vaccine messages. We continue to promote the importance of screening via targeted messages using Pacific and Asian languages.

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

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

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

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

Output Class 2: Early Detection and Management

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

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Primary health care					
Rate of primary care enrolment in Māori (C)	82%[11]	83%	81%[21]	90%	🔴
Number of referrals to Primary Options for Acute Care (POAC) (V)	13,173	9,050	11,797	10,811	🟢
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices who does not have an HbA1c recorded in the last 15 months (C)	15%	12%	11%	<12.0%	🟢
- Māori	24%	19%	17%[22]	<12.0%	🔴
- Pacific	16%	14%	14%[22]	<12.0%	🔴
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol (Q)	59%	63%	63%	65%	🔵
- Māori	45%	49%	51%[22]	65%	🔴
- Pacific	48%	49%	50%[22]	65%	🔴
% of Māori patients with a prior CVD event who are prescribed triple therapy (Q)	55%	59%	64%	70%	🟡
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds (Q)[23]	4,275[11]	3,908	4,099	<4,052	🔵
- Māori	8,454[11]	7,472	7,528	<8,031	🟢
- Pacific	12,873[11]	10,024	11,894	<11,482	🔵
Pharmacy					
Number of prescription items subsidised (V)	7,639,059	8,165,354	9,241,220	Ω	n/a
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	39,398	34,003	39,775	Ω	n/a
Number of community laboratory tests (V)	4,250,213	4,013,632	4,516,955	Ω	n/a

[21] We are working with our partners to increase enrolment. Māori health providers check the enrolment status of their clients, and data match between Māori health providers and PHOs to find whānau who are not enrolled.

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

[23] This indicator was not included in our 2020/21 Annual Plan.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Oral health[6]					
% of children 0-4 enrolled in DHB-funded oral health services (C)	96%[11]	98%	98%	95%	
- Māori	75%[11]	75%	74%[24]	95%	
- Pacific	91%[11]	96%	97%	95%	
- Asian	91%[11]	93%	91%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.60	0.61	0.48	<0.56	
- Māori	0.92	0.85	0.71[25]	<0.56	
- Pacific	0.82	0.79	0.68[25]	<0.56	
- Asian	0.61	0.63	0.51	<0.56	
% of children caries free at five years of age (Q)	62%	58%	50%[25]	65%	
- Māori	52%	49%	41%[25]	65%	
- Pacific	38%	38%	28%[25]	65%	
- Asian	53%	47%	43%[25]	65%	
Utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including age 17 years (C)	68%[11]	68%	58%[26]	85%	

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

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

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

Output Class 3: Intensive Assessment and Treatment

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

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

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

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Acute services					
Number of ED attendances (V)	131,625	122,215	121,481	Ω	n/a
% of ED patients discharged, admitted or transferred within six hours of arrival (T)	94%	96%	92%	95%	🔵
Rate of alcohol-related ED admissions for 15-24 year olds (Q)	New indicator	4.9%[27]	4.7%	<5.0%[27]	🟢
% 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)	88%	89%	90%	90%	🟢
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7) (C)	New indicator	13%	15%	12%	🟢
% of ACS inpatients receiving coronary angiography within 3 days (T)	71%	76%	69%	70%	🔵
Maternity					
Number of births in Waitematā DHB hospitals (V)	6,722	6,627	6,730	Ω	n/a
% of babies exclusively breastfed on discharge (Q)	78%	75%	72%	75%	🔵
Elective (inpatient/outpatient)					
Number of Planned Care interventions (V)[23]	New indicator	32,032	36,167 (111%)	32,531	🟢
- Inpatient surgical discharges		19,413	21,931	21,331	n/a
- Minor procedures		12,619	14,235	10,866	n/a
- Non-surgical interventions		0	1	334	n/a
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	98%	99%	96%	90%	🟢
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	53%	42%	42%[28]	70%	🔴
% of patients waiting longer than 4 months for their first specialist assessment (T)	4.5%	15.4%	6.9%[29]	0%	🔴
% of accepted referrals receiving their CT scan within 6 weeks (T)	70%	63%	73%[30]	95%	🔴
% of accepted referrals receiving their MRI scan within 6 weeks (T)	76%	83%	68%[31]	90%	🔴

[27] These values differ from those published in the 2019/20 annual report and 2020/21 annual plan, which are incorrect. The correct values are provided here (the previously published result is for the 10-24 year-old age group and the target could not be set previously).

[28] COVID-19 disruptions have led to increased numbers of patients waiting. We continue to prioritise patients who have waited the longest and progress against our recovery plan.

[29] COVID-19 disruptions have led to increased numbers of patients waiting. Most services are now compliant and most that are non-compliant show improving trends; we continue with additional weekday and weekend clinics and surgical locums, where available.

[30] COVID-19 disruptions significantly increased our waiting list and we experienced increased demand and staff shortages; we continue with outsourcing and performance improvement initiatives.

[31] Demand continues to significantly exceed projections, and outsourcing was limited by private sector capacity constraints.

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Quality and patient safety					
% of opportunities for hand hygiene taken (Q)	89%	89%[32]	91%[33]	80%	
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.05	0.09	0.09[34]	<0.13	
% of older patients assessed for the risk of falling (Q)	97%	98%[34]	99%[34]	90%	
% of falls risk patients who received an individualised care plan (Q)	97%	99%[34]	98%[34]	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	12.5	11.8	10.0	<9.7	
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision (Q)	97%	99%[34]	98%[35]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	98%	100%[34]	98%[35]	95%	
Surgical site infections per 100 hip and knee operations (Q)	0.52	0.50[34]	0.63[34]	<0.97	
Friends and Family Test Net Promoter Score[36] (Q)	74	79	81	>65	
Mental health					
% of population who access mental health services (C)					
- Age 0-19 years	4.02%[11]	3.69%	4.28%	≥3.82%	
- Māori	5.72%[11]	5.09%	5.66%	≥5.25%	
- Age 20-64 years	3.86%[11]	3.83%	3.62%	≥3.77%	
- Māori	8.80%[11]	9.03%	8.61%[37]	≥9.40%	
- Age 65+ years	2.35%[11]	2.19%	2.20%	≥2.14%	
- Māori	2.48%[11]	2.40%	2.28%	≥2.23%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental health	70%	70%	51%[38]	80%	
- Addictions	93%	81%	75%[38]	80%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental health	93%	90%	92%	95%	
- Addictions	99%	96%	96%	95%	

[32] July 2019 to February 2020 result.

[33] November 2020 to June 2021 result.

[34] Q1-Q3 result (measure only reported every six months in Q1 and Q3 therefore Q4 data not available at time of publication).

[35] Q1 result only available at time of publication

[36] The proportion of responses that are promoters and the proportion that are detractors are calculated and the proportion of detractors is then subtracted from the proportion of promoters to provide an overall 'net promoter' score. Those that say they are 'extremely likely' are counted as promoters. 'Likely' is neutral, 'neither unlikely nor likely', 'unlikely' and 'extremely unlikely' are all counted as detractors.

[37] Access to referral sources was reduced during COVID-19 outbreaks and continued staff vacancy jointly reduced volume of patients seen.

[38] We experienced a significant increase in referral rates, including complex cases, and staff vacancy. During COVID-19 outbreaks, telehealth appointments were not always appropriate or acceptable. We continue to prioritise patients to be seen and recruitment to meet demand.

Output Class 4: Rehabilitation and Support Services

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

Outputs measured by	2018/19 baseline	2019/20 result	2020/21 result	2020/21 target	Rating
Home-based support					
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	98%	99%[34]	98%	95%	●
Palliative care					
Hospice					
Total number of contacts in the community (V)	21,010	19,940	18,151	Ω	n/a
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	21%	0.5%	2.9%	<5%	●
Hospital					
Total number of referrals (V)	1,158	1,387	1,374	Ω	n/a
Average time to first contact with referrer (T)	4.4 h	7.6 h	6.7 h[39]	≤6 h	●
Average time from referral to first face-to-face patient assessment (T)	8.55 h	9.25 h	12.9 h	≤24 h	●
Residential care					
ARC bed days (V)	974,841	982,979	1,002,882	Ω	n/a

[39] This result includes weekend referrals that are not processed until Mondays, inflating the apparent wait time. Data entry issues may have affected performance in Q3 but the impact is not expected to be significant. Despite this, the average time from referral to first face-to-face contact target continues to meet target.

COVID-19 Vaccination

This information has been provided by the Ministry of Health.

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

Ethnicity	Proportion fully vaccinated
Asian	9.43%
European or other	9.58%
Māori	10.46%
Pacific peoples	10.06%
Unknown	22.37%
Total	**9.68%**

*Note 1,5

Age	Proportion fully vaccinated	Age	Proportion fully vaccinated
12 to 15	_	55 to 59	11.48%
16 to 19	2.80%	60 to 64	11.96%
20 to 24	7.86%	65 to 69	14.92%
25 to 29	8.88%	70 to 74	15.39%
30 to 34	8.65%	75 to 79	15.57%
35 to 40	7.41%	80 to 84	13.99%
40 to 44	7.73%	85 to 89	14.66%
45 to 49	7.91%	95+	17.86%
50 to 54	9.32%	**Total**	**9.68%**

*Note 1,5

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

Ethnicity	Dose 1	Dose 2	Total
Asian	14,220	6,332	20,552
European or other	35,264	15,996	51,260
Māori	4,345	2,530	6,875
Pacific peoples	5,427	2,659	8,086
Unknown	254	146	400
Total	**59,510**	**27,663**	**87,173**

*Note 4

Sequencing group	Dose 1	Dose 2	Total
Group 1	562	781	1,343
Group 2	20,986	14,705	35,691
Group 3	30,288	9,796	40,084
Group 4	7,674	2,381	10,055
Total	**59,510**	**27,663**	**87,173**

*Note 3,4

Age	Dose 1	Dose 2	Total	Age	Dose 1	Dose 2	Total
12 to 15	1	0	1	55 to 59	4,893	2,591	7,484
16 to 19	687	358	1,045	60 to 64	5,835	2,545	8,380
20 to 24	1,914	1,222	3,136	65 to 69	8,669	3,446	12,115
25 to 29	2,490	1,532	4,022	70 to 74	8,464	3,131	11,595
30 to 34	3,085	1,898	4,983	75 to 79	6,028	2,244	8,272
35 to 40	2,847	1,713	4,560	80 to 84	3,590	1,183	4,773
40 to 44	2,560	1,534	4,094	85 to 89	1,603	476	2,079
45 to 49	2,803	1,682	4,485	95+	634	173	807
50 to 54	3,407	1,935	5,342	**Total**	**59,510**	**27,663**	**87,173**

*Note 4

Notes regarding vaccination performance information

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

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

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

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

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

The Waitemata DHB total population estimate based on HSU as at 30 June 2020 is 629,153. This is 10,747 below the Stats NZ projected population of 639,900 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

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

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

Waitemata DHB population	HSU	Stats NZ	Difference
Māori	55,523	64,400	(8,877)
Pacific	48,260	46,300	1,960
Asian	154,917	174,000	(19,083)
Other	370,453	355,200	15,253
Total	629,153	639,900	(10,747)

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

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

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

Health Quality and Safety Commission Markers

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred.

Health Quality and Safety markers	Oct-Dec 2019[40]	2020/21
80% compliance with good hand hygiene practice	90%[41]	91%[42]
Falls		
90% of older patients are given a falls risk assessment	99%	99%[34]
% of patients assessed at risk of falling who received an individualised care plan	98%	98%[34]
Safe surgery		
100% of hip and knee arthroplasty primary procedures given correct antibiotic in the hour before incision	99%	98%[35]
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	100%	98%[35]
95% of audits of surgical safety checklist engagement score levels of 5 or higher	Sign in: 97% Time out: 100% Sign out: 98%	Sign in: 92% Time out: 97% Sign out: 100%
Patient deterioration		
% of early warning score calculated correctly	100%	100%
% of patients who triggered an escalation of care and received the appropriate response	78%	85%
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1,000 admissions	1.4	0.9
Rate of rapid response escalations per 1,000 admissions	19	23
Pressure injuries		
% of patients with a documented and current pressure injury risk assessment	89%	91%
% of at-risk patients with a documented and current individualised care plan	65%	63%
% of patients with hospital-acquired pressure injury	0.6%	0.7%
% of patients with a non-hospital-acquired pressure injury	1.4%	2.0%
Safe use of opioids		
% of patients whose sedation levels are monitored and documented following local guidelines	86%	80%
% of patients who have had bowel function activity recorded in relevant documentation	3%	5%
% of patients prescribed an opioid who have uncontrolled pain	0.0%	0.1%
% of surgical episodes of care with opioid-related harm	0.4%	0.6%

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

[41] November 2019 to February 2020 result.

[42] November 2020 to June 2021 result.

Cost of Service Statement – for year ended 30 June 2021

	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support		Total Excluding COVID-19	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**440,952**	**449,247**	**1,227,046**	**1,220,339**	**25,496**	**26,201**	**323,284**	**331,972**	**2,020,442**	**2,027,760**
Expenditure										
Personnel	86,231	84,848	696,877	666,672	1,916	2,013	27,763	28,797	812,787	782,330
Outsourced Services	12,575	11,663	81,027	73,425	418	399	5,650	5,374	99,670	90,861
Clinical Supplies	14,334	14,398	109,430	119,541	297	299	4,370	4,388	128,431	138,626
Infrastructure & Non-Clinical Supplies	10,216	7,534	105,518	82,613	112	21	1,962	737	117,808	90,905
Payments to Providers	317,878	334,347	294,318	309,565	22,370	23,529	279,133	293,595	913,699	961,036
Total Expenditure	**441,234**	**452,791**	**1,287,170**	**1,251,816**	**25,113**	**26,261**	**318,878**	**332,892**	**2,072,395**	**2,063,760**
Net Surplus/ (Deficit)	**(282)**	**(3,544)**	**(60,124)**	**(31,477)**	**383**	**(60)**	**4,406**	**(920)**	**(55,617)**	**(36,000)**

	Total Excluding COVID-19		COVID-19		Total	
	$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**2,020,442**	**2,027,760**	**52,867**	**0**	**2,069,645**	**2,027,760**
Expenditure						
Personnel	812,787	782,330	18,646	0	831,433	782,330
Outsourced Services	99,670	90,861	482	0	100,152	90,862
Clinical Supplies	128,431	138,626	1,664	0	130,095	138,626
Infrastructure & Non-Clinical Supplies	117,808	90,905	1,003	0	118,811	90,906
Payments to Providers	913,699	961,036	36,473	0	950,172	961,036
Total Expenditure	**2,072,395**	**2,063,760**	**58,268**	**0**	**2,130,663**	**2,063,760**
Net Surplus/(Deficit)	**(55,617)**	**(36,000)**	**(5,401)**	**0**	**(61,018)**	**(36,000)**

Net Deficit for the year totals to $61.0m against a planned deficit of $36.0m. It is mainly driven by $25.9m Holidays Act provision and $5.4m of COVID-19 financial impacts.

An increase in the estimated cost to satisfy non-compliance with the Holidays Act has caused significant variance in personnel expenditure compared to plan, where Intensive Assessment and Treatment had been impacted the most. The Intensive Assessment and Treatment output class makes up a significant amount of the Group's revenue funding and expenditure. The main variances along with the outline of COVID-19 financial impacts are provided in note 31 of the Financial Statements.

Ministerial Directions

Directions issued by a Minister that remain current, are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in Apr-14 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in Jul-08, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF
- The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID‑19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand. Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction
- Direction to support a whole of government approach to pay restraint issued on 28 April 2021 under s.95(c) of the Public Service Act 2020 https://www.publicservice.govt.nz/our-work/er/public-service-pay-guidance-2021/

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 Waitematā DHB Board 08 July 2020
With regard to an item on the 'Relocation of West Auckland BreastScreening Clinic' Warren Flaunty noted that he was looking at property in the same vicinity. The Board noted his declaration was satisfied under Schedule 3, clause 36 (4) that he could stay for the discussion and decision making of this item.

Meeting of the Waitematā DHB Board 14 October 2020
Warren Flaunty noted his disclosed interest as a Trustee of the Waitakere Licencing Trust and a donation made in relation to an item 'Expansion of the Special Care Baby Unit at Waitakere Hospital'. The Board noted this declaration and was satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of the item, but could not participate in the voting of the item.

Meeting of the Waitematā DHB Board 15 February 2021
Warren Flaunty noted his disclosed interest as a Trustee (Vice President) of the Waitakere Licensing Trust in relation to an item 'Reducing Harms from Hazardous Alcohol in our Communities.' The Board noted his declaration was satisfied under Schedule 3, clause 36 (4) that he could stay for the discussion of the item.

Meeting of the Waitematā DHB Board 21 April 2021
With regard to an item 'Service Level Agreement between Waitematā DHB and Serco New Zealand Ltd', David Lui declared an interest with SERCO. The Board noted this declaration and was satisfied under Schedule 3, clause 36 (4) that David Lui could remain in the meeting for the discussion of the item, but could not participate in the voting of the item.

Vote Health: Health and Disability Support Services Waitematā 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 Waitematā DHB's 2020/21 appropriations is detailed below.

Appropriations allocated and scope

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

What is intended to be achieved with this appropriation?

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

How performance will be assessed and end of year reporting

Each DHB has a statutory responsibility to prepare:

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

These documents are brought together into a single DHB Annual Plan with the Statement of Intent and Statement of Performance Expectations, and are known as the 'Annual Plan'. The Statement of Performance Expectations provides specific measures/targets for the coming year, with comparative prior year and current year forecast (at a minimum). Four Output Classes are used by all DHBs to reflect the nature of services provided: 1) prevention, 2) early detection and management, 3) intensive assessment and treatment, 4) rehabilitation and support.

Amount of appropriations

	2019/20		2020/21	
	Final Budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,622,080	1,622,080	1,727,434	1,727,434
Supplementary estimates	-	30,390	-	7,163
Addition to the supplementary estimates	-	3,988	-	-
Total appropriation revenue	1,622,080	1,656,458	1,727,434	1,734,507

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

Trusts

Waitematā DHB controls the Three Harbours Health Foundation.

Wilson Home Trust: Waitematā 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. Waitematā DHB leases from the Trust premises on the Wilson Home site from which the DHB provides services for children with physical disabilities.

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

Waitematā DHB is required 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 (19) 6: 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.

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

- Condition
- Utilisation
- Functionality (fitness for purpose)

Waitematā DHB defines 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. This Group undertakes a formal review of all asset performance measures on a quarterly basis in order to drive continual improvement of WDHB's asset management practice.

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 the condition of building stock is surveyed on a rolling 5-year basis to help inform future building and plant works.

Measure		Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
1.1	**Facility condition** Percentage of occupied buildings rated as 'poor' or 'very poor' condition *Assessment of facility condition based on visual inspection, reported as % of overall buildings value in 'poor' or 'very poor' condition (condition grading levels: very poor, poor, average, good, very good).*	Condition	<5%	2.69%	<5%	2.6%
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%	92.1%	≥85%	86%
1.3	**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%	96.3%	≥95%	80%
1.4	**Seismic compliance** Number of owned occupied buildings classed as 'potentially earthquake prone' *Number of owned occupied buildings with seismic state based on NBS of <34%. The target reflects the importance of having facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	0	1	0	0
1.5	**Seismic compliance** Number of owned occupied buildings classed as "Potentially Earthquake Risk" *Number of owned occupied buildings with seismic state based on NBS of between 34% and 67%. The target reflects the importance of having patient and staff facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	≤10	10	≤10	10
1.6	**Seismic status of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is known *The current seismic status of some leased buildings is unknown as assessments have either not been carried out by landlords, or the information has not been provided by landlords.*	Functionality (Fitness for Purpose)	>85%	88.6%	>85%	86%
1.7	**Seismic compliance of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is >67% NBS. *This is to assess the current state of leased buildings and indicate where further work is required or alternative accommodation options should be considered (where possible). Actions are in progress with landlords to bring buildings up to >67%.*	Functionality (Fitness for Purpose)	>70%	70.5%	>70%	61%
1.8	**Car parking compliance** Mobility car park spaces as a percentage of total car park spaces to be greater than New Zealand Guideline 4121 *Percentage of mobility spaces at Waitakere and North Shore Hospitals as percentage of total spaces. The target is based on the New Zealand Standards 4121 and was approved by the Waitematā DHB Disability Advisory Committee as part of delivering the New Zealand Disability Strategy.*	Functionality (Fitness for Purpose)	100%	133%	100%	166%

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.

Measure		Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 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%	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%	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%	115%	≥100%	109%
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%	141%	≥100%	123%
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 consequences associated with failure.*	Functionality (Fitness for Purpose)	100%	97%	100%	100%
2.6	**Clinical Equipment Condition (Age Based)** Critical clinical equipment less than 3 years past End-of-Life *Percentage of critical clinical equipment that has not reached the end of its useful life, or is up to 3 years past the end of its useful life, where useful life is an assumed typical working life for each type of equipment. This is a new measure introduced on 1 July 2018. The target reflects current performance and is being actively increased over time.*	Condition	>80%	83%	>80%	81%
2.7	**Clinical Equipment Condition** Critical clinical equipment in above average or average condition *Percentage of critical clinical equipment in above average or average condition based on the methodology for measuring asset condition against AS/New Zealand 3551 as developed by the Clinical Engineering New Zealand Managers Forum (March 2017).*	Condition	>85%	100%	>75%	82%
2.8	**Clinical Equipment Maintenance** Number of non-scheduled maintenance visits/total number of maintenance visits (critical clinical equipment) *Based on the number of assets that are subject to non-scheduled corrective maintenance, or risk/incident management as a percentage of total maintenance visits (annual preventative maintenance plus non-scheduled maintenance). This is a new measure introduced on 1 July 2018.*	Functionality (Fitness for Purpose)	<35%	21%	<35%	32%

ICT Asset Portfolio

Waitematā DHB's ICT asset portfolio is owned, managed and maintained by healthAlliance, the shared service company owned by the DHBs in the Northern Region. Waitematā DHB has been working with healthAlliance and Treasury to improve the level of reporting for critical ICT assets.

Measure		Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
3.1	**ICT Tier 1 Applications Functionality** Availability of IT Services (Tier 1 Apps) *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%	100%	99.8%	99.99%
3.2	**ICT Tier 2 Applications Functionality** Availability of IT Services (Tier 2 Apps) *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%	100%	99.8%	99.99%
3.3	**End User Devices – Asset Age** Percentage of devices compliant with asset age replacement policy *The percentage of end user devices (excl. mobile and tablet) that comply with the asset age specified in the DHB replacement policy.*	Condition	>75%	87%	>75%	88%
3.4	**End User Devices - Security** Percentage of devices compliant with security update policy *Measures the date of the last security patch of end user devices (excl. mobile and tablet), then determines how many devices expressed as a percentage comply with the DHB security update policy.*	Condition	>80%	94%	>80%	58%
3.5	**Software (Applications) - Condition** Percentage of applications with installed version number older than n-1 *Shows which applications are either at the current version or are one version behind the current version.*	Condition	>55%	77%	>55%	63%
3.6	**Software (Applications) – Service Interruptions** % of applications not experiencing Service Level Agreement (SLA) breaches (service interruptions) *Measures the percentage of applications that do not show as 'SLA breached' (service interruptions) on a per monthly count over a 12-month period.*	Functionality (Fitness for Purpose)	>80%	100%	>80%	94%
3.7	**Software (Applications) – Redundancy or Resiliency** Percentage of applications architected for redundancy or resiliency *Percentage of Top 55 Tier 1 applications that are deployed on corresponding Tier 1 architecture at the end of the reporting period. Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).*	Functionality (Fitness for Purpose)	>30%	67%	>30%	56%

Measure		Indicator	2020/21 Target	2020/21 Actual	2019/20 Target	2019/20 Actual
3.8	**Software (Applications) – Supportability** Percentage of assets supportable under Tier 1 Service Level Agreement (SLA) guidelines *Percentage of Top 55 Tier 1 applications that are labelled 'supportable to Tier 1' at the end of the reporting period. Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).*	Functionality (Fitness for Purpose)	>31%	78%	>31%	67%
3.9	**Technology Platforms (Physical and Virtual) – Condition** Percentage of windows systems that have been checked and patched, across all production and non-production environments. *Measures the percentage of systems that are captured and updated under the recently implemented rolling 13 week programme for server patching.*	Condition	>75%	92%	>75%	73%
3.10	**Technology (Tier 1 and Tier 2 systems) – Service Interruptions** Number of Service Level Agreement (SLA) breaches (service interruptions) recorded against application asset over 12 month period. *Measures the count of unplanned service interruptions.*	Condition	<20	3.08	<20	6.05
3.11	**Technology (Remote Platform) Utilisation** Percentage of staff able to access clinical/non-clinical system platforms remotely. *Measures the percentage of unique user's activity against the total users.*	Utilisation	>35%	58 %	>35%	50%

Financial statements

Statement of Responsibility

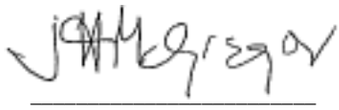
We are responsible for the preparation of the Waitematā District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Waitematā 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 Waitematā District Health Board for the year ended 30 June 2021.

Signed on behalf of the Board:



Dr Judy McGregor, CNZM

Chair

Dated: 15 December 2021

Kylie Clegg

Deputy Chair

Dated: 15 December 2021

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

		Group		Parent	Group and Parent	Parent
	Notes	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Revenue						
Patient care revenue	2	2,020,028	1,903,540	2,020,028	1,981,099	1,903,540
Interest revenue		1,276	1,817	905	623	1,439
Other revenue	3	48,341	32,148	49,826	46,038	31,528
Total revenue	31	2,069,645	1,937,505	2,070,759	2,027,760	1,936,507
Expenditure						
Personnel costs	4	831,433	789,361	831,433	782,330	789,361
Depreciation and amortisation expense	13,14	30,838	28,926	30,838	31,005	28,926
Outsourced services		100,152	92,460	100,152	90,863	92,460
Clinical supplies		130,095	125,428	130,095	132,642	125,428
Infrastructure and non-clinical expenses		40,924	44,361	44,588	29,954	44,361
Other district health boards		351,705	326,880	351,705	354,207	326,880
Non-health board provider expenses		598,467	553,646	598,467	606,829	553,646
Capital charge	5	21,347	29,315	21,347	26,177	29,315
Other expenses	6	25,702	15,326	25,702	9,753	15,326
Total expenditure	31	2,130,663	2,005,703	2,134,327	2,063,760	2,005,703
Surplus/(deficit)		**(61,018)**	**(68,198)**	**(63,568)**	**(36,000)**	**(69,196)**
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations	19	149,424	0	149,424	0	0
Total other comprehensive revenue and expense		149,424	0	149,424	0	0
Total comprehensive revenue and expense		**88,406**	**(68,198)**	**85,856**	**(36,000)**	**(69,196)**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2021

		Group		Parent	Group and Parent	Parent
	Notes	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Budget 2021 $000	Actual 2020 $000
Balance at 1 July		460,149	502,297	443,122	460,149	486,268
Equity injections		24,400	26,050	24,400	56,563	26,050
		484,549	528,347	467,522	516,712	512,318
Comprehensive Income						
Surplus/(Deficit)		(61,018)	(68,198)	(63,568)	(36,000)	(69,196)
Prior year adjustments		0	0	0	0	0
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations		149,424	0	149,424	0	0
Total comprehensive revenue and expense for the year		**88,406**	**(68,198)**	**85,856**	**(36,000)**	**(69,196)**
Balance at 30 June	19	**572,955**	**460,149**	**553,378**	**480,712**	**443,122**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2021

	Notes	Group Actual 2021 $000	Group Actual 2020 $000	Parent Actual 2021 $000	Group and Parent Budget 2021 $000	Parent Actual 2020 $000
Assets						
Current assets						
Cash and cash equivalents	7	81,691	56,565	77,468	15,994	52,373
Receivables	8	70,165	55,583	71,025	55,800	54,913
Investments	9	962	3,042	0	0	0
Inventories	10	9,729	9,021	9,729	9,740	9,021
Prepayments		4,898	1,128	4,898	1,600	1,128
Assets held for sale	11	0	21,600	0	0	21,600
Total current assets		167,445	146,939	163,120	83,134	139,035
Non-current assets						
Investments	9	15,407	11,023	0	11,723	0
Investments in associates and joint ventures	12	48,553	47,236	48,553	47,235	47,236
Property, plant and equipment	13	933,381	741,649	933,382	824,086	741,649
Intangible assets	14	11,147	12,256	11,147	8,518	12,556
Total non-current assets		1,008,489	812,164	993,082	891,562	801,141
Total assets		1,175,934	**959,103**	**1,156,202**	**974,696**	**940,176**
Liabilities						
Current liabilities						
Payables	15	173,772	139,998	173,617	138,794	138,098
Employee entitlements	17	361,885	309,563	361,885	305,305	309,563
Provisions	18	11,129	4,270	11,129	1,850	4,270
Total current liabilities		546,786	453,831	546,631	445,949	451,931
Non-current liabilities						
Employee entitlements	17	56,193	45,123	56,193	48,035	45,123
Total non-current liabilities		56,193	45,123	56,193	48,035	45,123
Total liabilities		602,979	**498,954**	**602,824**	**493,984**	**497,054**
Net assets		**572,955**	**460,149**	**553,378**	**480,712**	**443,122**
Equity						
Contributed Capital	19	432,371	407,971	432,371	464,534	407,971
Accumulated surpluses/(deficits)	19	(317,867)	(254,299)	(317,867)	(290,300)	(254,299)
Property Revaluation Reserves	19	438,874	289,450	438,874	289,451	289,450
Trust funds	19	19,577	17,027	0	17,027	0
Total equity		**572,955**	**460,149**	**553,378**	**480,712**	**443,122**

Explanations of major variances against budget are provided in note 31.

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2021

	Notes	Group Actual 2021 $000	Group Actual 2020 $000	Parent Actual 2021 $000	Group and Parent Budget 2021 $000	Parent Actual 2020 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,997,835	1,886,916	1,997,835	1,985,875	1,886,916
Other		54,425	42,649	54,725	25,262	42,825
Interest received		1,003	1,596	672	623	1,596
Payments to suppliers		(1,222,540)	(1,136,436)	(1,222,540)	(1,224,254)	(1,136,436)
Payments to employees		(768,514)	(722,580)	(768,514)	(782,330)	(722,580)
Payments for capital charge		(21,397)	(28,834)	(21,397)	(26,177)	(28,834)
GST (net)		(1,184)	417	(1,184)	0	417
Net cash flow from operating activities	20	39,628	43,728	39,597	(21,001)	43,904
Cash flows from investing activities						
Sale of fixed assets		38,832	0	38,832	38,729	0
Purchase of property, plant and equipment		(76,418)	(47,122)	(76,418)	(114,861)	(47,122)
Acquisition of investments		(1,316)	(7,144)	(1,316)	0	(7,144)
Net cash flow from investing activities		(38,902)	(54,266)	(38,902)	(76,132)	(54,266)
Cash flows from financing activities						
Capital contributions from the Crown		24,400	26,050	24,400	56,563	26,050
Net cash flow from financing activities		24,400	26,050	24,400	56,563	26,050
Net (decrease)/increase in cash and cash equivalents		**25,126**	**15,512**	**25,095**	**(40,570)**	**15,688**
Cash and cash equivalents at the start of the year		56,565	41,053	52,373	56,564	36,685
Cash and cash equivalents at the end of the year	7	**81,691**	**56,565**	**77,468**	**15,994**	**52,373**

Explanations of major variances against budget are provided in note 31.

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 2021

Reporting entity

The Waitematā 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 consolidated financial statements of Waitematā DHB for the year ended 30 June 2021 comprise Waitematā DHB and its subsidiaries (together referred to as the "Group"). The Group consists of the controlling entity, Waitematā District Health Board and the Three Harbours Health Foundation.

The Waitematā 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 and Group are public benefit entities (PBE) for financial reporting purposes.

The DHB's subsidiaries, associates and joint arrangements are incorporated and domiciled in New Zealand.

The DHB has reported in note 30 on the patient trust monies which it administers.

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

Basis of preparation

Health Sector Reforms
On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly. Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

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

Statement of compliance
The financial statements of the DHB and Group 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).

These financial statements of the DHB and Group comply with PBE Standards.

Measurement base
The financial statements have been prepared on a historical cost basis, except for items identified below which have been measured at fair value.

Presentation currency and rounding
The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($,000's).

Changes in accounting policies and disclosures – New and amended standards and interpretations
The Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

Standards issued and not yet effective, and not early adopted
Amendment to PBE IPSAS 2 Statement of Cash Flows

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

1 Statement of accounting policies for the year ended 30 June 2021 (continued)

PBE FRS 48 Service Performance Reporting
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for the year ending 30 June 2023, with earlier adoption permitted. The Group has not yet determined how the application of PBE FRS 48 will affect its statement of performance.

PBE IPSAS 41 Financial Instruments
PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The group has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The group does not intend to early adopt the standard.

Subsidiaries
Subsidiaries are entities controlled by Waitematā DHB that it is exposed to, or it has rights, to variable benefits from its involvement with the other entity and has the ability to affect the nature or amount of those benefits through its power over the other entity. These financial statements include Waitematā DHB and its subsidiaries, the acquisition of which are accounted for using the acquisition method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In Waitematā DHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

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

Joint Venture
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint control is the agreed sharing of control of an arrangement by way of a binding arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. 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.

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

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

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

Revenue from exchange transactions
MoH population-based revenue
The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Waitematā 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

Statement of accounting policies for the year ended 30 June 2021 (continued)

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 were fulfilled.

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

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 when the outcome of the transactions can be estimated reliably. Revenue from these services is recognised in proportion to the stage of completion in the Statement of Comprehensive Revenue and Expense.

Non exchange transactions
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.

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 New Zealand dollars (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.

Financial Instruments – Initial recognition and subsequent measurement
A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

1 Statement of accounting policies for the year ended 30 June 2021 (continued)

Financial Assets
Initial recognition
Financial assets are classified, at initial recognition, as 'measured at amortised cost', 'fair value through other comprehensive revenue and expense' and 'fair value through surplus or deficit'. See discussion below for determination of classification. A financial asset is initially measured at its fair value plus, in the case of a financial asset not at fair value through surplus or deficit, transaction costs that are directly attributable to the acquisition or issue of the financial asset or financial liability.

Subsequent measurement
Financial assets at amortised cost
This category is the most relevant to the DHB and Group. The classification of financial assets at amortised cost at initial recognition depends on the financial asset's contractual cash flow characteristics and the business model for managing them. In order for a financial asset to be classified and measured at amortised cost, it needs to give rise to cash flows that are 'solely payments of principal and interest' on the principal amount outstanding (SPPI). This assessment is referred to as the SPPI test and is performed at an instrument level. The business model for managing financial assets refers to how it manages its financial assets in order to generate cash flows. The business model determines whether cash flows will result from collecting contractual cash flows, selling the financial assets, or both.

Financial assets at amortised cost are subsequently measured using the effective interest rate (EIR) method and are subject to impairment. Gains and losses are recognised in surplus or deficit when the asset is derecognised, modified or impaired. The DHB and Group measure the following financial assets at amortised cost, Cash and cash equivalents, Short Term Deposits, Trade and Other Receivables, Prepayments and Trusts and Special Purpose Funds not recognised at a market value. Cash and cash equivalents include 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.

Financial assets at fair value through surplus or deficit
Financial assets at fair value through surplus or deficit include financial assets held for trading, financial assets designated upon initial recognition at fair value through surplus or deficit, or financial assets mandatorily required to be measured at fair value. Financial assets are classified as held for trading if they are acquired for the purpose of selling or repurchasing in the near term. Financial assets with cash flows that are not solely payments of principal and interest are classified and measured at fair value through surplus or deficit, irrespective of the business model. Notwithstanding the criteria for debt instruments to be classified at amortised cost or at fair value through other comprehensive revenue and expense, as described above, debt instruments may be designated at fair value through surplus or deficit on initial recognition if doing so eliminates, or significantly reduces, an accounting mismatch.

Financial assets at fair value through surplus or deficit are carried in the statement of financial position at fair value with net changes in fair value recognised in the statement of surplus or deficit. The DHB and Group have the following financial assets classified at fair value though surplus or deficit, Investments in associates and portfolio investments.

Financial assets at fair value through other comprehensive revenue and expense
Financial assets at fair value through other comprehensive revenue and expenses comprise those equity instruments that the DHB and Group has elected to classify as fair value through other comprehensive income on initial recognition when they meet the definition of equity instruments. Gains and losses on these financial assets are never recycled to surplus or deficit. Dividends are recognised in surplus or deficit, when the right to receive payment has been established.

The Group does not hold any financial assets classified at fair value through other comprehensive revenue and expense.

Assets held for sale
An asset is classified as held for sale if its carrying amount will be recovered principally through sale rather than through continuing use. Assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell. Any impairment losses for write-downs of assets held for sale, while classified as held for sale, are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

De-recognition
A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is primarily derecognised (i.e. removed from the Group's consolidated statement of financial position) when the rights to receive cash flows from the asset have expired.

Statement of accounting policies for the year ended 30 June 2021 (continued)

Impairment of financial assets
The DHB recognises an allowance for expected credit losses (ECLs) for all debt instruments not held at fair value through surplus or deficit. ECLs are based on the difference between the contractual cash flows due in accordance with the contract and all the cash flows that the DHB and Group expects to receive, discounted at an approximation of the original effective interest rate. ECLs are recognised in two stages. For credit exposures for which there has not been a significant increase in credit risk since initial recognition, ECLs are provided for credit losses that result from default events that are possible within the next 12-months (a 12-month ECL). For those credit exposures for which there has been a significant increase in credit risk since initial recognition, a loss allowance is required for credit losses expected over the remaining life of the exposure, irrespective of the timing of the default (a lifetime ECL).

For trade and other receivables, the DHB and Group apply a simplified approach in calculating ECLs. Therefore, credit risk is not tracked, but instead the DHB and Group recognise a loss allowance based on lifetime ECLs at each reporting date. The DHB and Group have established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. The DHB and Group considers a financial asset in default when contractual payments are 90 days past due. However, in certain cases, the DHB and Group may also consider a financial asset to be in default when internal or external information indicates that the DHB and Group is unlikely to receive the outstanding contractual amounts in full before taking into account any credit enhancements held. A financial asset is written off when there is no reasonable expectation of recovering the contractual cash flows.

Financial liabilities at amortised cost
Initial recognition and measurement
Financial liabilities are classified, at initial recognition, as financial liabilities at fair value through surplus or deficit, or at amortised costs, as appropriate. All financial liabilities are recognised initially at fair value and, in the case financial liabilities at amortised cost, net of directly attributable transaction costs. The DHB's and Group's financial liabilities include trade creditors and other payables, borrowings including an overdraft facility which are classified at amortised cost. The DHB has not classified any financial liabilities as financial liabilities through surplus or deficit. 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.

Subsequent measurement
The measurement of financial liabilities depends on their classification, as described below. This is the category most relevant to the DHB. After initial recognition, financial liabilities at amortised cost are subsequently measured at amortised cost using the effective interest rate (EIR) method. Gains and losses are recognised in surplus or deficit when the liabilities are derecognised as well as through the EIR amortisation process. Amortised cost is calculated by taking into account any discount or premium on acquisition and fees or costs that are an integral part of the EIR. The EIR amortisation is included as finance costs in the statement of surplus or deficit. Short-term payables are recorded at their face value; due to the short-term nature of them they are not discounted.

De-recognition
A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

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 at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge 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.

Statement of accounting policies for the year ended 30 June 2021 (continued)

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 at the reporting date. 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 is recognised as an expense when incurred.

Statement of accounting policies for the year ended 30 June 2021 (continued)

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

- 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.

Finance, Procurement and Information Management System (formerly National Oracle Solution)
The Finance, Procurement and Information Management System (FPIM) (previously part of the National Oracle Solution programme), is an initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver benefits to the DHBs involved. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitematā DHB holds an asset at cost of capital invested by the DHB in FPIM. This investment represents the right to access the FPIM assets and is considered to have an indefinite life. DHBs have the ability and intention to renew 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
Cash generating 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 asset 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.

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. An actuarial 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 event 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, vested long service and sabbatical leave that are 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.

Statement of accounting policies for the year ended 30 June 2021 (continued)

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.

Make Good Lease Provision

A make good lease provision is made where operating leases contain clauses which specify that the Group should incur periodic charges for maintenance, make good dilapidations or other damage occurring during the rental period or requires the Group to return the asset to the configuration that existed at inception of the lease. The provision reflects the estimate of only the conditions as at the reporting date. The outflow of the provision would be expected at cessation of each lease. Assumptions were made around the term of the period of the lease based on the contractual term and expectations around exercising rights of renewal, which is subject to uncertainty. Further assumptions are made around the expected cost of meeting these lease obligations and estimating the present value of the provision, which also come with inherent uncertainty.

ACC Accredited Employers Programme

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan) whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

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

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
- trust/special funds.

Contributions from/ (repayment to) the Crown

Contributions from the Crown for DHB Crown approved projects.

Property Revaluation reserve

The revaluation reserve movement relates to the independent valuation of land and buildings carried out by Telfer Young (Auckland) Ltd.

Statement of accounting policies for the year ended 30 June 2021 (continued)

Trust/special funds
Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds. All trust funds are held in bank accounts that are separate from the DHB's normal banking facilities. Refer to Note 30 for details.

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 (SPE) as approved by the Board at the beginning of the financial year to ensure we report against original approved budget. The budget figures were prepared in accordance with NZ GAAP, using accounting policies consistent with those adopted by the Board in preparing these financial statements.

The format of the budget is different to that shown in the Financial Statements. The amounts that are disclosed are the same, however what has been presented has been reformatted to the purpose of 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:

Estimating the fair value of Land and building
The most recent valuation of land and buildings was performed by an independent registered valuer, Evan Gamby – M Prop Stud (Distn); Dip UV; FNZIV (Life); LPINZ; FRICS; Registered Valuer of TelferYoung Limited. The valuation is effective as at 30 June 2021. Note 13 provides more details.

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.

1 Statement of accounting policies for the year ended 30 June 2021 (continued)

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

Estimating the liabilities for retirement gratuities, sabbatical leave and continuing medical education leave
Note 17 provides an analysis of the exposure in relation to estimates and uncertainties surrounding these leave liabilities.

Measuring the liabilities for Holidays Act 2003 remediation
Refer to Note 17 for details on the exposure in relation to the estimates and uncertainties surrounding provisions for Holidays Act 2003 remediation.

Provision for expected credit losses
The Group uses a provision matrix to calculate ECLs for trade and other receivables and contract assets. The provision rates are based on days past due. The ECL calculation is initially based on the Group's historical observed default rates. The Group will adjust the historical credit loss experience with forward-looking information. For instance, if forecast economic conditions are expected to deteriorate over the next year, the historical default rates are adjusted. At every reporting date, the historical observed default rates are updated and changes in the forward-looking estimates are analysed. The assessment of the correlation between historical observed default rates, forecast economic conditions and ECLs is a significant estimate. The amount of ECLs is sensitive to changes in circumstances and of forecast economic conditions. The

Group's historical credit loss experience and forecast of economic conditions may also not be representative of customer's actual default in the future. The information about the ECLs on the Group's trade receivables and contract assets is disclosed in Note 8.

Critical judgements in applying accounting policies
The Board 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.

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 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 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Health and disability services (MOH contracted revenue)	1,885,270	1,779,469	1,885,270	1,779,469
ACC contract revenue	12,651	11,512	12,651	11,512
Inter district patient inflows	88,797	85,439	88,797	85,439
Revenue from other district health boards	15,396	8,436	15,396	8,436
Other patient sourced revenue	17,914	18,684	17,914	18,684
Total patient care revenue	**2,020,028**	**1,903,540**	**2,020,028**	**1,903,540**

3 Other revenue

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Clinical Training Agency	9,886	9,750	9,886	9,750
Donations and bequests received	1,735	5,767	1,735	5,767
Rental revenue	883	855	883	855
Professional, training and research	3,072	5,255	6,736	5,255
Dividend income	0	167	0	167
Gain on sale of assets held for sale	10,496	0	10,496	0
Other revenue	22,269	10,354	20,090	9,734
Total other revenue	**48,341**	**32,148**	**49,826**	**31,528**

4 Personnel costs

	Group		Parent	
Notes	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Salaries and wages	746,869	700,289	746,869	700,289
Contributions to defined contribution schemes	21,172	22,511	21,172	22,511
Increase/(decrease) in liability for employee entitlements	63,392	66,561	63,392	66,561
Total personnel costs	**831,433**	**789,361**	**831,433**	**789,361**

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

5 Capital charge

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six-month actual closing equity balance. The capital charge rate for the year ended 30 June 2021 was 5% (2020: 6%).

6 Other expenses

	Notes	Group Actual 2021 $000	Group Actual 2020 $000	Parent Actual 2021 $000	Parent Actual 2020 $000
Audit fees for Waitematā DHB financial statement audit		266	249	266	249
Audit fees (for subsidiary financial statements)		0	0	0	0
Operating lease expense		11,427	9,823	11,427	9,823
Impairment of debtors	8	1,794	1,938	1,794	1,938
Impairment of Work in Progress	13	10,530	0	10,530	0
Disposal of Work in Progress	13	1,091	1,539	1,091	1,539
Board members fees	24	357	362	357	362
Other expenses		236	1,415	236	1,415
Total other expenses		**25,702**	**15,326**	**25,702**	**15,326**

No audit fees have been incurred for the subsidiary financial statements for the current or prior financial year as these audits are still outstanding. The DHB is working with their external auditors to complete the work required to obtain an appropriate level of assurance.

7 Cash and cash equivalents

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 $4.230m (2020: $4.192m) 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.

Waitematā DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited and the participating DHBs. This Agreement enables New Zealand Health Partnerships Limited to 'sweep' DHB bank accounts and invest surplus funds on their behalf. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZ Health Partnerships Limited.

	Group Actual 2021 $000	Group Actual 2020 $000	Parent Actual 2021 $000	Parent Actual 2020 $000
Cash at bank and on hand	4,230	4,194	7	2
Call deposits	0	0	0	0
NZ Health Partnerships Limited	77,461	52,371	77,461	52,371
Total cash and cash equivalents for the purposes of the statement of cash flows	**81,691**	**56,565**	**77,468**	**52,373**

8 Receivables

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Ministry of Health	43,644	27,142	43,644	27,142
Other receivables	15,723	10,502	15,051	9,851
Other accrued revenue	13,886	21,131	15,418	21,112
Less: Provision for impairment	(3,088)	(3,192)	(3,088)	(3,192)
Total receivables	**70,165**	**55,583**	**71,025**	**54,913**

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 2021			Group 2020		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	66,329	(29)	66,300	51,815	(22)	51,793
Past due 1-30 days	1,805	(130)	1,675	1,067	(239)	828
Past due 31-60 days	1,391	(147)	1,244	1,361	(202)	1,159
Past due 61-90 days	868	(173)	695	362	(173)	189
Past due >90 days	4,392	(2,609)	1,783	4,170	(2,556)	1,614
Total	**74,785**	**(3,088)**	**71,697**	**58,775**	**(3,192)**	**55,583**

	Parent 2021			Parent 2020		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	67,153	(29)	67,124	51,145	(22)	51,123
Past due 1-30 days	1,067	(130)	937	1,067	(239)	828
Past due 31-60 days	1,361	(147)	1,214	1,361	(202)	1,159
Past due 61-90 days	362	(173)	189	362	(173)	189
Past due >90 days	4,170	(2,609)	1,561	4,170	(2,556)	1,614
Total	**74,113**	**(3,088)**	**71,025**	**58,105**	**(3,192)**	**54,913**

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

The average expected credit loss rates are detailed below.

	Group		Parent	
	2021 Rate	2020 Rate	2021 Rate	2020 Rate
Not past due	0%	0%	0%	0%
Past due 1-30 days	7%	22%	12%	22%
Past due 31-60 days	11%	15%	11%	15%
Past due 61-90 days	20%	48%	48%	48%
Past due >90 days	59%	61%	63%	61%

Provision for impairment is calculated based on a review of significant debtor balances and an assessment of impairment using an “expected credit loss” model. The impairment assessment is based on an analysis of the likelihood to pay based on current circumstances and past collection history and write-offs. The expected credit loss rate is variable depending on the debtor category, therefore average rates across all categories have been included above.

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

	Group		Parent	
	2021 $000	2020 $000	2021 $000	2020 $000
Balance at 1 July	(3,192)	(3,240)	(3,192)	(3,240)
Additional provisions made	(1,794)	(1,938)	(1,794)	(1,938)
Receivables written off	1,898	1,986	1,898	1,986
Balance at 30 June	**(3,088)**	**(3,192)**	**(3,088)**	**(3,192)**

FINANCIAL PERFORMANCE

9 Investments

Portfolio investments are held by Three Harbours Health Foundation and are comprised of New Zealand and international fixed interest bonds, property and other equities ordinary shares and multi-currency term deposits.

	Group		Parent	
	2021 $000	2020 $000	2021 $000	2020 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	962	3,042	0	0
Total current portion	962	3,042	0	0
Non-current portion				
Portfolio investments	15,407	11,023	0	0
Total non-current portion	15,407	11,023	0	0
Total investments	**16,369**	**14,065**	**0**	**0**

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

Portfolio investments are measured at fair value through the surplus or deficit, having been designated as such on initial recognition.

The fair value of portfolio investment with a remaining duration greater than 12 months is $15.407m (2020: $11.023m). 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 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Pharmaceuticals	764	787	764	787
Surgical and medical supplies	8,965	8,234	8,965	8,234
Total inventories	**9,729**	**9,021**	**9,729**	**9,021**

The write-down of inventories held for distribution amounted to $nil (2020: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2020: $nil). However, some inventories are subject to retention of title clauses.

11 Assets held for sale

Parent and group	Land $000	Buildings $000	Total $000
Balance at 1 July 2020	12,212	9,388	21,600
Transfer to Statement of Comprehensive Income	(12,212)	(9,388)	(21,600)
Total assets held for sale	**0**	**0**	**0**

On 27 November 2020, 44 Taharoto Road and 9 Karaka Street were sold for $39m. A gain on sale of $10.5m was recognised directly in the Statement of Comprehensive Income. The gain on sale is net of $6.9m of cost of settlement and expected capital works required under the settlement conditions.

12 Investments in associates and joint ventures

	Principal activity	Interest held 30 Jun 2021	Balance date
Investments in joint ventures			
healthAlliance N.Z. Limited – Class A shares	Provider of shared services	25%	30 Jun
Healthsource New Zealand Limited	Provider of shared services	25%	30 Jun
Investments in associates			
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	Provision of health support services	33.3%	30 Jun

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

Investments in joint ventures
In 2019/20 healthAlliance (FPSC) Limited was renamed to HealthSource New Zealand Limited. In June 2020 25% interest of HealthSource New Zealand Limited was purchased from healthAlliance N.Z. Limited to the DHB's direct ownership.

The contractual arrangements with healthAlliance N.Z. Limited and HealthSource New Zealand Limited provide the Group with only the rights to the net assets of the joint arrangement. Under PBE IPSAS 37 these joint arrangements are classified as joint ventures.

Joint operations
Awhina Waitakere Health Campus is a jointly controlled operation between Unitec Institute of Technology and Waitematā 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	
	2021 $000	2020 $000	2021 $000	2020 $000
healthAlliance N.Z. Limited	47,783	46,842	47,783	46,842
HealthSource New Zealand Limited	170	170	170	170
McCrae Research	600	224	600	224
Total investments	**48,553**	**47,236**	**48,553**	**47,236**

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

There were no impairment losses in the value of associates and joint ventures assessed for 2021 (2020: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $47.783m (2020: $46.842m).

Summary of financial information of associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2021					
Northern Regional Alliance Ltd	26,653	21,890	4,764	18,576	1,207
Total	**26,653**	**21,890**	**4,764**	**18,576**	**1,207**
2020					
Northern Regional Alliance Ltd	23,770	20,211	3,559	18,223	1,101
Total	**23,770**	**20,211**	**3,559**	**18,223**	**1,101**

12 Investments in associates and joint ventures (continued)

healthAlliance N.Z. Limited	2021 $000	2020 $000
Current assets	42,384	25,192
Non-current assets	197,263	199,102
Current Liabilities	32,058	22,851
Non-current liabilities	9,639	11,436
Included in the above amounts are:		
Cash and cash equivalents	25,731	15,653
Current financial liabilities (excluding trade payables)	10,286	10,082
Non-current financial liabilities (excluding trade payables)	9,639	11,436
Net assets (100%)	**197,951**	**190,007**
Revenue	152,357	137,819
Other comprehensive income	0	0
Total comprehensive income (100%)	(80)	(2,087)
Included in the above amounts are:		
Depreciation and amortisation	47,363	42,658
Interest income	68	207
Interest expense	507	0

HealthSource New Zealand Limited	2021 $000	2020 $000
Current assets	8,876	7,977
Non-current assets	206	217
Current Liabilities	6,706	5,865
Non-current liabilities	1,663	1,693
Included in the above amounts are:		
Cash and cash equivalents	7,553	6,458
Current financial liabilities (excluding trade payables)	4,378	4,191
Non-current financial liabilities (excluding trade payables)	1,663	1,693
Net assets (100%)	**711**	**636**
Revenue	42,265	34,131
Other comprehensive income	0	0
Total comprehensive income (100%)	76	(41)
Included in the above amounts are:		
Depreciation and amortisation	95	55
Interest income	49	56
Interest expense	0	0

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

	2021 $000	2020 $000
Share of surplus/(deficit) before tax:	401	(165)
Less: Tax expense	0	0
Share of surplus/(deficit)	**401**	**(165)**

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

13 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 2019	249,915	419,926	137,415	36,459	4,881	23,387	871,983
Additions from WIP	16,923	4,961	6,696	1,451	1,226	(31,258)	0
Revaluation increase/(decrease)	0	0	0	0	0	0	0
Additions to WIP	0	0	0	0	0	56,635	56,635
Disposals	0	0	0	(89)	0	(1,539)	(1,628)
Transfer to intangible assets	0	0	0	0	0	0	0
Transfer to assets held for sale	0	0	0	0	0	0	0
Balance at 30 June 2020	266,838	424,887	144,111	37,821	6,107	47,225	926,989
Balance at 1 July 2020	266,838	424,887	144,111	37,821	6,107	47,225	926,989
Additions from WIP	0	33,324	8,890	1,289	626	(44,129)	0
Revaluation increase/(decrease)	77,433	13,899	0	0	0	0	91,333
Additions to WIP	0	0	0	0	0	82,074	82,074
Disposals	0	0	0	(362)	(855)	(1,091)	(2,308)
Transfer to intangible assets	0	0	0	0	0	0	0
Transfer to assets held for sale	0	0	0	0	0	0	0
Balance at 30 June 2021	344,271	472,110	153,001	38,748	5,878	84,079	1,098,088
Accumulated depreciation and impairment losses							
Balance at 1 July 2019	0	23,360	103,163	27,140	4,354	0	158,017
Depreciation expense	0	17,398	7,331	2,070	612	0	27,411
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	(88)	0	0	(88)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2020	0	40,758	110,494	29,122	4,966	0	185,340
Balance at 1 July 2020	0	40,758	110,494	29,122	4,966	0	185,340
Depreciation expense	0	17,335	7,625	2,167	163	0	27,290
Impairment losses	0	0	0	0	0	10,531	10,530
Elimination on disposal/transfer	0	0	0	(362)	0	0	(362)
Elimination on revaluation	0	(58,093)	0	0	0	0	(58,092)
Balance at 30 June 2021	0	0	118,119	30,927	5,129	10,531	164,707
Carrying amounts							
At 1 July 2019	249,915	396,566	34,252	9,319	527	23,387	713,966
At 30 June and 1 July 2020	266,838	384,129	33,617	8,699	1,141	47,225	741,649
At 30 June 2021	**344,271**	**472,110**	**34,882**	**7,821**	**749**	**73,548**	**933,381**

The net carrying amounts of assets held under finance leases is nil (2020: nil) for clinical equipment. There are no IT assets in Work in Progress that need to be transferred to healthAlliance N.Z. Limited (2020: nil).

Impairment losses of $10.5m were recognised in the year (2020: nil) against work in progress projects. This has been recognised where there is risk that costs will not result in an asset due to uncertainty around the project's completion or the value that the completed project would provide the DHB. In addition, $1.1m (2020: $1.5m) of work in progress costs were disposed off for projects that have been discontinued.

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, Evan Gamby – M Prop Stud (Distn); Dip UV; FNZIV(Life); LPINZ; FRICS; Registered Valuer of TelferYoung Limited. The valuation is effective as at 30 June 2021.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. 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. There has been added uncertainty to the estimated land values due to the high levels of appreciation in the market over the last 12 months. There is an on-going concerted effort from the Local and Central Government to manage land values and this may influence the fair value allocated at this point.

13 Property, plant and equipment (continued)

Land values were determined using a number of significant assumptions. Significant assumptions used in the 30 June 2021 valuation include:

- The land values that have been applied across the sites range from $435 to $3,000 (2018: $335 to $1,810) per square meter across all sites. The increases haven been driven by a growing demand for land in the Auckland Region and this has been evidenced by a review of recent sales in the region. The values of recent sales in this review varied from $138.28/m2 to $9,113.65/m2.
- Deductions have been applied to estimated land values to reflect impediments that prevent the land from being used at its highest and best use. These deductions range from 10% to 15% (2018: 10% to 15%) of the highest and best use value.

Buildings

All DHB Assets that have been valued are specialised hospital buildings (with the exception of 3 Mary Poynton Crescent). They are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. There is has been added uncertainty to the estimate of replacement cost forecasts due to the impact that COVID-19 and other related events have had and may have on supply chain of materials and labour market shortages.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions used in the 30 June 2021 valuation include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity. There have been no optimisation adjustments for the most recent valuation
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information
- There are no significant asbestos issues associated with the buildings and therefore no allowance made for deferred maintenance in this regard
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, the DHB's future maintenance and replacement plans, and experience with similar buildings
- Future maintenance costs relating to the current state of buildings have been considered over a 5 year period from 1 July 2021. This cost is estimated to be $55.1m and has been factored into the valuation of the buildings
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset
- The valuation considered the current understanding of the seismic condition of the buildings. Buildings that are an earthquake risk have been accorded a low or nil value by an adjustment to their respective residual life and an allowance for deferred maintenance where known.

Depreciation replacement costs varied depending on the location and nature of the building space. The following depreciation replacements ranges have been applied to the valuation estimation:

2021 Valuation	Specialist Patient Care buildings ($/m2)	Non-Specialist Patient buildings ($/m2)
North Shore Hospital Site	$3,042 to $18,674	$892 to $8,757
Waitakere Hospital Site	$3,601 to $11,682	$658 to $2,738
Mason Clinic Site	$1,420 to $8,929	$577 to $1,519
Dental Clinics	$3,986 to $6,726	n/a

2018 Valuation (excluding buildings sold during the 2021 financial year)	Specialist Patient Care buildings ($/m2)	Non-Specialist Patient buildings ($/m2)
North Shore Hospital Site	$2,704 to $16,599	$793 to $7,784
Waitakere Hospital Site	$3,201 to $10,384	$585 to $2,434
Mason Clinic Site	$1,262 to $7,937	$1,350 to $1,350
Dental Clinics	$3,543 to $5,979	n/a

Specialist patient care buildings and spaces are those that are purpose built for caring for patients. Non specialist patient buildings include building areas such as car parking buildings, office spaces, workshops and cafeterias.

The only non-specialised buildings included in the valuation is 3 Mary Poynton Crescent which is valued at fair value using market-based evidence using the capitalisation method under the income approach. The fair valuation of 3 Mary Poynton Crescent building was estimated to be $238k as at 30 June 2021 (2018: $679k).

13 Property, plant and equipment (continued)

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

	2021 $000	2020 $000
Buildings	67,143	38,427
Clinical equipment	5,858	6,411
Other equipment	547	1,824
IT equipment	0	562
Total work in progress	**73,548**	**47,225**

Impairment
No impairment loss has been identified in property, plant and equipment in 2021 (2020: 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.

14 Intangible assets

Finance, Procurement and Information Management System (FPIM); previously known as the National Oracle Solution (NOS)
The FPIM rights were tested for impairment at 30 June 2021 by comparing the carrying amount of the intangible asset to its recoverable service amount. A review of the assets value in use has been performed by considering the progress of the FPIM rollout across the DHBs. Based on this assessment, no impairment has been identified for the year ended 30 June 2021.

14 Intangible assets (continued)

Movements for each class of intangible assets are as follows.

Parent and Group	FPIM Rights $000	Acquired Software $000	Work in Progress $000	Total $000
Cost				
Balance at 30 June 2019	2,849	14,038	5,092	21,979
Additions to WIP*	0	0	5,036	5,036
Additions from WIP	0	3,416	(3,416)	0
Transferred to healthAlliance N.Z. Limited	0	(7,042)	(803)	(7,845)
Disposals	0	(100)	(23)	(123)
Impairment	0	0	0	0
Balance at 30 June 2020	**2,849**	**10,312**	**5,886**	**19,047**
Additions to WIP*	0	0	2,503	2,503
Additions from WIP	0	2,549	(2,549)	0
Transferred to healthAlliance N.Z. Limited	0	0	0	0
Disposals	0	0	(292)	(292)
Impairment	0	0	0	0
Balance at 30 June 2021	2,849	12,861	5,548	21,258
Accumulated amortisation and impairment losses				
Balance at 30 June 2019	0	6,915	0	6,915
Amortisation expense	0	2,091	0	2,091
Transferred to healthAlliance N.Z. Limited	0	(2,214)	0	(2,214)
Balance at 30 June 2020	**0**	**6,792**	**0**	**6,792**
Amortisation expense	0	3,320	0	3,320
Transferred to healthAlliance N.Z. Limited	0	0	0	0
Balance at 30 June 2021	0	10,111	0	10,111
Carrying amounts				
At 1 July 2019	2,849	7,123	5,092	15,064
At 30 June 2020	**2,849**	**3,520**	**5,886**	**12,256**
At 30 June 2021	**2,849**	**2,750**	**5,548**	**11,147**

*This includes transfer from PPE WIP

15 Payables

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Creditors and accrued expenses	141,550	123,329	141,395	121,429
Revenue in advance	23,798	7,011	23,798	7,011
GST payable	7,994	9,177	7,994	9,177
Capital charge payable	430	481	430	481
Total payables	**173,772**	**139,998**	**173,617**	**138,098**

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.

16 Borrowings

There are no current finance leases held by the DHB.

17 Employee entitlements

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Current portion				
Holidays Act 2003 remediation	192,494	166,600	192,494	166,600
Accrued salaries and wages	14,987	19,488	14,987	19,488
Annual leave	104,071	95,329	104,071	95,329
Sick leave	1,584	1,311	1,584	1,311
Sabbatical leave	416	232	416	232
Continuing medical education	9,844	7,014	9,844	7,014
Work-related entitlements	0	(2)	0	(2)
Other employee entitlements	9,375	8,538	9,375	8,538
Unsettled CEAs	18,290	1,230	18,290	1,230
Long service leave	3,957	3,605	3,957	3,605
Retirement gratuities	6,867	6,218	6,867	6,218
Total current portion	361,885	309,563	361,885	309,563
Non-current portion				
Continuing medical education	12,528	8,927	12,528	8,927
Long service leave	8,873	8,102	8,873	8,102
Sabbatical leave	6,354	2,929	6,354	2,929
Retirement gratuities	24,809	22,432	24,809	22,432
Sick leave	3,629	2,733	3,629	2,733
Total non-current portion	56,193	45,123	56,193	45,123
Total employee entitlements	**418,078**	**354,686**	**418,078**	**354,686**

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 of 1.06% (2020: 1.08%) and the salary inflation factor 1.85% (2020: 1.7%). In addition a risk margin of 10% (2020: 8.2%) was applied to the central estimate. Any changes in these assumptions will affect the carrying amount of the liability.

Holidays Act 2003 remediation

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all noncompliance progressed during the 2019/20 and current financial years. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability was estimated by:

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

This liability recognised is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

17 Employee entitlements (continued)

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

An estimated contingent liability of $62.4m (2020: $55.9m) relating to the Holidays Act has also been disclosed. Further details of this contingency has been detailed in note 22.

18 Provisions

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Current portion				
ACC Partnership Programme	1,539	1,800	1,539	1,800
Make good provision	2,690	2,470	2,690	2,470
Cost of settlement - 44 Taharoto Road and 9 Karaka Street (note 11)	6,900	0	6,900	0
Total current portion	**11,129**	**4,270**	**11,129**	**4,270**
Total provisions	**11,129**	**4,270**	**11,129**	**4,270**

Movements for each class of provision	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Balance at 1 July	4,270	4,776	4,270	4,776
Movement in provisions	6,859	(506)	6,859	(506)
Amounts used	0	0	0	0
Balance at 30 June	**11,129**	**4,270**	**11,129**	**4,270**

ACC Partnership Programme

Liability valuation

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

Risk margin

A risk margin of 10% (2020: 8.2%) has been assessed to allow for the inherent uncertainty in the central estimate of the claim's 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 1.85% (2020: 1.7%)
- a weighted average discount factor of 1.06% (2020: 1.08%) was 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.

19 Equity

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Crown equity				
Balance at 1 July	407,971	381,921	407,971	381,921
Capital contributions from the Crown	24,400	26,050	24,400	26,050
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	432,371	407,971	432,371	407,971
Accumulated surpluses/(deficits)				
Balance at 1 July	(254,299)	(185,103)	(254,299)	(185,103)
Prior year adjustments	0	0	0	0
	(254,299)	(185,103)	(254,299)	(185,103)
Surplus/(deficit) for the year	(61,018)	(68,198)	(63,568)	(69,196)
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(2,550)	(998)	0	0
Balance at 30 June	(317,867)	(254,299)	(317,867)	(254,299)
Revaluation reserves				
Balance at 1 July	289,450	289,450	289,450	289,450
Impairment loss	0	0	0	0
Revaluations	149,424	0	149,424	0
Balance at 30 June	438,874	289,450	438,874	289,450
Revaluation reserves consist of:				
Land	324,788	247,275	324,788	247,275
Buildings	114,086	42,175	114,086	42,175
Total revaluation reserves	438,874	289,450	438,874	289,450
Trust Funds				
Balance at 1 July	17,027	16,029	0	0
Movement	2,550	998	0	0
Balance at 30 June	19,577	17,027	0	0
Total equity	**572,955**	**460,149**	**553,378**	**443,122**

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

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Net surplus/(deficit)	**(61,018)**	**(68,198)**	**(63,568)**	**(69,196)**
Add/(less) non-cash items				
Depreciation and amortisation expense	30,838	28,926	30,838	28,926
Total non-cash items	**30,838**	**28,926**	**30,838**	**28,926**
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/loss investments	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	(10,559)	1,658	(10,559)	1,658
	(10,559)	**1,658**	**(10,559)**	**1,658**
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(18,659)	1,447	(18,659)	1,447
Inventories	(707)	(765)	(707)	(765)
Creditors and other payables	29,955	14,389	32,474	15,563
Provisions	6,859	(506)	6,859	(506)
Employee entitlements	62,919	66,777	62,919	66,777
Net movements in working capital items	**80,367**	**81,342**	**82,886**	**82,516**
Net cash flow from operating activities	**39,628**	**43,728**	**39,597**	**43,904**

21 Capital commitments and operating leases

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Capital commitments				
Property	138,376	43,038	138,376	43,038
Equipment	3,730	2,022	3,730	2,022
Total capital commitments	**142,106**	**45,060**	**142,106**	**45,060**

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 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Not later than one year	9,417	6,956	9,417	6,956
Later than one year and not later than five years	24,843	14,524	24,843	14,524
Later than five years	16,475	4,142	16,475	4,142
Total non-cancellable operating leases as lessee	**50,735**	**25,622**	**50,735**	**25,622**

22 Contingencies

Contingent liabilities
Lawsuits against the DHB
Waitematā DHB and its associates were notified of potential legal claims at 30th June 2021 which creates a contingent liability totalling approximately $910k (2020: approximately $285k) which related to various disputed claims against the DHB.

At balance date, Unitec Institute of Technology have granted nil (2020: $87k) towards the refurbishment of Awhina Health Campus which was completed on 2 November 2011. If certain conditions in the joint operation agreement are not fulfilled, Waitematā DHB would need to repay some, or all, of this amount.

Holidays Act
An estimated contingent liability of $62.4m (2020: $55.9m) relates to the Holidays Act. The estimate is made up mainly of two key components detailed below:

- A potential underpayment of $27.7m (2020: $24.8m) for the underpayment of annual leave to Registered Medical Officers (RMO)
    - Under the Multiple Employer Collective Agreement (MECA) with the Resident Doctors Association (RDA) when RMO leave one DHB and join another one in the region, any annual leave liability is transferred to the receiving DHB and the leave balance is paid to that DHB.
    - The Labour Inspectorate has ruled that this is a breach and that each DHB should have paid out the annual leave to the RMO when they left the DHB. Given the specific circumstances that protects the employee's entitlement to take leave when transferring between DHBs and the written agreements that are in place the Labour Inspectorate does not intend to take further enforcement action in relation to the historical practice of crediting annual leave entitlements. This does not prevent an affected employee bringing the claim against the employer and does not prevent the Labour Inspectorate from taking action in the future.
    - The extent of any liability is contingent upon a future action being made by the Labour Inspectorate or an affected employee. In addition, this is not an area that has yet been contested in the courts and there is an indication of significant uncertainty to the probability and reliability of any estimation.

22 Contingencies (continued)

- A potential underpayment of holiday pay of $34.4m (2020: $30.8m) for the exclusion of allowances from gross earnings when calculating annual leave entitlements
    - These allowances (like higher duties and Clinical Leadership) are paid irrespective of whether or not an employee is on annual leave. Because of this, the DHB exclude these payments from gross earnings when calculating the rate at which annual leave should be paid.
    - The Labour Inspectorate's view is that leave is underpaid because these payments should be included in gross earnings when calculating the rate of annual leave payments. They also advised that the specific allowances should not be paid when staff are on leave.
    - An estimate of the underpayment has been included in the Holiday Pay Provision of $192.5m (2020: $166.6m) This is based on the assumption that a line by line method of remediation will be undertaken and that the difference between what was paid for holiday pay (Gross earnings plus the allowance) and what should have been paid using the correct Average Weekly Earnings.
    - The $34.4m (2020: $30.80m) represents an estimate of the potential underpayment if the gross earnings are adjusted to include the allowances and no consideration is taken to include the allowance in the comparison of what has been paid to what was paid. The DHB is working through how this issue can be remediated and for the extent and value of any liability is contingent upon the result of this remediation or any future action being made by the Labour Inspectorate or an affected employee.

23 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. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2020: $nil).

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $1.898b (2020: $1.791b) to provide health services in the Waitematā area for the year ended 30 June 2021.

Transactions with key management personnel

Key management personnel compensation	Actual 2021 $000	Actual 2020 $000
Board members:		
Remuneration	357	362
Full-time equivalent members	9	11
Salaries and other employee benefits of Executive Leadership Team (ELT)	3,595	3,448
Average full-time equivalent ELT members during the year	10	10
Number of ELT members as at 30 June	11	12
Total key management personnel remuneration	**3,952**	**4,257**
Total full-time equivalent personnel	**19**	**21**

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. As at 30 June 2021, the number of key management personnel included the Chief Executive Officer and ten members of the management team (2020: eleven members). Salaries and other employee benefits of Executive Leadership Team exclude leave cash out payments and any settlement costs of $200k (2020: $226k).

24 Board member remuneration

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

	Actual 2021 $000	Actual 2020 $000
Prof Judith McGregor (Chair)	67	60
Prof Max Abbott	0	32
Edward Benson-Cooper	37	32
Sandra Coney	35	31
Kylie Clegg	43	40
Warren Flaunty	37	34
James Le Fevre	0	13
John Bottomley	32	0
Morris Pita	0	12
Allison Roe	35	30
Matire Harwood	0	11
Brian Neeson	0	14
Christopher Carter	34	18
Renata Watene	37	18
Arena Williams	0	17
Total board member remuneration	**357**	**362**

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $26k (2020: $28k) – Norman Wong (Audit and Finance Committee).

The DHB provided a deed of indemnity to Board members for certain activities undertaken in the performance of DHB functions. The DHB 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 (2020: $nil).

25 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 2021	Actual 2020		Actual 2021	Actual 2020
$100,000 – 109,999	527	478	$370,000 – 379,999	7	9
$110,000 – 119,999	322	264	$380,000 – 389,999	11	6
$120,000 – 129,999	231	186	$390,000 – 399,999	12	3
$130,000 – 139,999	148	109	$400,000 – 409,999	9	10
$140,000 – 149,999	75	74	$410,000 – 419,999	8	8
$150,000 – 159,999	50	52	$420,000 – 429,999	9	10
$160,000 – 169,999	44	31	$430,000 – 439,999	5	6
$170,000 – 179,999	28	16	$440,000 – 449,999	6	5
$180,000 – 189,999	34	34	$450,000 – 459,999	10	4
$190,000 – 199,999	19	27	$460,000 – 469,999	4	4
$200,000 – 209,999	24	20	$470,000 – 479,999	2	7
$210,000 – 219,999	23	16	$480,000 – 489,999	2	7
$220,000 – 229,999	28	25	$490,000 – 499,999	3	2
$230,000 – 239,999	28	23	$500,000 – 509,999	7	0
$240,000 – 249,999	19	21	$510,000 – 519,999	3	1
$250,000 – 259,999	21	25	$520,000 – 529,999	1	1
$260,000 – 269,999	27	20	$530,000 – 539,999	3	1
$270,000 – 279,999	20	24	$540,000 – 549,999	2	1
$280,000 – 289,999	15	12	$550,000 – 559,999	1	0
$290,000 – 299,999	22	13	$570,000 – 579,999	1	1
$300,000 – 309,999	20	22	$630,000 – 639,999	0	1
$310,000 – 319,999	10	14	$650,000 – 659,999	0	1
$320,000 – 329,999	18	18	$670,000 – 679,999	1	0
$330,000 – 339,999	14	13	$680,000 – 689,999	1	0
$340,000 – 349,999	19	16	$710,000 – 719,999	1	0
$350,000 – 359,999	15	16	$730,000 – 739,999	0	1
$360,000 – 369,999	9	11			
			Grand Total	**1,919**	**1,669**

During the year ended 30 June 2021 there were 135 (2020: 100) employees who received compensation and other benefits in relation to cessation totalling $2.084m (2020: $2.259m).

26 Events after the balance date

As a result of further COVID-19 outbreaks the whole of New Zealand moved to alert level 4 on 17 August 2021. The Auckland region remained at this alert level until 21 September 2021 when they moved down to alert level 3. Auckland remained at various steps within alert level 3 until 2 December 2021 when the whole country moved into the protection framework. All of these changes in alert levels and the DHB response to the outbreaks have had significant operational impacts on the DHB. This has resulted in an increased emphasis on COVID testing, vaccinations and preparedness. In addition, many of the DHB planned outputs have been directly impeded by COVID-19 due to the redeployment of facilities, equipment and staff to support the COVID-19 response and many non-urgent procedures were deferred to reduce risks to patients and staff. Although these events will have a significant impact on the 2021/22 financial year, the DHB does not consider these events to have materially impacted the 2020/2021 financial statements and the estimations made within these. No adjustments have been made in relation to these events.

On 3 December 2021 the Government announced the approved funding for a six bed intensive care unit at Waitakere Hospital. This with the previously announced additional ward at Waitakere Hospital is the biggest capital injection at the site in almost 20 years with $65.1 million being approved. In addition to this, the Government announced $5.6 million for further development at the North Shore Hospital. Both of these investments along with other works being carried out at the DHB will help assist the DHB in managing the care needs of COVID-19 positive patients as well as provide an increased capacity to care. No adjustments have been made to 2020/21 financial statements in relation to this announcement.

27 Financial instruments

27a Financial instrument categories

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

	Group		Parent	
Financial assets measured at amortised cost	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Cash and cash equivalents	81,691	56,565	77,468	52,373
Debtors and other receivables	70,165	55,583	71,025	54,913
Term investments	962	3,042	0	0
Portfolio investments	15,407	11,023	0	0
Total financial assets	**168,225**	**126,213**	**148,493**	**107,286**
Financial liabilities measured at amortised cost				
Creditors and other payables (excluding revenue in advance and GST)	141,980	123,810	141,825	121,910
Total financial liabilities measured at amortised cost	**141,980**	**123,810**	**141,825**	**121,910**

27b 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. The exposure on the on-call deposits 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 The Group had no direct exposure to foreign currency risk (2020: nil).

Sensitivity analysis

As at 30 June 2021, if the New Zealand dollar had weakened/strengthened 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 and is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

27 Financial instruments (continued)

Credit quality of financial assets

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

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	102	0	0	0
AA -	81,843	57,245	77,468	52,373
A	537	465	0	0
A+	0	0	0	0
A-	351	361	0	0
BBB+	682	450	0	0
BBB	452	509	0	0
BB+	0	0	0	0
Total counterparties with credit ratings	**83,967**	**59,030**	**77,468**	**52,373**
Total counterparties without credit ratings				
Cash, cash equivalents	0	0	0	0
Investments	14,093	11,600	0	0
Total counterparties without credit ratings	**14,093**	**11,600**	**0**	**0**
Total cash, cash equivalents and investments	**98,060**	**70,630**	**77,468**	**52,373**
Debtors and other receivables				
Existing counterparty with no defaults in the past	71,697	55,583	71,025	54,913
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**71,697**	**55,583**	**71,025**	**54,913**

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 receives funding from the Ministry of Health in advance of the 4th of each month.

27 Financial instruments (continued)

Contractual maturity analysis of financial assets

	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
Group						
2020						
Cash on hand	56,565	56,565	56,565	0	0	0
Debtors and other receivables	55,583	55,583	55,583	0	0	0
Investments	14,065	14,065	3,041	9,281	1,688	55
Total	**126,213**	**126,213**	**115,189**	**9,281**	**1,688**	**55**
2021						
Cash on hand	81,691	81,691	81,691	0	0	0
Debtors and other receivables	70,165	70,165	70,165	0	0	0
Investments	16,369	16,369	5,345	9,281	1,688	55
Total	**168,225**	**168,225**	**157,201**	**9,281**	**1,688**	**55**
Parent						
2020						
Cash on hand	52,373	52,373	52,373	0	0	0
Debtors and other receivables	54,913	54,913	54,913	0	0	0
Total	**107,286**	**107,286**	**107,286**	**0**	**0**	**0**
2021						
Cash on hand	77,468	77,468	77,468	0	0	0
Debtors and other receivables	71,025	71,025	71,025	0	0	0
Total	**148,493**	**148,493**	**148,493**	**0**	**0**	**0**

The table above 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. Investments on call are included under the 'Less than 1 year' category.

Contractual maturity analysis of financial liabilities

	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
Group						
2020						
Creditors and other payables	123,810	123,810	123,810	0	0	0
Total	**123,810**	**123,810**	**123,810**	**0**	**0**	**0**
2021						
Creditors and other payables	141,980	141,980	141,980	0	0	0
Total	**141,980**	**141,980**	**141,980**	**0**	**0**	**0**
Parent						
2020						
Creditors and other payables	121,910	121,910	121,910	0	0	0
Total	**121,910**	**121,910**	**121,910**	**0**	**0**	**0**
2021						
Creditors and other payables	141,825	141,825	141,825	0	0	0
Total	**141,825**	**141,825**	**141,825**	**0**	**0**	**0**

The table above 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.

FINANCIAL PERFORMANCE

28 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 purpose, while remaining a going concern. There were no material changes in DHB's management of capital during the period.

29 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary – Three Harbours Health Foundation (THHF). The DHB does not hold an equity investment in its wholly owned subsidiary (2020: $nil).

Summary of financial information of Three Harbours Health Foundation

	Assets $000	Liabilities $000	Revenue $000	Surplus/(Deficit) $000
2021	19,577	1,687	6,172	2,550
2020	18,926	1,900	6,235	998

30 Patient trust monies and restricted funds

Patient trust monies
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.

The amounts of patient trust monies are detailed below.

	Actual 2021 $000	Actual 2020 $000
Balance at 1 July 2020	162	114
Monies received	683	1,096
Payments made	(689)	(1,048)
Balance at 30 June 2021	**156**	**162**

Trust/special fund assets (restricted)
The assets are funds held by the Three Harbours Health Foundation and comprise donated and research funds. The use of the funds must comply with the specific terms of the sources from which the funds were derived. These funds have been included on the Balance Sheet as cash, receivables and investments.

The amounts of restricted cash and investments are detailed below.

	Group		Parent	
	Actual 2021 $000	Actual 2020 $000	Actual 2021 $000	Actual 2020 $000
Current assets				
Cash and cash equivalents	4,223	4,192	0	0
Receivables	672	670	0	0
Investments	962	3,042	0	0
	5,857	**7,904**	**0**	**0**
Non-current assets				
Investments	15,407	11,023	0	0
Total trust/special fund	**21,264**	**18,927**	**0**	**0**

FINANCIAL PERFORMANCE

31 Explanation of major variances against budget

The major variances in the Statement of Comprehensive revenue and expenses **excluding COVID-19** impacts, are due to:

- Patient Care revenue for the year was below budget by $7.6m mostly due to a $4.0m reduction in funding received resulting from changes to Ministry funded initiatives after budgets were finalised.
- Expenditure for the year was $13.6m below budget, which is mostly due to:
  - Personnel costs being higher than budget due to the Holidays Act 2003 Remediation liability being increased by $25.9m to reflect the in year additional cost
  - Outsourced services costs being $8.8m higher than budget mostly due to three key drivers
    - Additional unbudgeted locum cover costs of $3.1m mostly as cover for vacancies and to catch up on procedures across clinical Provider services
    - Additional unbudgeted costs of $3.0m to cover management and administration personnel vacancies
    - Additional unbudgeted cost with shared service providers of $1.7m
  - Infrastructure and non-clinical expenses being $11.0m higher than budget mostly due to:
    - $16.0m of the cost savings budget is included in the Infrastructure and non-clinical expenses line, however the actual savings that have resulted from the DHB's financial sustainability programme are realised across all revenue and expenditure lines
  - Other expenses are higher than budget mainly due to $11.9m of unbudgeted costs for disposals and additional impairment accruals for work in progress assets
  - NGO expenses were $44.8m favourable to budget mainly due to a lower than planned spend in Funder NGO contracts and the impact of accrual reassessments.
- Other comprehensive revenue and expense was $149.4m for the period and is unbudgeted. This relates to the gain on property valuations of $77.5m for Land and $71.9m for Buildings.

COVID-19 impacts were $5.4m unfavourable and are broken down as follows:

- Net additional revenue associated with COVID-19 was $52.9m, which is due to:
  - Additional funding received from the Crown in response to COVID-19 of $53.9m
  - $1.0m revenue lost attributed to COVID-19.
- Total expenditure attributed to COVID-19 was $58.3m, which is mostly due to:
  - Payments to external NGO providers in response to COVID-19 were $36.5m mainly for testing and vaccination related costs.
  - Additional personnel costs of $18.6m
  - Additional outsourced services costs of $0.5m
  - Additional Clinical supplies costs of $1.7m
  - Additional Infrastructure and non-clinical additional costs of $1.0m

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

- Receivables being $14.4m greater than budget mostly due to additional COVID-19 related receivables at 30 June 2021.
- Plant, property and equipment being $109.3m greater than budget mostly due to:
  - The gain on property valuations of $77.5m for Land and $71.9m for Buildings
  - Actual capital expenditure being $32.8m less than budget due to timing of key major infrastructure projects. This is evident in the reduction in net investing cashflows being $37.2m lower than budget.
- Payables being $35.0m greater than budget mostly due to:
  - Increases in external provider contract accruals of $14.7m from the prior year mainly relating to vaccination and testing for COVID-19
  - Increase of $5.9m for capital expenditure accruals
  - Increase of $16.8m for revenue received in advance across various contracts
- Employee entitlements being $56.6m greater than budget mostly due to:
  - The Holidays Act 2003 Remediation liability being increased by $25.9m to reflect the additional in year cost
  - Unsettled Collective Employment Agreement provision increased by $17.1m as the agreements are still in negotiation with the respective unions
  - Annual Leave balances increased by $8.7m mainly due to travel restrictions relating to COVID-19 resulting in staff taking less annual leave than budgeted
- Provisions are higher than budget mainly due to a $6.9m provision to allow for the cost of settlement of 44 Taharoto Road and 9 Karaka as detailed in note 11.
- Contributed capital being $32.2m less than budget due to lower than planned equity injections as a result of major capital projects requiring less cash funding as at 30 June 2021.
- Property revaluations reserves being $149.4m greater than budget as a result of the Land and Buildings valuations

31 Explanation of major variances against budget (continued)

The major variances in the Statement of Cash flow

- Cash and cash equivalents as at 30 June 2021 were $65.7m higher than budget. The major variances are due to:
  - Net operating cashflows were $60.6m higher than budget with the main reasons being:
    - Payables being $36.5m higher than budget as discussed above
    - Unsettled Collective Employment Agreements liability increasing by $17.1m as discussed above
    - Annual leave liability increasing by $8.7m as discussed above
  - Net investing cashflows were $37.2m favourable to budget due to timing of spend on major infrastructure projects as discussed above
  - Net financing cashflows were $32.2m unfavourable to budget as Ministry of Health capital contributions were not required to support major infrastructure projects as discussed above.

32 Disestablishment Basis

These financial statements are prepared on a disestablishment basis (discussed in note 1) as a result of the Health Sector Reform and the planned disestablishment of the DHB on 1 July 2022.

The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations until the date of disestablishment based on current trading terms and legislative requirements. The Board reached this conclusion after reflecting on circumstances which it considers likely to affect the DHB during the period from the date of signing the 2020/21 financial statements to the date of disestablishment. The key considerations are set out below.

32.1 Holidays Act non-compliance

As at 30 June 2021, Waitematā DHB maintains a liability for Holidays Act non-compliance of $192.5m. This represents management's best estimate at this date. Work is still on-going between District Health Boards, the Council of Trade Unions (CTU) health sector unions and the Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate to rectify and remediate any Holidays Act non-compliance by DHBs. This estimated liability indicates a significant obligation for the DHB to settle. Based on current and projected cash balances, the DHB would not be able to pay this amount without support from the Government.

32.2 Declining projected cash flows

As detailed in our Statement of Performance Expectations for the financial year, the DHB is projecting negative net cashflows for the 30 June 2022 financial year. Although the DHB is focused on a detailed and significant financial sustainability programme, based on the current funding assumptions, the Waitematā DHB may not be in a position to cover their on-going obligations without support from the Government. However, as at the date of signing, the DHB is forecasting to have sufficient cash to meet its financial obligations until 30 June 2022.

32.3 Unforeseen Cost of COVID-19

COVID-19 has brought to light the impact that unexpected events can have on a DHB's financial planning. COVID-19 had a $5.402m net impact on the Waitematā DHB's performance during the financial year. It is a continued financial risk and continues to have on going implications for the DHB.

32.4 Letter of support

The Board received a letter of comfort from the Ministers of Health and Finance, which acknowledges that equity support may be required, and the Crown will provide such support where necessary to maintain viability up until the date of disestablishment.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

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

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

We have audited:

- the financial statements of the Health Board and Group on pages 60 to 95, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 15 to 20, 22 to 24, 26 to 28; 39 to 48; 50 and 52.

Opinion

In our opinion:

- the financial statements of the Health Board and Group on pages 60 to 95, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 15 to 20, 22 to 24, 26 to 28; 39 to 48; 50 and 52:
    - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2021, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
        - what has been achieved with the appropriation; and
        - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
    - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 15 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures in the financial statements and performance information.

The financial statements have been appropriately prepared on a disestablishment basis

Note 32 on page 95 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

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

Note 17 on pages 83 and 84 outlines that the Health Board and Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board and Group has estimated a provision of $192.5 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Group is reliant on financial support from the Crown

Note 32 on page 95 outlines the Health Board and Group's financial performance difficulties. There is uncertainty whether the Health Board and Group will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The Health Board and Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Group with financial support, where necessary.

Impact of Covid-19

Note 31 on page 94 and Note 26 on page 89 of the financial statements and 15 to 20, 22 to 24, 26 to 28; 39 to 48; and 50 of the performance information outline the impact of Covid-19 on the Health Board and Group.

Health Service User population information was used in reporting Covid-19 vaccine strategy performance results

Note 2 on page 48 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Health Board and Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out in Note 2. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board and Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Basis for our opinion

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

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

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

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board and Group for assessing the Health Board and Group's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures. The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 14; 21; 25; 29 to 38; 49; 51; and 53 to 59, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

Wikus Jansen van Rensburg

Audit New Zealand
On behalf of the Auditor-General

Auckland, New Zealand

“best care for everyone

This is our promise to the Waitematā 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 Waitematā 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.”

Waitematā
District Health Board

Best Care for Everyone

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