WAITEMATA DISTRICT HEALTH BOARD

ANNUAL REPORT

2016/17

PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 150 OF THE CROWN ENTITIES ACT 2004

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CHAIRMAN/CEO STATEMENT

DR LESTER LEVY
CHAIRMAN

DR DALE BRAMLEY
CHIEF EXECUTIVE OFFICER

Reflecting back on the last 12 months of phenomenal growth and development across the Waitemata DHB, we first and foremost acknowledge our own people and give them our thanks.

We have just over 7000 committed and dedicated staff working hard in our hospitals and community sites to relieve suffering, reduce inequalities and promote wellness.

Their efforts, combined with a renaissance of our buildings and services has allowed our DHB to meet the demands of unprecedented population growth and ensure the best care for everyone.

We are the largest and one of the fastest growing DHBs in the country and our 2016/17 population of over 599,000 people is projected to rise by over 100,000 in the next decade.

New and upgraded facilities are designed to help us meet this growth in line with our board's priorities to improve patient outcomes and enhance their experience while in our care.

We have also brought our academic partners onto our North Shore Hospital site, in the modernised Kāhui Manaaki building and the impressive new Whenua Pupuke Waitemata Clinical Skills centre where collaborative educational opportunities help foster a highly skilled workforce of health professionals for years to come.

The successful clinical rollout of ePrescribing and eVitals removes the need for paper drug charts and observation records. These initiatives along with others create a system utilising the latest in digital technology to improve the accuracy and efficiency of data-gathering directly linked to patient care and safe practice.

We continue to place more emphasis on augmenting mental health services – launching the *Our Health in Mind* project to provide our primary care partners and their patients with greater support; opening a new Child and Adolescent Mental Health Service in Rodney North; establishing an Infant Mental Health Service and opening Te Aka, a new 15-bed facility at Mason Clinic.

Our efforts continue to be reflected in the health of our population, with our population's life expectancy at 83.8 years, 2.1 years higher than the national figure. Life expectancy for Māori (78.9 years) and Pacific people (78.5 years) is also among the highest in New Zealand and increasing at a faster rate than other populations.

Our DHB has the lowest rate of mortality from amenable conditions in New Zealand and one of the highest 5-year cancer survival rates. Smoking rates within our population are reducing and we are well-positioned to be smoke-free by 2025. Our hospitals are safe with one of the lowest standardised mortality rates of any DHB and continued excellent performance across the range of Health Quality and Safety Commission measures.

We have continued to increase the number of positive interventions to relieve suffering and support our patients to lead active, productive and independent lives. A clear demonstration of this is the 23,998 elective surgeries delivered in the 2016/17 year, 2000 more than the previous year.

The Early Discharge and Rehabilitation Service (EDARS) achieved similar outcomes for a number of stroke and other eligible patients, sending them home sooner and then delivering the same high level of care and support they would otherwise have received in the Assessment, Treatment and Rehabilitation (AT&R) wards.

Our population has grown by 46,000 in the last three years, yet we have continued to meet or exceed our surgical intervention rate targets for key elective procedures while still maintaining our waiting time targets. This has been a very challenging and demanding achievement.

A number of other significant new projects were also completed in 2016/17.

We delivered on the completion of the Waitakere Hospital Emergency Department project – opening a new ED paediatric zone as well as two negative pressure rooms and an expanded radiology suite for the people of west Auckland. We also opened a modern Medicine and Older Adults outpatient facility on the ground floor of the remodelled Kāhui Manaaki complex.

Our TransforMED project made an impact on general medicine wards at North Shore Hospital, creating home wards for doctors who now get to work with the same staff all of the time. We expect to see the same enhanced levels of communication, teamwork and streamlined patient care evident at Waitakere Hospital once the scheme is rolled-out there in the near future.

The North Shore Hospital TransforMED team

All our initiatives exist with one purpose in mind – to meet the health care needs of a community that deserves the very best care we can possible provide.

We thank our healthcare partners and community providers who support us in our never-ending drive to be better, best and brilliant in all that we do.

And again we pay tribute to every single member of staff who helps make our organisational aspiration of best care for everyone a daily reality for thousands of patients and their families.

They are our greatest asset and we look to them with gratitude.

Dr Lester Levy, CNZM

Chairman
Waitemata District Health Board

Dr Dale Bramley

Chief Executive Officer
Waitemata District Health Board

TE TIRITI - PARTNERSHIP STATEMENT

Tū Tonu ngā Manaakitanga!

R. NAIDA GLAVISH, ONZM. JP
CHIEF ADVISOR TIKANGA

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

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

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

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

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

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

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with Waitemata DHB. This annual report highlights the importance of our partnership, but, more importantly, it provides the basis for our partnership as we look forward to the years ahead. Albeit we have much work still to do together to lift the performance of the health system for our diverse but important Māori communities.

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

R. Glavish ONZM JP

R. Naida Glavish ONZM. JP
Co-Chair, Te Rūnanga o Ngāti Whātua

ABOUT WAITEMATA DHB

Who we are and what we do

Waitemata DHB is the Government's funder and provider of health services to nearly 600,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and fastest growing DHB in the country, and are expecting an extra 99,000 people by 2025.

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

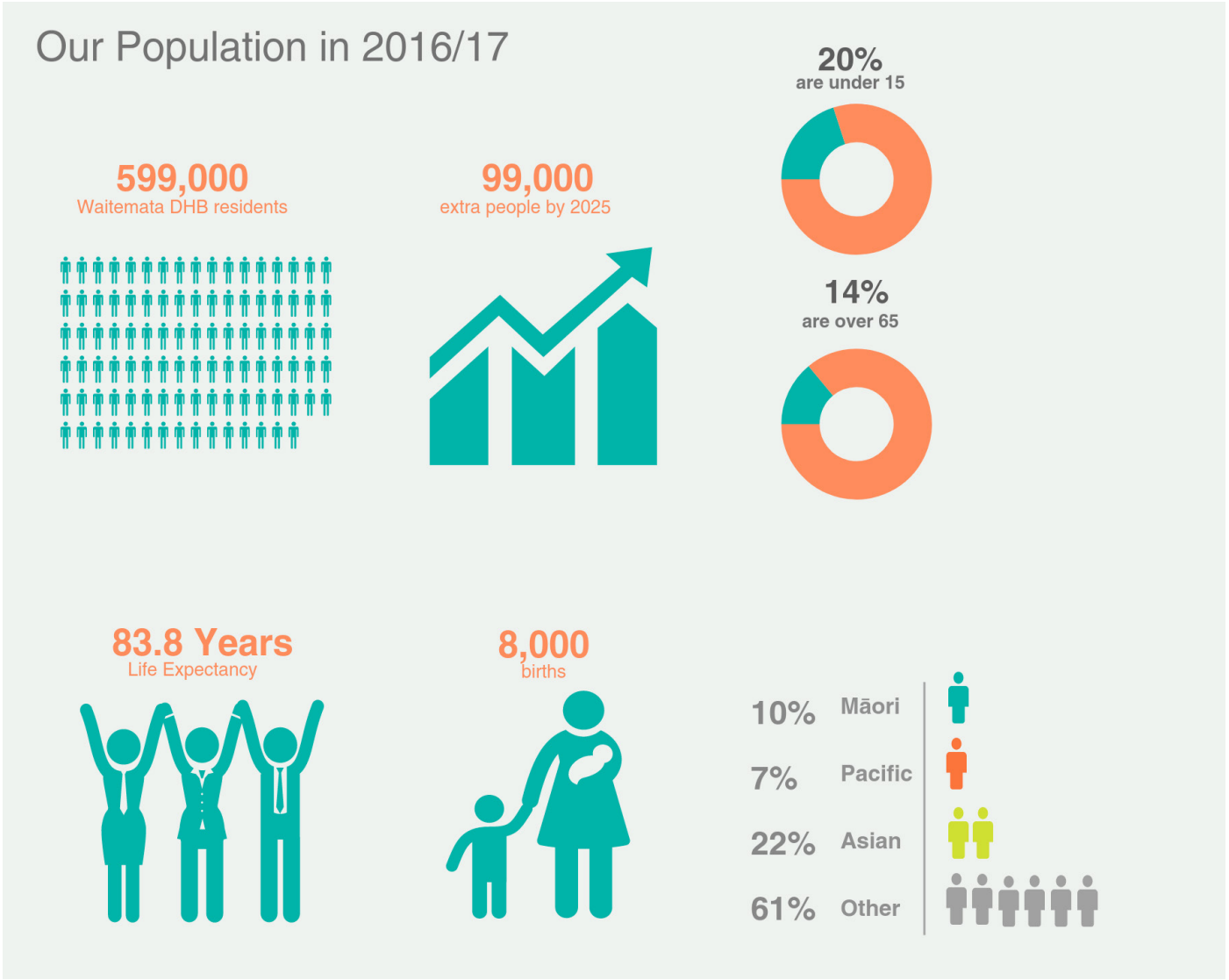
Waitemata DHB provides hospital and community services from 31 sites, including North Shore Hospital, Waitakere Hospital and the Mason Clinic.

Just over 7,000 people are employed by Waitemata DHB.

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

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

Our budget in 2016/17 was $1.6 billion.

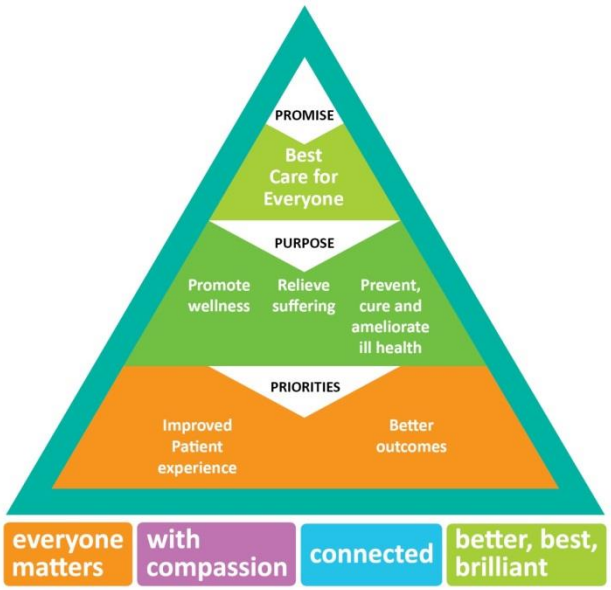


WHAT ARE WE TRYING TO ACHIEVE?

Best care for everyone

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

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



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

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

Community, family/whānau and patient-centred model of care
Patients, whānau and our community are at the centre of our health system. The quality of patient and whānau experience and their outcomes should be the starting point for the way we think, act and invest. Our focus is on empowering people to achieve the health outcomes they want.

Emphasis and investment on treatment and keeping people healthy
We are investing in our people, services and facilities across the spectrum of care, with increasing focus on preventing ill health. Lifestyle and preventative programmes and primary and community-based services will increase wellness and reduce the need for hospital admission. We will direct resources at high needs communities.

Service integration and/or consolidation
We need to **work collaboratively** to ensure that services are delivered by the best provider in the right place. We will focus on **what we do best -** deliver higher standards of care through dedicated centres of excellence, and more local health care.

Intelligence and insight
The dynamic use of data, information and technology will improve clinical decision making and develop our health insights. Data will be used to support quality improvement, population health management and innovation. Patients will have greater access to information via new technologies.

Consistent evidence-informed decision making practice
Delivering safe and high quality care is an integral part of our culture. Evidence from research, clinical expertise, patients and whānau, and other resources will drive our decisions.

Outward focus and flexible service orientation
We put patients first and strive for fundamental standards of care. We must have an openness to change, improve and learn and be outward focused and flexible. Strong clinical leadership is embedded at all levels of the organisation. We are an advocate for the health of our population.

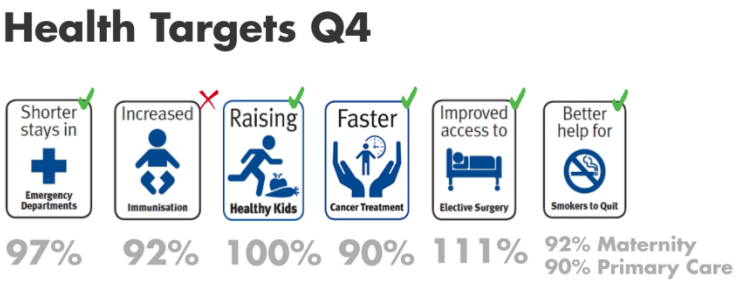
Emphasis on operational and financial sustainability
Operational and financial sustainability is critical to our ability to deliver on our organisational promise and purpose. We need a longer-term view. To achieve more with the funding we have we will work with others to develop the best service configuration and optimise models of care for efficiency and the best health outcomes. Our workforce must have the highest standard of expertise.

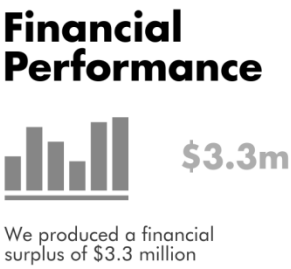
KEY ACHIEVEMENTS

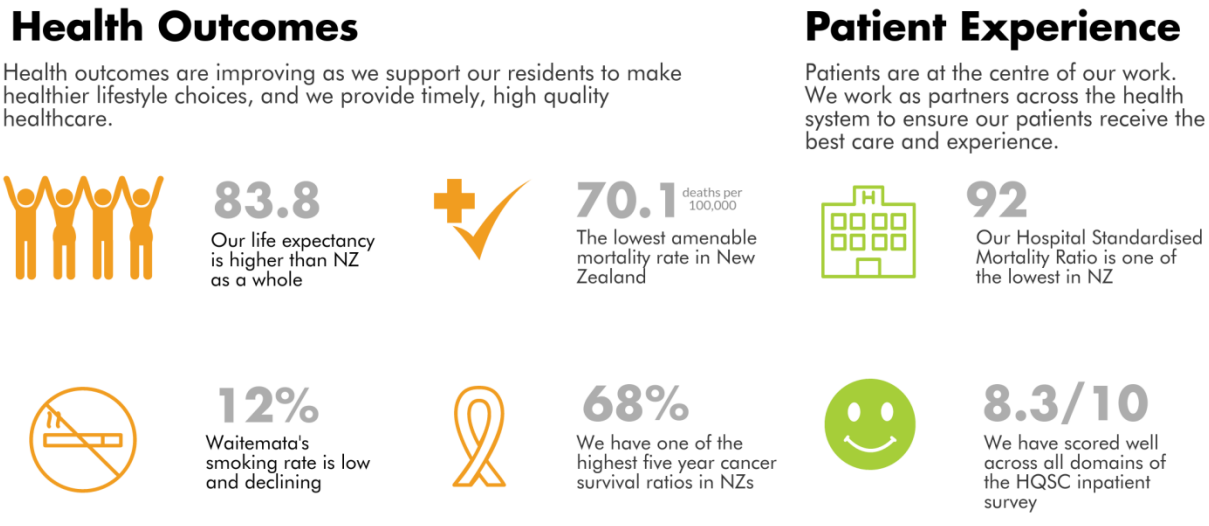
Waitemata DHB is one of the healthiest communities in New Zealand and we have performed well against our key indicators in 2016/17. The life expectancy of our population is the highest in New Zealand, and we achieved five of the six national health targets in quarter four. We performed well financially, recording a surplus of $3.3m.

Our achievements in 2016/17 include:

- The life expectancy of our population is the highest in New Zealand at nearly 84 years and the gap between ethnic groups is closing
- Our smoking rate is one of the lowest in New Zealand and declining
- We achieved 100% against the Raising Healthy Kids health target meaning all children identified as obese were referred for further help. We were the first DHB in the country to achieve this target
- Waitemata DHB led the country in performance against the Faster Cancer Treatment health target, achieving 90% in quarter four. We also have one of the highest 5-year cancer survival rates in New Zealand
- We delivered nearly 24,000 elective surgeries, 2,000 more procedures than last year, exceeding the elective surgery health target by 11%.
- We also achieved the Shorter Stays in ED, and both domains of the Better Help for Smokers to Quit health targets
- Ambulatory sensitive hospitalisation (ASH) rates for children aged 0-4 are lower than New Zealand as a whole
- Our amenable mortality rate is the lowest in New Zealand, and we also have one of the lowest rates of hospital mortality in the country
- Most inpatients rated their care as very good or excellent, and our average score in the HQSC inpatient survey was 8.3 (out of 10).







THE WAITEMATA COMMUNITY

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

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

Patient stories

The DHB has a collection of stories from patients and their families, telling us what matters most to them when they need care, what we do well, and what they would like to see changed. They are an important part of how we learn and develop our services so that we can build on our successes and improve things that are not working. They also have important messages for others who might be going through similar health journeys. These stories are viewable on our website. We are grateful to all those who have been generous in sharing their experience with us.

Community contributes to new look

A review of all our external signage took place in 2016. The review was designed to make it easier for visitors and patients to find their way around and multiple signs have since been replaced at Waitakere as well as North Shore Hospital and the Mason Clinic.

Members of the public were consulted and in October and November site walkabouts with community members were organised to explore other issues such as accessibility and language barriers before an overall approach was decided.

"We listened to what people told us and are now working to address the issues that we have seen through their eyes," Director of Nursing and Midwifery Jocelyn Peach says.

Waitakere Health Link is working closely with the Waitemata DHB to ensure community input takes place. Co-ordinator Tracy McIntyre says all new internal signs will be consistent in colour and design – avoiding medical jargon and using internationally recognised symbols wherever possible. Te Reo Māori translations will be provided where relevant.

A committee is now working on internal signage based on further feedback from the public, patients and Waitemata DHB volunteers.

Reaching out to Pacific communities

In January 2017, we held a community outreach event at the Pasifika Youth Cup rugby league tournament. As 400-500 people were expected to attend it was a good opportunity to reach some of the communities who are not always well represented in consultation on health services.

Many different Pacific health services were involved, providing health promotion, advice and engagement. The Fono provided smoking cessation and healthy eating guidance and Hapai te Hauora provided information on their Fizz free campaign, gambling, smoke free and Well Child. The Waitemata DHB mobile clinic provided rheumatic fever guidance and hearing checks, along with Auckland DHB rheumatic fever nurses. Information and support was also available around immunisation, mental health and stroke.

A short survey was conducted and feedback was collected on ideas for a healthier community. The results have helped to identify health priorities for some of our quieter communities. Feedback has largely focused on wanting more support for healthy eating and exercise which can be costly. It was requested that healthy eating messages be adapted for different cultures, for example showing how to incorporate traditional food into a healthy diet, or how to be healthier at events and shared meals.

Overall the day was very beneficial, helping to build relationships with other services, and gain a greater understanding of the needs of different Pacific communities.

Our health information zone at the Pasifika Youth rugby league tournament. The mobile clinic provided hearing checks, and Harbour Sport organised sports activities for children.

INNOVATION AND IMPROVEMENT

Institute for Innovation and Improvement i3

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

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

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

Care Redesign Projects

We began an ambitious sepsis improvement project, the Survive Sepsis Improvement Collaborative, across our two hospitals in 2016. Sepsis is a life threatening condition that arises in response to infection. Early recognition and treatment is vital. Over forty nurses and doctors have participated in the programmes and developed a range of improvements including a sepsis kit, systematic use of a standardised communication tool, and a sepsis screening tool and alert system in the new eVitals system.

The Early Discharge and Rehabilitation Service (EDARS) is a new model of care delivering individually prescribed rehabilitation in a patient's home environment. The service is delivered by a team of senior clinicians across social work, dietetics, speech-language therapy, occupational therapy, physiotherapy and nursing, in collaboration with our geriatricians. The response from service users has been overwhelmingly positive.

We have commenced a Green Spaces project, developing salutogenic and human centred design principals to inform future environment design. The aim is to deliver healing spaces to take a 'hospital in the park' concept to a reality.

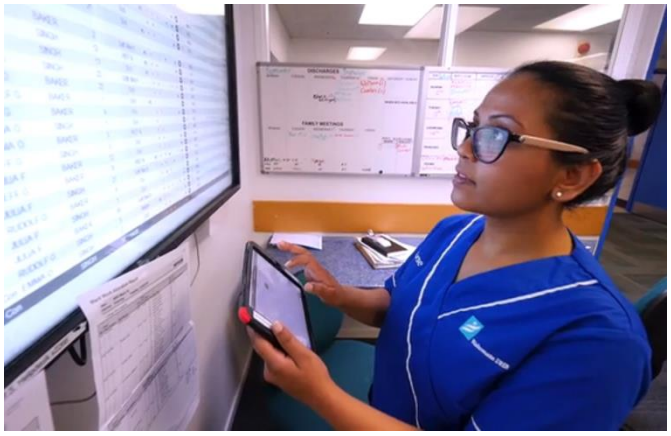
Leapfrog Programme

The Leapfrog Programme was established as a means for Waitemata DHB to take a large leap toward a mobile and digital future.

We are leading the way in Australasia in eVitals development, with over 2500 clinicians using the system.

Nurses across both our hospitals use mini-tablets to record patient observations and risk assessments. This allows a snapshot of the level of clinical risk in a ward and early alerts of any patient deterioration. Doctors use computers on wheels for prescribing and ordering laboratory tests and radiology procedures.

Outside the hospital we have provided our community clinicians with mobile devices to support their patients. Over 120 clinicians (including physiotherapists, occupational therapists, and speech and language therapists) are using devices, saving on administration time and increasing patient contact time. The use of pictures, videos and diagrams on the device contributes to improved patient understanding of their health.



A new Leapfrog project started this year is the implementation of Qlik Sense, a business intelligence tool which allows clinicians and others easy, responsive exploration of data to help them improve patient outcomes and experience. Each dashboard has a clinical lead guiding the design and content development and feedback from clinicians has been very positive.

Over the next year phase two of the Leapfrog Programme will include: introducing a closed loop, fully electronic medication system; roll out of the clinician app, My Patient List, which allows our doctors to see at an instant a list of their patients, their location, progress, vital signs, and latest laboratory results; and development of an electronic internal referrals system which will help eliminate delays and mislaid paper referrals.

SUSTAINABILITY

Waitemata DHB maintains a Sustainability Policy, which was updated this year, and was endorsed in June 2017. The policy covers procurement, energy and carbon management, water management, waste reduction and recycling, and the built environment.

Sustainability
Waitemata District Health Board

Our DHB has once again achieved the Enviro-mark Gold certification from Enviro-Mark Solutions (a subsidiary of Landcare Research), confirming we are taking credible action for a better environment. We are the only DHB in New Zealand to have reached this level of certification. Waitemata DHB is also a member of the Global Green and Healthy Hospitals, a worldwide network committed to reducing the health sector's environmental footprint and advocating for policies that promote environmental and public health.

We are seeking to conduct our first organisational carbon footprint, which will bring Waitemata into alignment with similar activities at Auckland and Counties Manukau DHBs. Energy audit reviews are under way at North Shore and Waitakere hospitals, which will support energy efficiency and reduction of emissions.

Increasing patient numbers are seeing greater demands for energy and water, and increased waste production, but we are working to be as efficient as possible. We have set ourselves targets for reductions in our use of energy and water, and for increases in the volume of waste that we recycle rather than sending to land fill. A report on progress goes to every meeting of the Hospital Advisory Committee (HAC).

Our electricity use increased 0.8% over the year (while inpatients numbers grew 5%), to 27.1 Gwh. Gas use decreased by 9.7% to 79.0 GJ, due to warmer weather.

We have obtained quotations for low-energy LED lighting in the NSH car park and for the installation of energy sub-meters. A new planned expansion to the Elective Surgery Centre has had an envelope design and energy modelling analysis conducted to help the design team make good decisions which will reduce the operational energy consumptions.

This work was fully subsided by EECA (Energy Efficiency and Conservation Authority), as part of the DHB's Collaboration Agreement.

General waste increased by 16% to 1,443 tonnes in 2016/17, and recycling decreased by 6% to 290 tonnes. Medical waste increased by 8% to 427 tonnes. Confidential paper decreased by 32% to 65 tonnes.

The waste reduction policy was updated, and we plan trials of PVC and battery recycling. We also plan to trial food waste composting, in association with Compass, who provide hospital meals.

Recycling in action

The DHB uses 2.6m disposable polystyrene cups per year, which cannot be recycled and take hundreds of years to break down in landfill. We have identified a biodegradable alternative and are in the process of tendering for these.

A staff travel plan has been completed, in collaboration with Auckland Transport and Flow Transport. As part of this, a survey of staff travel modes to work found that 73% of responding staff still commute as sole drivers in cars, while only 7% use public transport. There was an increase since the 2008 survey in the proportion using active transport, from 6% to 9%.

WDHB was recognised with two Travelwise Choices Awards for public transport and carpooling for our work to support better travel options for our staff. We have also negotiated discounts on e-bikes for staff, to encourage low-emission, active travel to work.

Improving outcomes

What difference have we made for the health of our population

PERFORMANCE FRAMEWORK

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

Our performance framework (over page) reflects key national and local priorities, and demonstrates our commitment to an outcome-based approach to measuring performance. Overall the progress against our indicators suggests we are delivering on our vision and we are a high performing DHB that is truly making a difference to the health of our population.

Waitemata DHB residents have the highest life expectancy in the country at 83.8 years

Our amenable mortality rate has reduced by 26% over the last 10 years, and is the lowest in New Zealand

Our children are staying out of hospital with ASH rates for those aged 0-4 lower than NZ as a whole

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

- Maintain the highest life expectancy in New Zealand
- Reduce the difference in life expectancy between different ethnic groups.

Outcome measures and supporting impact indicators have been identified that will support achievement of these goals. Our outcome measures are based on the 2016/17 System Level Measures set by the Ministry of Health. The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

Impact measures sit underneath the long-term outcome indicators and assess the direct impact of the services we provide over a shorter time period.

The Statement of Performance, in the 'Our People, our performance' section of this report, details a list of service level indicators that form part of our overall performance framework. These comprise a range of in-year measures to monitor DHB service performance within a set of four output classes that contribute to the success of the system as a whole. We monitor performance against these indicators annually.

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

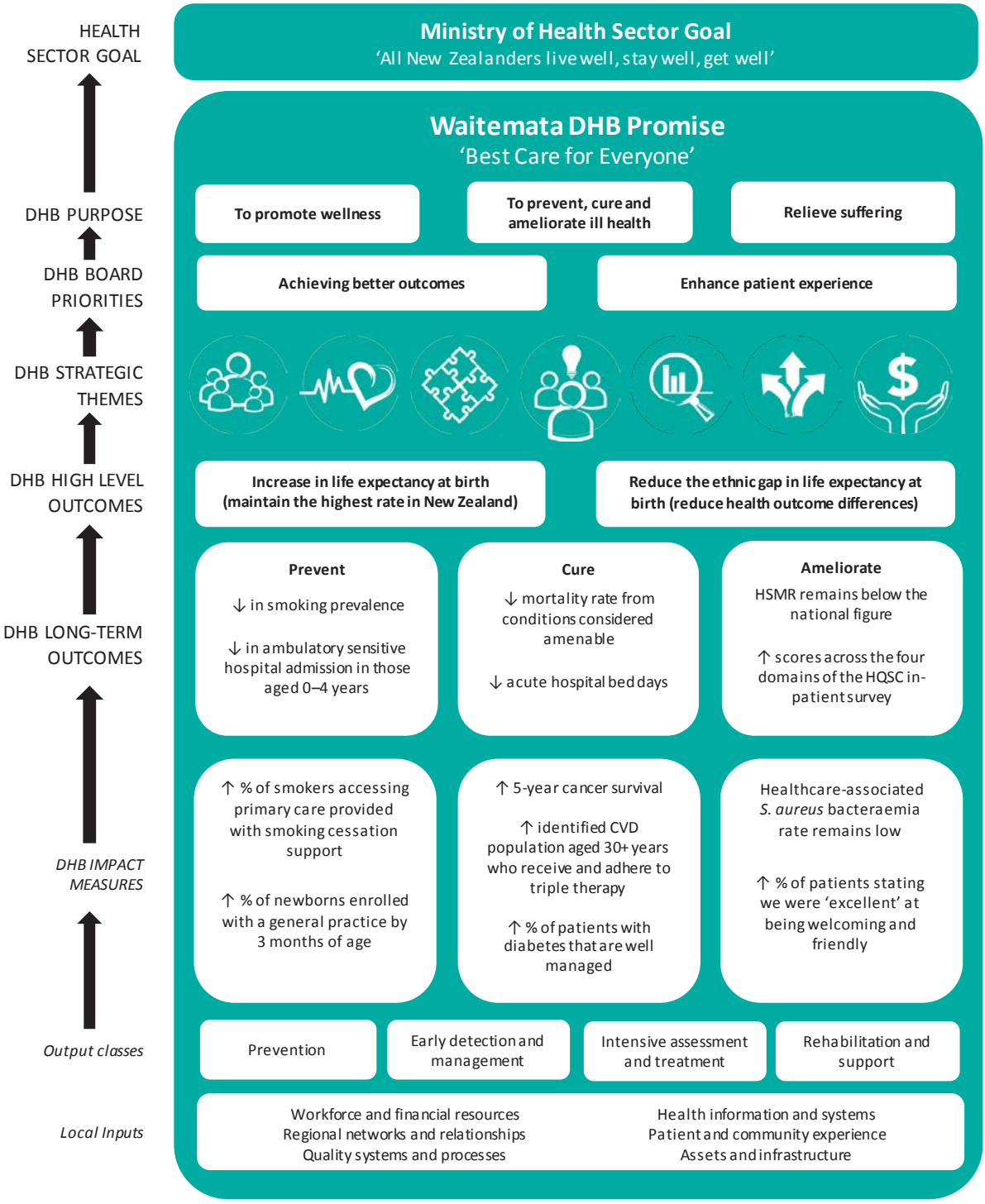
Life expectancy continues to improve, reaching 83.8 years (2014-16), the highest in the country and an increase of 2.2 years over the past decade. Māori and Pacific life expectancy has increased by more than 3 years over the past decade and the gap in life expectancy between ethnic groups has decreased by around 1.5 years over this period for both Māori and Pacific.

We have the lowest rate of amenable mortality - deaths potentially avoidable through healthcare intervention – in New Zealand. In 2014 (the latest available data) 70 deaths out of every 100,000 were considered amenable, lower than the national rate of 93. We estimate that 490 deaths (46% of all deaths in those aged under 75 years) in Waitemata DHB were amenable in 2014.

Our rate of acute bed days per capita is slowly declining but is higher than the national rate at 422 per 1,000 population (standardised for age) compared with 405 per 1,000 population nationally.

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

Waitemata DHB Performance Framework



HIGH LEVEL OUTCOMES

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

WAITEMATA HAS THE LONGEST LIFE EXPECTANCY IN NEW ZEALAND, AT

83.8 YEARS

LIFE EXPECTANCY HAS INCREASED

2.2 YEARS

OVER THE PAST DECADE

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

3 YEARS

OVER THE PAST DECADE

Note: The most recent mortality data available is for the 2016 calendar year. Three-year combined estimates have been presented to reduce the effect of year to year variations in death rates.

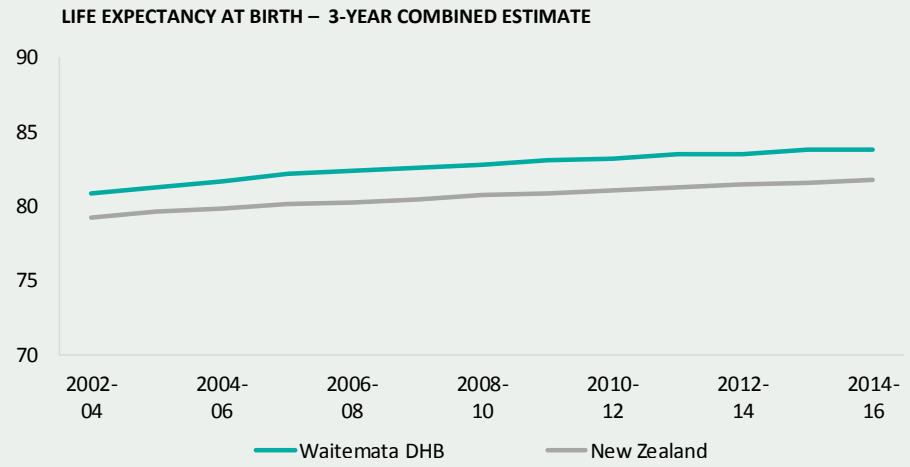
Improving life expectancy for everyone

Life expectancy at birth (LEB) is recognised as an overall measure of population health status. We have the highest life expectancy in New Zealand at 83.8 years (2014-16), which is 2.1 years higher than NZ as a whole. In Waitemata, life expectancy has increased by 2.2 years over the last decade, a greater increase than that for NZ as a whole (1.9 years).

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 5.6 years for Māori and 6.0 years for Pacific. Life expectancy is increasing in our Māori (3.3 years over the past decade) and Pacific (3.6 years) populations, and the gap between ethnic groups is decreasing. Deaths from avoidable conditions contribute nearly two thirds of the 5.6 year life expectancy gap between Māori and other populations and around half of the 6.0 year gap in Pacific.

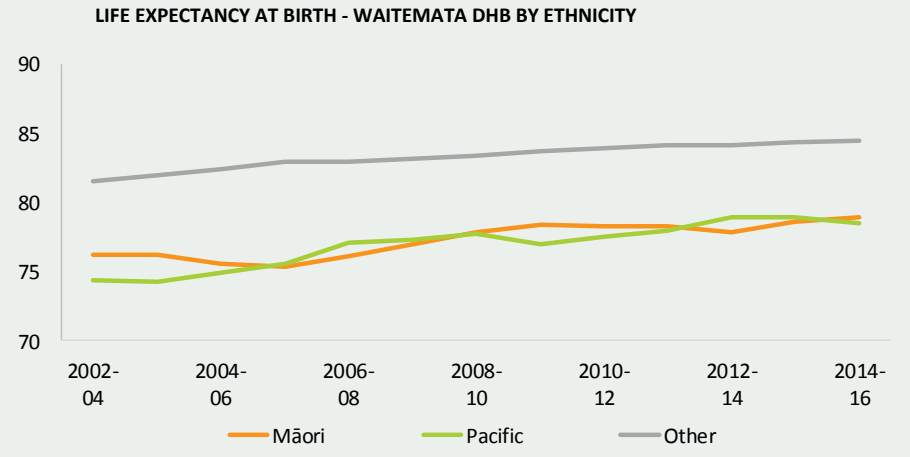
An increase in life expectancy

Our population has the highest life expectancy in the country at 83.8 years.



A reduction in the ethnic gap in life expectancy

The life expectancy gap for Māori has decreased by 1.2 years over the last decade, and the gap for Pacific people has decreased 1.5 years.



PREVENTING ILL HEALTH

Support people to lead healthier lives

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

12%

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

64,167

SMOKERS (32%) RECEIVED CESSATION SUPPORT, A SIMILAR RATE TO 2015/16

88%

OF PHO-ENROLLED SMOKERS RECEIVED BRIEF ADVICE TO QUIT

87%

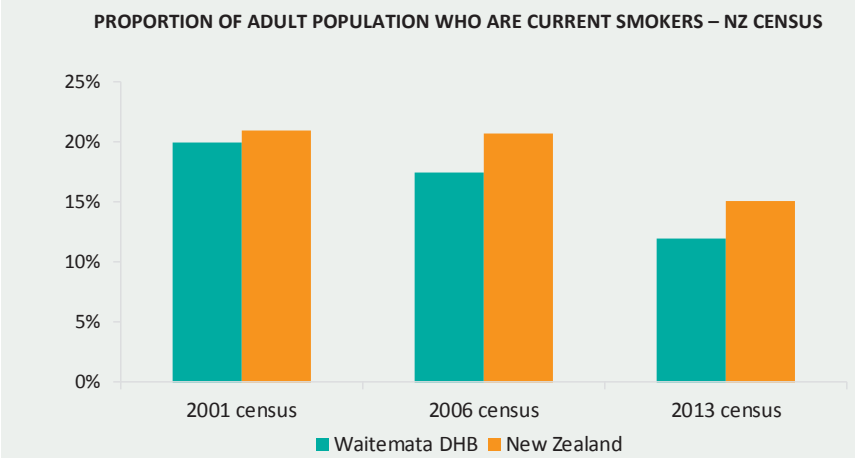
OR 236 PREGNANT WOMEN WHO SMOKED RECEIVED SMOKING CESSATION ADVICE

A smoke-free Waitemata

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

A reduction in the prevalence of smoking

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



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

In 2016/17, we provided brief smoking cessation advice to 88% of smokers registered with primary care services, and in Q4 the DHB met the 90% target. PHO Smokefree co-ordinators work with GP practices to identify and assist their smoking patients. Our PHOs have programmes in place to text and phone patients to provide brief advice to those who do not regularly visit their GP. In 2016/17, PHOs increased their staffing and performed additional activities to support general practices to work towards the 90% target.

One in three (32%) identified smokers accessing primary care are now provided with cessation support, either through a referral to 'quit smoking' services or by being provided with smoking cessation medication. This rate of support is improving but is lower than the national rate (32% in Q4 2016/17).

Smoking cessation was selected as a contributory measure for the Amenable Mortality System Level Measure. The focus in 2016/17 was on identifying the clinical indicators and the high level actions required for improvement. In 2017/18 we plan to improve pathways to smoking cessation providers, and improve our data reporting process.

Better help for smokers to quit

Individual support for those who need it most

Supporting smokers to quit is a priority for Waitemata DHB, both in the community and in hospital. In 2016/17 nearly all (98%) smokers admitted to our hospitals were offered brief advice to quit.

For some this brief advice was motivation enough to stop smoking, while for others smoking is so entrenched in their lives they find it very difficult to quit. Many people with health problems continue to smoke even though they know smoking is impacting on their health condition.
The challenge for the Smokefree service was reaching this group of patients.

In July 2016 the service implemented bedside interventions to maximise 'high motivation' moments as a result of their admission. Ongoing support is provided when patients are discharged home, as the chance of relapse is very high.

Hospital smoking cessation practitioners visit the patient on the ward and provide tailored advice on nicotine replacement therapy to manage withdrawal and motivational support to increase confidence in quitting. Once discharged, patients are supported either by the smoking cessation practitioner they met in hospital or through a community-based stop smoking service.

Systems were enhanced to ensure an effective streamlined approach to working with patients in the acute setting further increasing the services ability to link with difficult to reach populations.

The introduction of this service has seen a large increase in patients being supported to quit with over 3,000 being referred to a quit smoking provider and 54% agreeing to receive further input.

The Waitemata DHB Smokefree team celebrate World Smokefree Day

Smokefree success

Clifford, a long term smoker who had been admitted to hospital multiple times for a smoking related illness, is one of many patients who have quit with the support of the Smokefree service.

Clifford received brief advice every time he was in hospital and had tried to quit many times but found it was just too hard when he got back to his normal routines at home. Before long he always returned to smoking.

Although he wanted to quit smoking he found it impossible to sustain any change.

Clifford was seen by a smoking cessation practitioner on the ward several times during his admission. He was given advice on using nicotine replacement therapy and focused on the change in behavior required to remain smokefree once he got home.

Working together with the practitioner and encouraged by his son Warrick, he began to believe that it was possible to be free from smoking.

Clifford works with a smoking cessation practitioner

On discharge Clifford received face-to-face and telephone support through the hospital cessation service for a further 12 weeks and remained smokefree.

After 6 months smokefree Clifford and Warrick agreed to share their story through the hospital patient experience campaign in the hope that it would inspire others.

Warrick (right) says he's seen a big change in his father after quitting smoking. "I've seen a new dad."

5,463

PER 100,000 ASH ADMISSIONS IN 0-4 YEAR OLDS, A 12% DECREASE SINCE 2013

70%

OF BABIES* WERE ENROLLED WITH A PHO BY 3 MONTHS OF AGE, A DECREASE FROM 73% IN Q4 2015/16

*born 20/2/17-19/5/2017

92%

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

94%

OF FOUR YEAR OLDS RECEIVED A COMPREHENSIVE BEFORE SCHOOL CHECK

100%

OF OBESE CHILDREN (462 4-YEAR OLDS) WERE OFFERED A REFERRAL TO A HEALTH PROFESSIONAL FOR SUPPORT

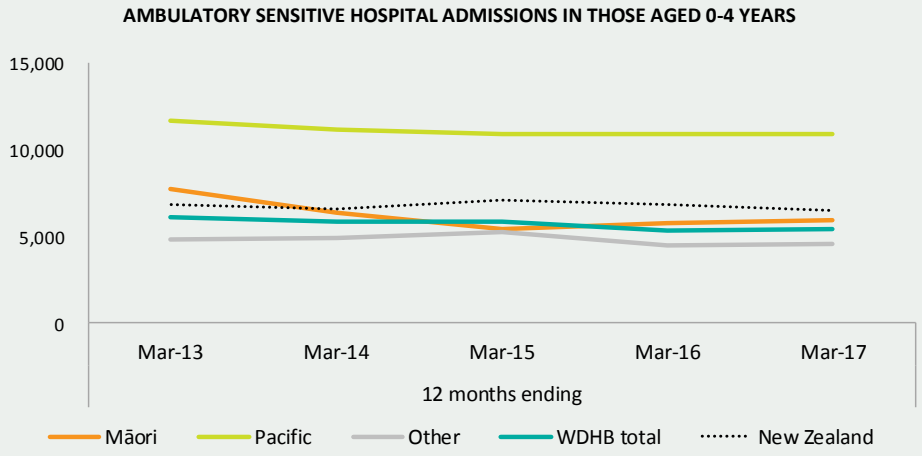
Children receive the best start to life

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 maintain good health, prevent health problems and improve health outcomes.

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

Keeping children out of hospital

In the 12 months to March 2017, there were 5,463 admissions per 100,000 in our 0–4 year old population (2,160 events) that were considered ambulatory sensitive, a slight increase on the previous year. Rates in the Pacific population are twice as high as other ethnicities.



Early enrolment with a GP/practice enables newborn babies to receive timely immunisation and other health checks. In 2016/17, 70% of babies born in our area were enrolled with a GP by 3 months of age. Waitemata DHB has collaborated with PHOs in the region through our Q4 Journey quality improvement project. We travelled with these babies, completing a review of all systems. General practices and the hospital Maternity services have streamlined and improved how we communicate early enrolment with new parents and caregivers.

Immunisation rates are increasing, and during 2016/17 we fully immunised 92% of children by eight months of age. The Q4 Journey project saw the babies turning 8 months in April to June 2017 followed from birth, and through each primary immunisation event. Babies overdue for immunisations at any point were actively followed up by immunisation coordinators.

Immunisation rates in Māori children are lower than the total population, at 86%. Our Māori case review group meets monthly with Ngāti Whātua, Well Child Tamariki Ora, oral health, immunisation services and the DHB to share information and support whānau and tamariki who are overdue for immunisations.

94% of our 4-year old children received a B4 School Check in 2016/17. The check aims to identify and address any behavioural, developmental or health concerns before a child starts school. All children identified as obese at their B4 School Check were either referred to their General Practice, already under care, or declined care, exceeding the new Raising Healthy Kids health target of 95%.

Oral health starts early

Maintaining good oral health in the first five years of a child's life is important for lifelong oral health. In contrast, poor oral health and dental decay at an early age can significantly affect physical, psychological and social development, leaving children susceptible to poor oral and general health throughout their lives.

Poor oral health is the cause of a significant number of hospital admissions in children. In the 12 months to March 2017, 180 children aged 0-4 were admitted to hospital for dental conditions.

In 2016, 66% of all 5-year old children had no dental decay (caries free), with higher rates of decay seen for Māori (54% caries free) and Pacific (43% caries free).

The Auckland Regional Dental Service (ARDS) provides oral health promotion, education and treatment to over 300,000 children across greater Auckland each year. All pre-school children and school year 1-8 children living in the metro Auckland area are eligible for enrolment with the service.

Improving preschool enrolment

To ensure that children are seen by ARDS, we have focused on early enrolment. This focus has seen enrolment increase by 10-15% for all ethnicities in the last 6 years. As at the end of December 2016, 93% of all children aged 0-4 years and living in Waitemata were enrolled with our oral health service.

Activities to increase enrolment have included an automatic enrolment process into the service from birth across all three Metro Auckland DHBs and working with community providers, such as Well Child Tamariki Ora providers to ensure contact details are updated.

ARDS is working to ensure that preschool children are seen before they become one year of age so that oral health care can start early.

In partnership with Plunket, ARDS is exploring opportunities to jointly deliver services (e.g. have a mobile dental clinic on site when a well-child clinic is being provided) to allow families access to both services at the same time.

ARDS also works with other child health providers so that at-risk children (those who have not attended appointments or where there are concerns for their oral health) are identified and referred to the service. ARDS can then support the families to attend appointments.

In the future, we plan to implement an outreach programme where staff provide fluoride varnish (a preventative treatment) to high needs children in the community.

Mobile clinics make it easier for families to access oral health services.

CURING ILL HEALTH

Support people to stay well with early detection and effective management

We aim to improve the detection and management of disease as well as providing rapid access to effective treatment for patients when they need it. Many conditions, such as CVD, some cancers and diabetes, are considered preventable or treatable through the provision of timely and high quality healthcare and we aim to improve our management of these to reduce hospital stays and avoidable deaths.

70.1

AMENABLE DEATHS PER 100,000 THE LOWEST IN NZ

68%

OF PEOPLE DIAGNOSED WITH CANCER IN 2012-13 SURVIVED FIVE YEARS AFTER THEIR DIAGNOSIS, AN INCREASE FROM 64% IN 2006/07

90%

RECEIVED THEIR FIRST CANCER TREATMENT WITHIN 62 DAYS

91%

OF OUR ELIGIBLE POPLULARTION HAVE HAD A CVD RISK ASSESSMENT IN THE LAST 5 YEARS

73%

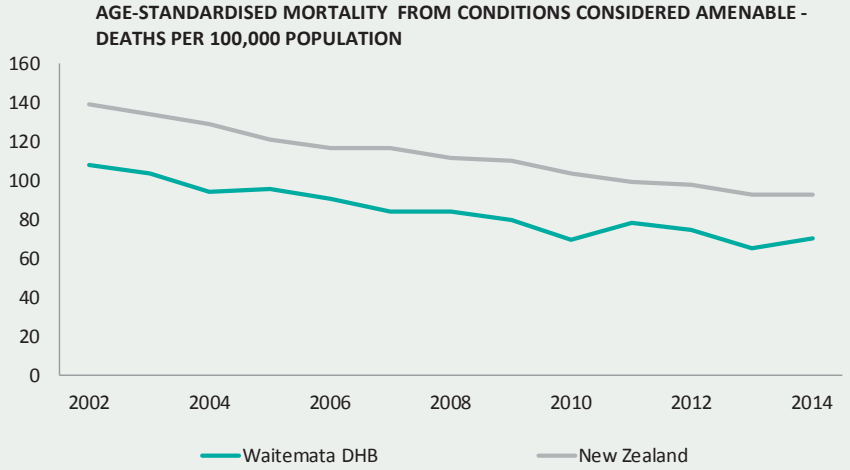
OF ACS INPATIENTS RECEIVED CORONARY ANGIOGRAPHY WITHIN 3 DAYS

Fewer deaths from amenable conditions

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

A reduction in mortality from conditions considered amenable

The rate of amenable mortality has steadily decreased over the past decade and is the lowest in New Zealand at 70.1 per 100,000 population. In 2014, we estimate that 433 deaths (47% of all deaths in those aged under 75 years) in Waitemata DHB were amenable.



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

We have achieved the Faster Cancer Treatment health target in 2016/17. Ninety percent of patients who received their first cancer treatment (or other management) in 2016/17 were treated within 62 days of being referred with a high suspicion of cancer compared with 72% in 2015/16.

Cardiovascular disease is largely preventable and is associated with large inequalities. Early detection and management of risk factors can lead to a reduction in sickness and premature death. 91% of our eligible population have had their cardiovascular disease risk assessed, exceeding the target of 90% set by the Ministry of Health.

Many people in our district require surgical intervention to treat their cardiovascular disease. For those admitted to hospital with ACS - acute coronary syndrome (sudden, reduced blood flow to the heart, e.g. unstable angina or heart attack) – it is important to perform coronary angiography quickly to inform further treatment options and prevent additional cardiovascular events. In 2016/17, 983 ACS patients living in Waitemata received an angiogram, 73% within 72 hours, exceeding the 70% target.

Bowel screening roll out

Bowel cancer is one of New Zealand's most common cancers and the second highest cause of cancer death. More than 3,000 New Zealanders are diagnosed with bowel cancer each year and more than 1,200 die from it. Bowel screening can detect cancer at an early stage when it can often be successfully treated.

The Bowel Screening Pilot began in Waitemata in late 2011. Eligible people aged 50 to 74 years living in the Waitemata DHB area began to be offered screening as part of Round 1 from January 2012 and the Pilot has continued into 2017.

The National Bowel Screening Programme (NBSP) began being rolled out across all DHBs in July 2017. The Waitemata Pilot will transition to the National Bowel Screening Programme in January 2018.

Information from the Waitemata DHB Bowel Screening Pilot has helped to inform decisions about the National Bowel Screening Programme. Data collected during the Pilot has provided vital information on participation levels, cancer detection rates and the impact on health services.

It is best practice internationally to pilot a screening programme before offering it more widely, to ensure it is safe for participants, there is capacity to provide timely diagnostic and treatment services and that all processes are working correctly.

Bowel Screening
Check Yourself Out

The value of bowel screening

Aucklander David Vinsen lives with his wife, daughter and two grandchildren. David leads a busy and active life, and was shocked to receive a positive result to the test he completed through the Waitemata DHB bowel screening pilot.

"I was sent for a colonoscopy, which found an early stage cancer. I was very fortunate that it wasn't invasive and hadn't spread widely," David says.

"I had major surgery to remove the cancer in February 2015, a colostomy bag for 4 months, minor surgery to connect things up again, and a period of recuperation. Not at all a pleasant experience, but far better than the alternative. I've just had a battery of tests on the second anniversary of my surgery – and been pronounced clear, as I was last year."

David is delighted that bowel screening will be available nationwide. He is encouraging those who are invited to do the free bowel screening test to take up the opportunity.

"Do the test; don't be scared about it. It's not at all embarrassing or awkward. There's no inconvenience. All you've got to do is take one small sample at home, post it off in the envelope and that's it. And if you are among the small group who are diagnosed with cancer, let those close to you know about it and seek their support. You'll be amazed at the support you get from family, friends and colleagues."

David, who is chief executive of the NZ Imported Motor Vehicle Association, says many people take better care of their cars than themselves.

"I also think men, who can sometimes be reluctant to go to the doctor, should consider going for a regular health check-up on or around their birthday. We look after our vehicles and have them regularly serviced and inspected. We should do the same for ourselves."

THERE WERE

422

ACUTE HOSPITAL BED DAYS (PER 1,000 POP), A DECREASE FROM 424 THE PREVIOUS YEAR

53%

OF PATIENTS WITH CVD ARE RECEIVING TRIPLE THERAPY MEDICATION, AN DECREASE FROM 54% THE PREVIOUS YEAR

30%

OF PEOPLE WITH DIABETES ARE WELL MANAGED

10,727

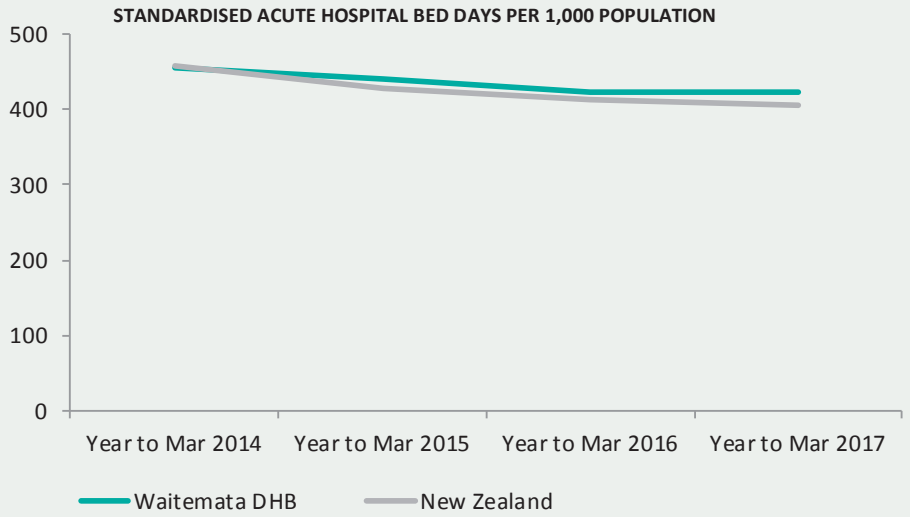
PEOPLE WERE REFERRED TO POAC FOR ACUTE CARE

Addressing the demand for acute care

The rate of acute hospital bed days per capita is a measure of the use of acute services in secondary care. The demand for acute care could 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. Reducing the number of acute hospital bed days will allow more effective use of our health resources.

A reduction in acute hospital bed days

Our standardised rate of acute bed days is slowly declining but remains higher than the National rate at 422 per 1,000 population compared with 405 per 1,000 population nationally.



Current New Zealand guidelines recommend that people who experience a heart attack or stroke (where appropriate) should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin), to reduce the risk of another event. In the 12 months to March 2017, 53% of our population who have had a CVD event received triple therapy medication.

Diabetes is a chronic illness that requires continuous medical care, patient self-management and education to reduce the risk of acute and long-term complications. How well a patient is managing their diabetes can be monitored through regular assessment of their HbA1c (an indicator of glycaemic control). In 2016/17, 30% of patients estimated to have diabetes (VDR) had HbA1c readings of less than 64mmols, an indication that their diabetes was well managed. There are a number of issues around extracting data from GP practices and this is impacting our ability to accurately report diabetes data. We believe that the reported proportion of patients with good diabetes management is understated.

Diabetes is a priority area for Waitemata DHB and we are working to resolve these data issues. The Auckland-Waitemata Diabetes Service Level Alliance (DSLA) has developed a 5-year action activity plan to improve the health of people with diabetes, which was endorsed in April 2017.

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for their patient, where the patient can be safely managed in the community, preventing an ED attendance and possible hospital admission. In 2016/17 10,727 patients were referred to POAC.

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

New rehabilitation model gets patients home faster

The Early Discharge and Rehabilitation Service (EDARS) is getting patients out of hospital and home more quickly.

The Early Discharge and Rehabilitation Service (EDARS) was launched in July 2016. This service is allowing patients with stroke and some other conditions to leave hospital earlier and undertake rehabilitation at home, while freeing up hospital beds for more unwell patients.

EDARS is run by a comprehensive inter-disciplinary clinical team that will grow to include 19 staff (12.8 FTE) working to rehabilitate patients to be as fully functional as possible and integrated back into their own environments. Instead of providing care in the Assessment, Treatment and Rehabilitation (AT&R) wards, the team delivers intensive rehabilitation in patients homes.

Waitemata DHB Clinical Director of Geriatric Medicine John Scott said EDARS is designed to give patients a tailored service to meet their own goals and needs.

"It's more meaningful if you're back in your own home, trying to use your own bathroom, your own kitchen and walk around your own yard."

The service is available for Māori or Pacific inpatients aged 55 + and all others 65 + whose underlying medical conditions are stable. Up to 200 patients could be eligible each year.

EDARS a success with patients

"The feedback from patients was unanimously positive, that getting out of hospital and back into their own environments benefited both their experience and their health outcomes as they saw it," says Jay O'Brien, Waitemata DHB patient experience manager.

John Rennie was one of the first patients to go through EDARS after a stroke in May.

"Speech was a little slurred initially….I couldn't hold a knife and fork….couldn't walk properly…," he says.

But John was out of hospital a week after the stroke and focussed on intensive rehabilitation in his home environment.

The Greenhithe resident credits the service with his rapid return to good health and the bowling green - one of the goals outlined in the programme he set up with his physiotherapist.

"Being able to be in a place where you can do normal things when you want to was huge," he said. "Like drying dishes and cooking food and chopping vegetables and things like that, which was good therapy anyway."

Physiotherapist Hannah Zuhir provides rehabilitation care to stroke patient John Rennie in his own home

AMELIORATING ILL HEALTH

People receive timely, high quality, supportive and safe services

The experience patients have when engaging with our services is as important as clinical effectiveness and safety. It is vital that the services we provide are of the highest quality, safe and that we meet the physical and emotional needs of our patients.

8.3/10

AVERAGE SCORE IN THE HQSC INPATIENT SURVEY, SIMILAR TO JUNE 2016

98.4%

OF PATIENTS THOUGHT WE WERE WELCOMING AND FRIENDLY

72

NET PROMOTER SCORE

52%

OF PHO PRACTICES HAVE A PATIENT PORTAL

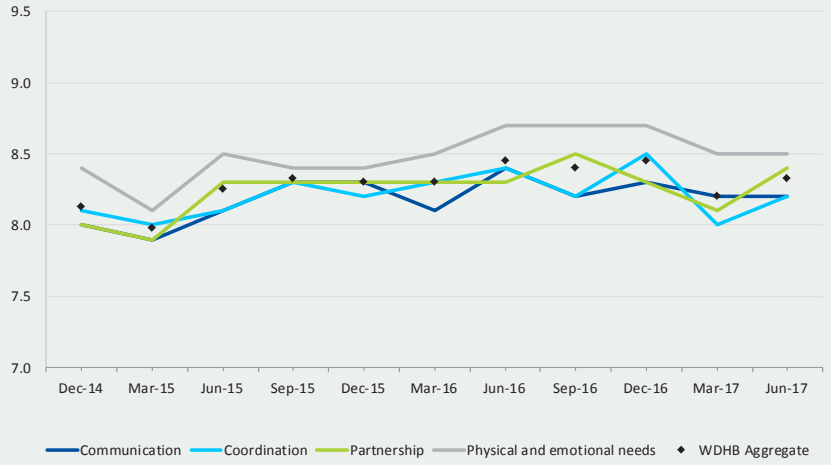
(All metro Auckland PHOs)

Improved experience of healthcare services

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. Our focus is on individualised care, tailoring services to meet patient and whānau needs, and engaging them as partners in their care.

An increase in the average score across the four domains of the Health Quality and Safety Commission (HQSC) inpatient survey

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. Our average scores out of ten have remained above 8/10 since late 2014 and are similar to New Zealand as a whole.



Patient experience measures are now routinely in place for hospitals. Our patient experience surveys allow us insight into what patients say make the most difference to their care and treatment. We can also use their responses to understand where making improvements would have the most positive impact on patient experience.

Happy or Not machines are distributed in various touch points and thoroughfares throughout our hospitals. Patients and visitors to these areas are asked “Were we Welcoming and Friendly?” and can select from four progressively happy ‘smiley face’ buttons to answer. In 2016/17 nearly 14,000 people submitted responses and 98.4% rated us ‘excellent’ or ‘good’ at being welcoming and friendly.

The Friends and Family Test is a way of gathering feedback about patients and their families experience of care. In 2016/17, 76% of the respondents said that they were extremely likely to recommend our ward/service to friends and family, resulting in a Net Promotor Score of 72. The Net Promoter Score is a percentage of service ‘promoters’ - people who answered extremely likely, minus the percentage of ‘detractors’ - those who answered, extremely unlikely, unlikely, or neither likely/unlikely to recommend.

Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a portal, people can better manage their own health care. As at February 2017, 52% of metro Auckland PHO practices have a patient portal.

Better experiences for our patients and their families

Spending time in hospital can be stressful for our patients and their families. We're taking many steps to improve the experience our patients have while under our care.

Helping patients get a good night's sleep

Getting a good night's sleep helps recovery and general well being, but it's not always easy in hospital. But in late 2016 sleep packs were introduced to three wards across the DHB.

The packs include earplugs, an eye mask and chamomile tea, as well as information about how to get a better night's sleep and not disturb other patients.

Jason Russell, a charge nurse manager for Ward 2 at North Shore Hospital, has seen the benefits of a quality night's sleep for his patients since the introduction of the sleep packs.

"Sleep's something we take really seriously because sleep is great for recovery, especially for our stroke patients on this ward."

Jason says that hospitals commonly have bright lights on all night to allow staff to carry out their work. "This means patients are often disturbed through the night with various noises and lights on around them. It makes it difficult to rest completely." he says.

On Ward 2, all lights are dimmed between 8pm and 8.30am. Special LED lights were installed at ankle level in the corridors to assist night shift staff. Jason says staff are also more aware of their movements during sleep periods and schedule some patient check-ups at more appropriate times to avoid disturbing a patient's sleep.

Photo courtesy of North Shore Times

North Shore Hospital patient Trish Tunnicliffe with one of the packs designed to help her get a good night's sleep

Supporting families at a tough time

Very ill or premature babies often start their lives in the Neonatal Intensive Care Unit (NICU) at Auckland City Hospital, and once they are well enough they leave the NICU to continue their care journey at the Special Care Baby Unit (SCBU) in a Waitemata DHB hospital closer to home. Moving to an unfamiliar hospital can be an unsettling time.

Two years ago, Debbie Daniel, SCBU charge nurse manager for Waitakere, and Karen Boyle, charge nurse manager for SCBU at North Shore Hospital, started a fortnightly programme to visit families in NICU ahead of their scheduled moves to another hospital in the Waitemata district.

"It is a time of stress for families leaving NICU to come to an unknown environment, so this eases the transition," she says. Packing up baby and moving to another hospital is tough. You're already nervous about baby and then you've got to come into a new environment with a whole new team. What these visits do is make families comfortable and familiar before they make the move so that when they come to our hospitals, they already feel safe and supported."

Families coming to SCBU also receive a 'welcome to SCBU' booklet, while a virtual booklet is available for mothers in the postnatal wards, with photos and explanations.

Baby Zoe Hutton was born at 32 weeks and started her life in NICU. Zoe's parents were visited by Waitemata DHB's visiting charge nurse managers ahead of the shift to Waitakere Hospital.

"You do get used to the one place, so it really made a difference to meet them before we came here," Zoe's mother Rebecca says. "Everyone seems to love their job here and the nurses have been so lovely which has been great for making me feel comfortable and calm. We know Zoe is in safe hands when we go home at night."

Patients stay safe in our hospitals

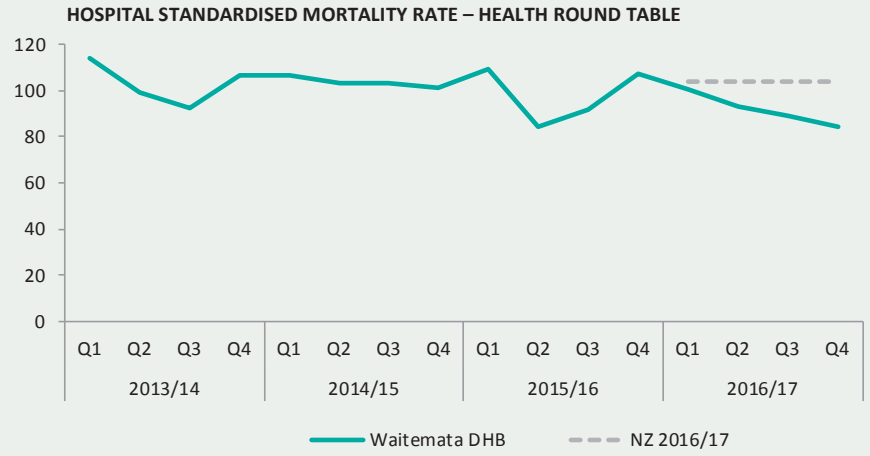
To provide the very best care for all our patients, we need to ensure that the care we provide is safe and clinically effective. We have continued improving patient safety through the regional First, Do No Harm programme, and our quality and safety strategy drives initiatives focused around the three key elements of quality: safe care, clinically effective care and patient and family centred care.

92

OUR HSMR IS ONE OF THE LOWEST IN NEW ZEALAND

A reduction in the Hospital Standardised Mortality* Ratio

The Health Round Table compares Hospital Standardised Mortality between participating New Zealand hospitals and measures whether the death rate at a hospital is higher or lower than would be expected. Our HSMR has decreased over the last year and is one of the lowest in New Zealand.



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

0.07

S. AUREUS INFECTION RATE

86%

COMPLIANCE WITH THE FIVE MOMENTS FOR HAND HYGIENE

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**	Q4 2015/16	Q4 2016/17
80% compliance with good hand hygiene practice	83%	86%
Health care associated staphylococcus aureus bacteraemia per 1000 bed days	0.05	0.07
90% of older patients assessed for the risk of falling	97%	95%
% of patients assessed at risk of falling who received an individualised care plan	98%	97%
Number of in hospital falls causing fractured neck of femur, per 100,000 admissions	3.96	3.79
100% of hip and knee arthroplasty primary procedures given antibiotic in right time	92%[1]	94%[2]
95% of hip and knee arthroplasty procedures given right antibiotic in right dose	94%[1]	96%[2]
Surgical site infections per 100 hip and knee operations	0.29	0.9[3]
95% of audits of surgical safety checklist engagement score levels of 5 or higher [4]	sign in – 75% time out – 89% sign out – insufficient audits	
Medication safety – % of wards with electronic medicine reconciliation implementation	84%	87%

[1]Q3 2015/16
[2]Q3 2016/17
[3]Preliminary internal data
[4]New indicator, focus currently only embedding programme and auditing method

95%

OF OLDER PATIENTS HAD THEIR RISK OF FALLING ASSESSED

Providing 'best care for everyone'

Our promise to our community is 'Best Care for Everyone'. Therefore, we seek continuous improvement in everything we do. We aim to provide care that is safe, clinically effective, and focused on the individual needs of every patient and their whānau that enters our care.

The ED Survive Sepsis project

During any given week, an average of five patients in our hospitals are suffering from sepsis, one in four of whom will die. Sepsis is a life-threatening condition caused by the body's response to an infection. If not treated in time, sepsis can lead to septic shock, multiple organ failure and death (mortality) - there is an 8% higher chance of death for every hour delay in starting antibiotics. In September 2016, the DHB launched the Survive Sepsis Improvement Collaborative, with the aim of reducing sepsis mortality.

An audit of time taken to administer antibiotics in patients presenting to ED with sepsis demonstrated delays. The ED Survive Sepsis Project was set up and a pathway developed to promote the early recognition, risk stratification, treatment priorities and escalation of patients with potential sepsis, to ensure more timely treatment with antibiotics.

The project has been a success, improving the recognition of sepsis, and speeding up the time to treatment.

Prior to the introduction of the Sepsis Pathway, the median time for a patient presenting with sepsis to being administered antibiotics was 214 minutes. After the introduction of the pathway initiative the time to antibiotics dropped 34% to 142 minutes, reducing the risk of poor outcomes for our patients.

Reducing complications after abdominal surgery

Some of our patients suffer complications following surgery, prolonging their recovery and increasing the risk of death.

For upper abdominal surgery (UAS), pulmonary complications (e.g. pneumonia) occur most frequently.

In 2015, North Shore Hospital, along with two Australian hospitals, participated in a clinical trial developed to confirm whether a physiotherapy education session before surgery can reduce the rate of post-operative pulmonary complications (PPCs) following upper abdominal surgery (UAS).

The trial was a success with significantly improved clinical outcomes seen. The rate of PPC for high risk patients was reduced from 40% in the control group to 19% in the group receiving pre-operative physiotherapy. The overall rate of PPC was only 12% in the intervention group, compared to 27% in the control group. Average length of stay was reduced by almost 2 days, and readmissions to ICU were much lower.

Senior physiotherapist Lesley Anderson, along with AUT senior physiotherapy lecturer Dr Julie Reeve, won 2016 Waitemata DHB Health Excellence award for their work improving pre-operative care.

All patients about to undergo open upper gastrointestinal surgery at Waitemata DHB are now provided with booklets and an education session with a physiotherapist before their operations, in addition to post-operative physiotherapy.

"Before this trial patients wouldn't have the opportunity to meet with a physiotherapist until after surgery when they were often tired and in pain. It was difficult for a patient to retain any effective information given to them to assist them in recovery," Julie says.

Post-operative physiotherapy, including breathing exercises and early walking improve recovery after surgery

Patient feedback has been positive and physiotherapists report that patients are more engaged in their own treatment and motivation is improved.

"The physiotherapist session gave us the opportunity to explain why the exercises are important. We also found that patients felt a lot less anxious about what was coming after their operation." says Lesley.

Work has also begun on a programme that focuses on the aerobic fitness of a patient before surgery. Julie says research shows that if patients are more prepared for the physical demands of surgery, post-operative recovery can be more efficient and effective. "Patients could get home sooner and we should see better outcomes," she says.

Winners of the 2016 Health Excellence Award – Lesley Anderson and Dr Julie Reeve

Our people, our performance

Delivering on our plans

STATEMENT OF PERFORMANCE

Overview

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

Measuring our outputs helps us to understand how we are progressing towards achieving our impacts and outcomes set out in the improving outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitemata DHB population is now 83.8 years, an increase of 2.2 years over the last decade. The life expectancy gap is 5.6 years for Māori and 6.0 years for Pacific, compared to all other ethnicities.

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures in each section reflect the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Waitemata DHB Māori Health Plan 2016/17.

National health targets

2016/17 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show the full year's performance as well as the fourth quarter's result where relevant. For quarter four we achieved five of the six health targets according to Ministry of Health assessment criteria.

Health Targets	Health Target Description	2016/17				
		Q1	Q2	Q3	Q4	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	97%	97%	97%	97%	97%
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)[1] Target = 21,583	6,050 (105%)	11,750 (106%)	17,442 (108%)	23,998 (111%)	23,998 (111%)
Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment[2]	86%	90%	92%	90%	90%
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time	94%	92%	92%	92%	92%
Better Help for Smokers to Quit	90% seen in primary care provided with advice to help quit	87%	88%	88%	90%	88%
	90% of newly registered pregnant women provided with advice to help quit	89%	78%	91%	92%	87%
Raising Healthy Kids	95% of obese children identified in the B4SC programme will be offered a referral to a health professional[3]	83%	100%	100%	100%	100%

[1] Waitemata DHB's targeted increase (share of the NZ total additional 4,000 discharges) was 490 additional discharges, quarterly results are year to date.
[2] This result does not include patients that have not yet received their first treatment. If a patient has been waiting for more than 62 days as at the reporting date, he/she will not be reported as a breach because the first treatment has not yet occurred.
[3] Quarterly results are for checks completed in the rolling 6 month period ending one month prior to the end of the quarter, as per MOH definition. Ie, Q1=Mar-Aug16; Q2=Jun-Nov16; Q3=Sep16-Feb17; Q4=Dec16-May17. The FY result is for the 12 month period Jun16-May17 (thus Q1 result only partly represented in FY result).

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 for the year was revised in 2014/15 and we have continued with this grading system for 2016/17. This has been applied to assess performance against each indicator in the Output Measures section. A rating has not been applied to demand driven indicators.

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

The tables in this section include our output measures from the 2016/17 Statement of Performance Expectations by Output Class. The type of measure is shown in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, rather than quantative targets. These have been assigned the following symbols in the target column.

Symbol	Definition
Measure type	
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage
Ω	Measure is demand driven
Target symbols	
Ω	Measure is demand driven – not appropriate to set target or grade the result
↓	A reduction on the baseline value is expected
↑	An increase on the baseline value is expected
Other	
*	Measure not reported in previous year's annual report, therefore 2015/16 results shown have not been audited

Output Class 1: Prevention Services

Prevention services help to protect and promote health in the whole population or identifiable sub-populations. Prevention services include health promotion to help prevent the development of disease; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services such as immunisation and screening services. Outputs provided by General Practice teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment output class. A significant portion of the work of Primary Care is preventive in nature.

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
HEALTH PROMOTION						
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking (Q)	Q2 2015/16	98%	98%	95%	99%	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking (Q)	Q2 2015/16	88.2%	89%	90%	88%	
Percentage of pregnant women who identify as smokers upon registration with a DHB-midwife or LMC are offered brief advice and support to quit smoking	Q3 2015/16	90%	90%	90%	87%	
Raising Healthy Children HT: Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	-	New indicator	-	95%	100%	
Number of people accessing Green Prescriptions (V)	2014/15	6,511	7,206	7,288	6,375[1]	
% of decile 1-4 schools engaged in Health Promoting Schools (Q)	Nov-14	89%	66%	75%	79%	
Enforcement of the Smokefree Environments Act 1990[2]						
Number of retailer compliance checks conducted (V)	2014/15	284	341	300	316	
HEALTH PROTECTION						
Tuberculosis (TB)[2]						
Percentage of TB and LTBI (latent TB Infection) cases who have started treatment and have a recorded start date for treatment (Q)	2014/15	99.9%	98%	≥85%	94%	
POPULATION-BASED SCREENING						
Breast Screening						
Coverage rates among eligible groups (C)	Q1 2015/16	68%	67%	70%	66%	
Bowel Cancer Screening Programme Pilot						
Percentage of people invited to participate who returned a correctly completed test kit (C)	Round 2 Sep-15	53.4%	53.4%[3]	60%	55%[4]	
% of individuals referred for colonoscopy following positive iFOBT result who receive their procedure within 55 working days (T)	Dec-15	95%	96%	95%	97%	
Children						
Number of children referred for a Gateway assessment waiting over the contracted timeframe	Mar-16	30	16	0	24[5]	
Percentage of B4 School Checks completed (C)	Q4 2014/15	93%	93%	90%	94%	

[1] A current provider stopped enrolling new patients during Q4 as part of the transition process to a new provider. This indicator will be replaced with a new service specification with a target on engaged clients rather than referrals.
[2] These services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data is for all 3 DHBs.
[3] Round 2 participation.
[4] Round 3 participation (results as at June 2017 for people invited January – September 2016)
[5] The increase was partly due to non-attendances at assessments and availability during specific times (e.g. school holidays). A reduction has been observed with strategies such as extra clinics and working in partnership with Oranga Tamariki to support clinic attendance.

Output Class 2: Early Detection and Management

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

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

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
PRIMARY HEALTHCARE						
Primary care enrolment rates (C)	Q2 2015/16	93%	94%	95%	92%	
Number of referrals to Primary Options for Acute Care (POAC) (V)*	Apr-15 to Mar-16	8,489	8,642	9,500	10,727	
Increased immunisation HT: percent of eight months olds will have their primary course of immunisation on time (C)	Q3 2015/16	93%	83%	95%	92%	
Seasonal influenza immunisation rates – 65+ years (C)	Q1 2015/16	61%	41%[6]	75%	48%[7]	
HPV immunisation coverage (dose 3) (C)	Jan 2016	58%	60.2%	70%	60%	
Cervical screening coverage (C)	Q2 2015/16	77%	76%	80%	74%	
Percentage of people with diabetes whose HbA1c at their annual review was ≤64 mmol/mol	Q2 2015/16	67%	69%[8]	69%	n/a[9]	n/a
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years (C)	Q2 2015/16	90%	91.3%	90%	91%	
Percentage of patients with prior CVD who are prescribed triple therapy*	Oct 2014-Sep 2015	54.6%	54.0%[10]	55%	53.1%[10]	
COMMUNITY-REFERRED TESTING AND DIAGNOSTICS						
Number of radiological procedures referred by GPs to hospital (V)	CY2015	30,875	31,486	Ω	37,424	n/a
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks (T)	Dec 2015	CT 90% MRI 91%	CT 96%[11] MRI 88%	CT 95% MRI 85%	CT 96% MRI 91%	
ORAL HEALTH						
Mean decayed, missing, filled teeth (DMFT) at year 8 ratio (Q)	CY2015	0.74	0.74	0.82 (2016) 0.72 (2017)	0.67	
Children caries free at five years of age (Q)	CY2015	67%	67%	70% (2016) 72% (2017)	66%	

[6] CY2015 flu season result.
[7] CY2016 flu season result. Provision of funded vaccinations at pharmacies and continued focus between PHOs and general practices should increase 2017 performance; both activities are recorded on the National Immunisation Register and expected to improve data capture and accuracy.
[8] Q4 2015/16 result, patients receiving an annual diabetes review in Q4 2015/16
[9] Data are no longer available as this indicator has been changed by the Ministry to the most recent HbA1c measurement in the last 12 months.
[10] March 2016 result for 2015/16; March 2017 result for 2016/17.
[11] June 2016 result.

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 preventive, diagnostic, therapeutic, and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.

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

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
ACUTE SERVICES						
Number of ED attendances (V)	CY2015	117,291	121,524	Ω	121,352	n/a
Acute WIES total (DHB Provider)[12] (V)	CY2015[13]	56,704	60,322	56,561	62,869	
Shorter stays in Emergency Departments HT: percentage of ED patients discharged admitted or transferred within six hours of arrival (T)	Q2 2015/16	95%	95%	95%	97%	
Compliance with Faster Cancer Treatment national health target – 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016 (T)	Q2 2015/16	68%	71.5%	85%	90%	
Percentage of eligible stroke patients thrombolysed (T)	Q1 2015/16	2.9%	5.5%	6.0%	7.7%	
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (Q)	Q1 2015/16	82%	86%	80%	79%	
Percentage of acute coronary syndrome (ACS) inpatients receiving coronary angiography within 3 days (T)	Dec 2015	85%	81%	70%	72%	
MATERNITY						
Number of births (V)	CY2015	6,712	6,725	Ω	7,045	n/a
Third/fourth degree tears for all primiparous vaginal births (Q)	CY2015	3.14%	2.7%	↓	4.3%[14]	
Number of women booking before end of 1st trimester (Q)	CY2015	72%[15]	72%[15]	80%	72%[15]	
ELECTIVE (INPATIENT/OUTPATIENT)						
Improved access to elective surgery HT: number of elective surgical discharges (V)	2014/15	20,687	21,994	21,583	23,998	
Surgical standardised intervention rates, per 10,000 pop - SIR (C)						
Joints	Oct-14 – Sep-15	18.34	21.40	21	28.0	
Cataracts		38.15	33.17	27	39.7	
Cardiac		5.73	6.83	6.5	6.1[16]	
Angioplasty (PCR)		10.87	14.63	12.5	16.5	
Angiogram		29.69	40.83	34.7	41.7	
Percentage of people receiving urgent diagnostic colonoscopy in 14 days	Mar-16	85%		85%	92%	
Percentage of people receiving non-urgent diagnostic colonoscopy in 42 days	Mar-16	70%		60%	78%	
Patients waiting longer than 4 months for their first specialist assessment (T)	Dec-15	0%	0%	0%	0%	
Patients given a commitment to treatment but not treated within 4 months (T)	Dec-15	0.4%	0.5%	0%	0.5%[17]	

[12] Weighted inlier equivalent separations (WIES) – relative cost measure for inpatient episodes.
[13] Incorrectly stated as Q2 2015/16 in Annual Plan
[14] Our increase equates to a small number of patients and we remain consistent within the health roundtable benchmark of 6%.
[15] MoH MAT data 2015. Independent LMCs only. MOH have not released any later data. Baseline incorrect in 2016/17 AP.
[16] Rated 'not significantly different' from target by MOH.
[17] Assessment of performance is based on Ministry of Health criteria. Reported performance is for June 2017. Sub-optimal performance related to only a small number of patients in June 2017.

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
QUALTIY AND PATIENT SAFETY						
Percentage of opportunities for hand hygiene taken (Q)*	Q2 2015/16	80%	82%	85%	86%	
Percentage of patients aged 75+ (55+ for Māori and Pacific peoples) assessed for risk of falling (Q)*	Q2 2015/16	99%	97%	90%	97%	
Percentage of hip and knee arthroplasties where antibiotic given in hour before incision (Q)*	Q2 2015/16	98%	96%	100%	95%	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	2014/15	0.06	0.05	↓	0.10[18]	
Net Promoter Score[19] on patient and staff experience feedback system (Q)*	May-16	70	64	63	72	
% of falls risk patients who received an individualised care plan (Q)*	Q1 2016/17	99%	97%	90%	96%	
Rate of falls with major harm (per 1000 occupied bed days) (Q)*	Q1 2016/17	0.1	0.10	<2	0.10	
% of hip and knee procedures given right antibiotic in right dose (Q)*	Q3 2015/16	94%	95%	95%	96%	
% hip/knee procedures given appropriate skin preparation (Q)*	Q3 2015/16	100%	99%	100%	n/a[20]	n/a
Surgical site infections per 100 hip and knee operations (Q)*	Q4 2015/16	0.29	0.51	1.2-1.3	1.61[21]	
Number of pressure injuries grade 3 or 4 - Provider Arm (Q)*	Q1 2016/17	0	3	0	1[22]	
Rate of patients with pressure injuries per 100 patients (Q)*	Jul-16	0	1.48	0	1.51[23]	
MENTAL HEALTH						
% of the population who access mental health services (C) Age 0-19 years Age 20-64 years Age 65+ years	Nov-14 to Oct-15	 3.14% 3.50% 2.13%	 3.44% 3.55% 2.05%	 3.1% 3.4% 2.1%	 3.7% 3.6% 2.0%[24]	
Shorter Waits for Non-urgent Mental Health and Addiction Services for 0-19 year olds						
Percentage of 0-19 year old clients seen within 3 weeks (T) - Mental Health - Addictions Percentage of 0-19 year old clients seen within 8 weeks - Mental Health - Addictions	Oct-14 to Sep-15	 80% 96% 92% 99%	 61% 85% 91% 99%	 80% 80% 95% 95%	 71%[25] 89% 95% 98%	

[18] This rate is lower than the national adjusted median (0.13). We continue to meet the hand hygiene process marker and focus on reducing bacteraemia rates.
[19] The percentage of service 'promoters' (people who answered extremely likely to recommend the service to family or friends) minus the percentage of detractors (those who answered, extremely unlikely, unlikely, or neither likely nor unlikely to recommend).
[20] Marker retired by HQSC in July 2016
[21] Preliminary internal data. Our Infection Prevention and Control Committee are undertaking a quality improvement project to determine any additional perioperative risk factors for SSIs (e.g. wound care, drains) as rates are higher than previously reported.
[22] One patient with grade 3 pressure injury was reported in October 2016.
[23] Internal pressure injury target is 10% reduction per annum. Baseline incorrectly based on atypical single month's result. Data recording has improved, so pressure injuries more accurately recorded. Nurses are being educated on pressure injury prevention and most patients receive pressure injury risk assessment.
[24] Increase in estimated denominator population, patients receiving mental health support from other sources (e.g. primary care, aged residential sector) and some unmet need have resulted in lower access rates. We plan to improve our service delivery to patients and develop closer links with other services.
[25] Population growth has seen increasing referrals. Initiatives are in place to address waiting times.

Output Class 4: Rehabilitation and Support Services

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

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

Output measure	Baseline period	Baseline result	2015/16 result	2016/17 target	2016/17 result	Achievement
HOME-BASED SUPPORT						
Average number of hours per month of home-based support services for: (V) - Personal care - Household management	Sep-15	 67,505 16,331	 68,550 17,170	 Ω Ω	 76,238 15,962	 n/a n/a
The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan (Q)	Q1 2015/16	82%	98%	75%	97.8%	●
% of urgent interRAI referrals assessed within 5 working days % of non-urgent interRAI referrals assessed within 15 working days	Q1 2016/17	61% 28%	New indicator	↑ ↑	n/a[26]	n/a n/a
PALLIATIVE CARE						
Number of contacts (V)	2015/16	22,181	22,181	Ω	20,230	n/a
Proportion of hospice patient deaths that occur at home (Q)	Jul-Dec 2015	40%	38%	↑	33%[27]	●
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	Jul-Dec 2015	13%	7.4%	↓	4.5%	●
RESIDENTIAL CARE						
% of aged care providers with 4 year audit certification (Q)	2014/15	15%	19%	↑	20%	●

[26] Data quality for these indicators is a national issue and is currently being investigated. Robust results not available at this time.

[27] The 40% baseline was set prior to a definition change, which now excludes patient deaths occurring at high and low level residential aged care facilities (20% and 4%, respectively, in Q4 2016/17).

Cost of Service Statement – for year ended 30 June 2017

	Prevention Services		Early Detection & Management		Intensive Assessment & Treatment		Rehabilitation & Support		Total	
	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan	$000 Actual	$000 Plan
Total Revenue	30,755	29,258	406,068	420,149	978,547	981,221	211,263	209,397	1,626,634	1,640,025
Expenditure										
Personnel	10,192	10,189	75,656	78,586	490,900	492,907	27,260	27,679	604,009	609,361
Outsourced Services	1,384	1,175	12,182	11,168	57,564	49,544	5,149	4,703	76,280	66,590
Clinical Supplies	1,964	1,836	13,956	13,437	97,547	91,197	4,781	4,469	118,248	110,938
Infrastructure & Non-Clinical Supplies	1,552	1,428	9,219	8,483	85,777	77,253	2,403	2,063	98,953	89,228
Payments to Providers	16,459	14,515	289,877	305,922	260,396	269,942	160,495	169,028	727,227	759,408
Total Expenditure	**31,552**	**29,143**	**400,890**	**417,596**	**992,185**	**980,843**	**200,089**	**207,942**	**1,624,716**	**1,635,525**
Net Surplus/ (Deficit)	**(796)**	**115**	**5,179**	**2,553**	**(13,638)**	**378**	**11,173**	**1,455**	**1,918**	**4,500**

BEING A GOOD EMPLOYER

100%

COMPLIANCE WITH GOOD EMPLOYER PRINCIPLES

(1ST EQUAL IN NZ)

7,079

EMPLOYEES AT WAITEMATA DHB

(6,215 FTE)

24% MALE

76% FEMALE

53% NZ/EUROPEAN

6% MĀORI

5% PACIFIC

26% ASIAN

10% OTHER ETHNICITIES

At Waitemata DHB, our promise is the best care for everyone. We believe that our patients receive the best care from our people, when our people receive the best care from us as their employer. We are committed to being an Equal Employment Opportunities (EEO) employer through our organisation-wide good employer practices relating to the recruitment, development, management and retention of all staff and have been an employer member of Diversity Works for the last seven years.

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

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

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, union/staff forums, and our health, safety and wellbeing committee.

Recruitment, Selection and Development

The DHB runs, and recruits from, assessment programmes allowing nurses and health care assistants from overseas or returning to practice to showcase their skills, knowledge and experience. In 2017 the programme was extended to include orderlies and cleaners.

Waitemata DHB has a comprehensive training programme to equip new graduates with clinical and professional skills. There are also training programmes to support the transition of post graduate medical staff through to vocational training.

The DHB supports our Orderly, Cleaning, Therapy Assistants, Oral Health Assistants and Heath Care Assistant staff through NZQA accredited training via Careerforce.

In June, the DHB opened a new education and learning facility, Whenua Pupuke. The facility will support the education and celebration events for our diverse workforces, as well as host external conferences that support our commitment to learning.

Management and Leadership development

In 2016 the DHB launched *Transforming Care* - a development programme designed to support delivery of care redesign and enhanced care management. Tier 1 is directed at frontline staff and modules include organisational values and patient experience. Tier 2 is a clinical practice improvement and leadership programme and Tier 3 is an advanced programme for senior leaders wanting to take on responsibility and accountability for service design and operations.

The Fellows Programme enables service redesign by matching high performing individuals to areas of organisational need. Fellowships are 12-month roles that require completion of a project and a publication in areas including medical education, health innovation, health informatics, quality improvement, midwifery, health care design and health management.

In 2015, the Northern region DHBs introduced a management graduate programme. We took on two new graduates in 2016/17 applying a mix of on the job training, cohort based leadership, and cultural and academic coaching to build their leadership competencies.

Management Foundations is a learning programme for our managers. Topics covered include employee engagement, patient experience and quality, safety and wellbeing and financial and project management.

THE AVERAGE WAITEMATA EMPLOYEE IS

44 YEARS OLD

17% AGED <30

48% AGED 30-50

35% AGED OVER 50

35%

OF OUR EMPLOYEES WORK PART TIME

(2,153 FTE)

0.2%

OF OUR EMPLOYEES HAVE DECLARED A DISABILITY

Growing our Māori and Pacific Health workforce

The DHB has a strong focus on growing and building the capacity of our Māori and Pacific Health workforces and the programmes below contribute to this priority. To support and commit our efforts, the DHB has set employment growth targets to match Māori and Pacific working age district populations with levels of staff employment.

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

The Rangatahi Programme provides Māori and Pacific senior secondary school students with career experience in healthcare, and promotes tertiary education and transition into employment. Five students are given summer work placements with Waitemata DHB.

Since 2009 the DHB has supported over 200 Māori and Pacific students through their tertiary study. Since 2016 100% of scholarship graduates who applied for roles in the health sector gained employment.

In July 2017 the DHB joined other Auckland DHBs to sign a youth pledge so we can:

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

Volunteers

There are approximately 360 volunteers currently involved with the DHB who work across both North Shore and Waitakere Hospitals. An extensive recruitment campaign commenced in 2017 and has successfully recruited volunteers from a variety of ethnic backgrounds and age groups.

Organisational culture and values

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

Work in 2017 focused on a staff survey about living our values, teamwork and patient experience week activities including an experiential space where staff could walk in the shoes of patients and simulate experiences such as mobility, sight, hearing and swallowing difficulties.

Remuneration and recognition

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

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

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

OCCUPATION TYPE:

43% NURSING

25% ALLIED HEALTH

13% MEDICAL

19% OTHER

4,070

EMPLOYEES RECEIVED A FLU VACCINATION IN 2016

In Partnership with Unions

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

Workplace flexibility and design

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

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

Policies

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

Health, Safety and Wellbeing

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

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

Our working environment is an important component to wellbeing for patients and staff, with the DHB focusing improvements on the following throughout 2016/17: the values and professional behaviours that connect us and help us work well together; safety in the community; assessing public reception areas; hazardous substances; buildings; and the external physical environment such as loading zones, pathways and roads, where volunteers assist us with hazard identification.

A key work programme is our Healthy Workplaces Strategy which adopts the World Health Organisation Healthy Workplaces framework, and through 15 collaborative workstreams, supports an evidence base that staff wellbeing influences patient wellbeing. Through this strategy we have recently completed a well at work expo and opened a fitness centre at Waitakere Hospital. We have also introduced a fund that can be accessed by managers to make reasonable adjustments to the workplace for staff with impairments who are not funded through any other existing support agency.

Through our Safe Way of Working policies we have introduced a systematic approach to health and safety monitoring. Our new self-audit introduced in April 2017 measures 12 elements of health, safety and wellbeing allowing the DHB to take a whole of systems as well as a ward/unit quality improvement approach that defines, guides, measures and embeds our practises.

We remain committed to working with our regional DHB partners on employee participation and training programmes, as well as sharing audit programmes so we can collectively improve our health and safety performance across the region.

ABOUT OUR ORGANISATION

Waitemata DHB Board members

Current Board members			
	Dr Lester Levy, CNZM, Chairman		Dr James Le Fevre
	Kylie Clegg, Deputy Chairman		Dr Matire Harwood
	Prof Max Abbott		Brian Neeson
	Edward Benson-Cooper		Morris Pita
	Sandra Coney		Allison Roe
	Warren Flaunty		

Statement of Waivers

The New Zealand Public Health and Disability Act 2000 s 42(4) provides as follows:

For the purposes of s 151 (1)(j) of the Crown Entities Act 2004, the annual report of a DHB must disclose any interests to which a permission, waiver, or modification given under clause 36(4) or clause 37(1) of Schedule 3 or clause 38(4) or clause 39(1) of Schedule 4 relates, together with a statement of who gave the permission, waiver, or modification, and any conditions of amendments to, or revocation of, the permission, waiver, or modification.

The following waivers were given during the last year:

Meeting of the Waitemata DHB Board 21 September 2016 (public excluded) –
Dr Lester Levy and Kylie Clegg both disclosed an interest in the item 'Orion Precision Driven Health Joint Venture Agreement Amendment.' Dr Lester Levy's disclosed interest was as Chairman of the Health Research Council. Kylie Clegg's disclosed interest was as a Trustee and Beneficiary - M&K Investments Trust (includes a share of less than 1% in Orion Health Group and a shareholding in Nextminute Holdings Ltd). Having declared their interests, the Board were satisfied under Schedule 3, clause 36(4) that Dr Lester Levy and Kylie Clegg could participate in deliberations on this item.

Meeting of the Community and Public Health Advisory Committee 29 March 2017 (public excluded) –
Dr Matire Harwood and Warren Flaunty both disclosed an interest in the item 'Rheumatic Fever Prevention Programme'. Dr Matire Harwood's disclosed interest was as a GP at the Papakura Marae Health Clinic. Warren Flaunty's disclosed interest was his Pharmacy Directorships. Having declared their interests, the Committee were satisfied under Schedule 3, clause 38(4) that Dr Matire Harwood and Warren Flaunty could participate in the deliberations on this item.

Trusts

Waitemata DHB controls the Three Harbours Health Foundation.
Wilson Home Trust: Waitemata DHB is trustee for this trust, the primary functions of which are: provision and maintenance of building and grounds at the Wilson Home and the funding of equipment and amenities for children with physical disabilities. Waitemata DHB leases from the Trust premises on the Wilson Home site from which the DHB provides services for children with physical disabilities.
Waitemata DHB also holds a 20% shareholding in South Kaipara Medical Centre Limited Partnership. This is a joint venture with the Helensville District Health Trust and two local GPs to ensure sustainability of a rural general practice.

Ministerial Directions

Directions issued by a Minister during the 2016/17 year, or that remain current are as follows:

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

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

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

An assessment of what has been achieved with Waitemata DHB's 2016/17 appropriations is detailed below:

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

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

What is intended to be achieved with this appropriation
The DHB provides services that align with:

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

How performance will be assessed and end of year reporting
The performance measures outlined in Waitemata DHB's Statement of Intent are used to assess our performance. For performance results, refer to our Statement of Service Performance.

Amount of appropriations

	2015/16		2016/17		
	Budgeted $000	Estimated Actual $000	Estimates $000	Supplementary estimates[28] $000	Total $000
Total appropriations (revenue)	1,349,321	1,349,321	1,399,525	(7,850)	1,391,675

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

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

Financial statements

Where the money came from and what we spent it on

FINANCIAL STATEMENTS

Statement of Responsibility

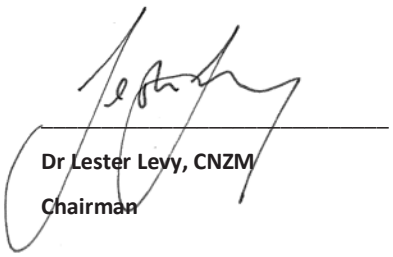
We are responsible for the preparation of the Waitemata District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waitemata District Health Board for the year ended 30 June 2017.

Signed on behalf of the Board:



Dr Lester Levy, CNZM
Chairman

Dated: 31 October 2017

Kylie Clegg
Deputy Chairman

Dated: 31 October 2017

Statement of comprehensive revenue and expense for the year ended 30 June 2017

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Revenue						
Patient care revenue	2	1,597,087	1,545,758	1,597,087	1,596,638	1,545,758
Interest revenue		3,088	5,802	2,747	6,010	5,454
Other revenue	3	26,800	25,319	26,800	37,377	25,319
Total revenue	30	1,626,975	1,576,879	1,626,634	1,640,025	1,576,531
Expenditure						
Personnel costs	4	604,008	582,218	604,008	609,361	582,218
Depreciation and amortisation expense	12,13	28,007	27,173	28,007	28,408	27,173
Outsourced services		76,280	71,571	76,280	66,590	71,571
Clinical supplies		109,936	102,033	109,936	101,737	102,033
Infrastructure and non-clinical expenses		39,713	39,550	39,713	21,602	39,550
Other district health boards		274,356	348,404	274,356	280,088	275,246
Non-health board provider expenses		452,872	356,650	452,872	479,320	429,808
Capital charge	5	21,560	24,501	21,560	24,526	24,501
Interest expense		6,532	10,712	6,532	11,136	10,712
Other expenses	6	10,419	11,110	11,452	12,757	11,870
Total expenditure	30	1,623,683	1,573,922	1,624,716	1,635,525	1,574,682
Surplus / (deficit)		**3,292**	**2,957**	**1,918**	**4,500**	**1,849**
Other comprehensive revenue and expense						
Gain /(Loss) on property revaluations	18	(379)	29,398	(379)	0	29,398
Total other comprehensive revenue and expense		(379)	29,398	(379)	0	29,398
Total comprehensive revenue and expense		**2,913**	**32,355**	**1,539**	**4,500**	**31,247**

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

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2017

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Budget 2017 $000	Actual 2016 $000
Balance at 1 July		346,077	313,722	335,970	338,354	304,723
Owner debt conversion to equity	18	276,706	0	276,706	0	0
		622,783	313,722	612,676	338,354	304,723
Comprehensive Income						
Surplus		3,292	2,957	1,918	4,500	1,849
Other comprehensive revenue and expense						
Gain / (Loss) on property revaluations		(379)	29,398	(379)	0	29,398
Total comprehensive revenue and expense for the year		**2,913**	**32,355**	**1,539**	**4,500**	**31,247**
Balance at 30 June	18	**625,696**	**346,077**	**614,215**	**342,854**	**335,970**

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

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2017

	Notes	Group		Parent	Group and Parent	Parent
		Actual	Actual	Actual	Budget	Actual
		2017	2016	2017	2017	2016
		$000	$000	$000	$000	$000
Assets						
Current assets						
Cash and cash equivalents	7	19,629	55,682	17,812	40,522	53,631
Receivables	8	55,939	48,051	55,291	49,713	47,953
Investments	9	1,163	28,732	0	2,437	28,000
Inventories	10	7,552	6,614	7,552	6,700	6,614
Prepayments		5,201	1,113	5,201	1,115	1,113
Total current assets		89,484	140,192	85,856	100,487	137,311
Non-current assets						
Investments	9	7,924	7,256	0	12,050	0
Investments in associates and joint ventures	11	36,830	33,270	36,830	33,269	33,270
Property, plant and equipment	12	742,488	710,189	742,488	754,924	710,189
Intangible assets	13	5,071	5,011	5,071	(14)	5,011
Total non-current assets		792,313	755,726	784,389	800,229	748,470
Total assets		**881,797**	**895,918**	**870,245**	**900,716**	**885,781**
Liabilities						
Current liabilities						
Payables	14	108,942	118,290	108,871	130,055	118,260
Borrowings	15	256	26,049	256	26,049	26,049
Employee entitlements	16	108,175	110,686	108,175	98,735	110,686
Provisions	17	1,051	704	1,051	620	704
Total current liabilities		218,424	255,729	218,353	255,459	255,699
Non-current liabilities						
Borrowings	15	342	251,519	342	249,568	251,519
Employee entitlements	16	37,335	42,593	37,335	52,835	42,593
Total non-current liabilities		37,677	294,112	37,677	302,403	294,112
Total liabilities		**256,101**	**549,841**	**256,030**	**557,862**	**549,811**
Net assets		**625,696**	**346,077**	**614,215**	**342,854**	**335,970**
Equity						
Crown equity	18	379,721	103,015	379,721	103,015	103,015
Accumulated surpluses / (deficits)	18	(39,018)	(40,936)	(39,018)	(33,974)	(40,936)
Property Revaluation Reserves	18	273,512	273,891	273,512	273,813	273,891
Trust funds	18	11,481	10,107	0	0	0
Total equity		**625,696**	**346,077**	**614,215**	**342,854**	**335,970**

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

Statement of cash flows for the year ended 30 June 2017

	Notes	Group Actual 2017 $000	Group Actual 2016 $000	Parent Actual 2017 $000	Group and Parent Budget 2017 $000	Parent Actual 2016 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,582,348	1,522,006	1,582,348	1,633,375	1,522,006
Other		38,321	47,035	38,587	706	46,527
Interest received		4,196	5,118	4,166	6,010	5,082
Payments to suppliers		(984,171)	(944,826)	(984,173)	(962,303)	(944,826)
Payments to employees		(608,107)	(575,928)	(608,107)	(609,360)	(575,928)
Payments for capital charge		(21,762)	(24,299)	(21,762)	(24,526)	(24,299)
Interest paid		(8,349)	(10,630)	(8,349)	(11,136)	(10,630)
GST (net)		749	(71)	749	0	(71)
Net cash flow from operating activities	19	3,225	18,405	3,459	32,766	17,861
Cash flows from investing activities						
Receipt from sale of property, plant and equipment		0	0	0	0	0
Receipt from sale or maturity of deposits		28,000	0	28,000	0	0
Purchase of property, plant and equipment		(63,718)	(72,208)	(63,718)	(74,926)	(72,208)
Purchase of intangible assets		0	0	0	0	0
Acquisition of investments/deposits		(3,560)	(35,415)	(3,560)	0	(35,415)
Net cash flow from investing activities		(39,278)	(107,623)	(39,278)	(74,926)	(107,623)
Cash flows from financing activities						
Capital contributions from the Crown		0	0	0	0	0
Proceeds from loans		0	0	0	0	0
Repayment of loans		0	0	0	(1,000)	0
Net cash flow from financing activities		0	0	0	(1,000)	0
Net (decrease) / increase in cash and cash equivalents		**(36,053)**	**(89,218)**	**(35,819)**	**(43,160)**	**(89,762)**
Cash and cash equivalents at the start of the year		55,682	144,900	53,631	83,682	143,393
Cash and cash equivalents at the end of the year	7	**19,629**	**55,682**	**17,812**	**40,522**	**53,631**

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

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1 Statement of accounting policies for the year ended 30 June 2017

Reporting entity

The Waitemata District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate controlling entity is the New Zealand Crown.

The Waitemata District Health Board's primary objective is to deliver health, disability, and mental health services to the community within its district. The group does not operate to make a financial return. Accordingly, the DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes.

The consolidated financial statements of Waitemata DHB for the year ended 30 June 2017 comprise Waitemata DHB and its subsidiaries (together referred to as "Group"). The Waitemata DHB group consists of the controlling entity, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board).

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

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

The financial statements for the DHB are for the year ended 30 June 2017, and were approved for issue by the Board on 31 October 2017.

Basis of preparation

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

Statement of compliance

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

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements comply with PBE accounting standards.

Presentation currency and rounding

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

Standards issued and not yet effective, and early adopted

Impairment of Revalued Assets

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

Standards issued and not yet effective, and not early adopted

Financial instruments

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

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

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

Subsidiaries

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

In the financial year ended 30 June 2017, Milford Secure Properties Limited was deregistered. In the prior year the DHB did not consolidate its controlled entity Milford Secure Properties Limited as it was dormant and not material.

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

Associates
An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The investment in an associate is recognised at cost. The DHB's interest in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) is not accounted for in the group financial statements as it is not material to the group.

The DHB is party to a Limited Partnership agreement, with 20% share of initial capital contributed to the South Kaipara Medical Centre Limited Partnership established on 1 November 2013.

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

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

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

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

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

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

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

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

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

Donations and bequests
Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity.

When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

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

Borrowing costs
Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases
Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

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

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.
Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.
Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Foreign currency transactions
Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the spot exchange rates at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

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

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

Investments
Bank term deposits
Investments in bank term deposits are initially measured at the amount invested.

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

Inventories
Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

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

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

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

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

- Land
- Buildings (including fit outs and underground infrastructure)

- Clinical Equipment
- IT Equipment
- Other Equipment and Motor Vehicles

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

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

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

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

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

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

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

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

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

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

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

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

- Buildings (including components) 2 to 80 years (1.25%-50%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%)

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

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

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

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

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

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

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

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

Indefinite life intangible assets are not amortised but are reviewed annually for impairment.

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

Impairment of property, plant, and equipment and intangible assets
The DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

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

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

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

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

Payables
Short-term payables are recorded at their face value.

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

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

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

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

A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

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

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

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

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

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

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

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

Provisions
A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

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

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

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

- crown equity;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- trust funds.

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

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

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

related asset or expense.

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

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

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

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

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

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

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

Land and building revaluations
Note 12 provides information about the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads.
Estimating the fair value of land and building revaluations
The significant assumptions applied in determining the fair value and buildings are disclosed in note 12.

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

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

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

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

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

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

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

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

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

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

The DHB has entered into a contract for services with providers for laboratory services. Services are provided across several DHB districts. The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. Therefore the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

2 Patient care revenue

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Health and disability services (MOH contracted revenue)	1,496,896	1,447,641	1,496,896	1,447,641
ACC contract revenue	9,755	10,008	9,755	10,008
Inter district patient inflows	79,486	77,001	79,486	77,001
Revenue from other district health boards	5,773	5,704	5,773	5,704
Other patient sourced revenue	5,177	5,404	5,177	5,404
Total patient care revenue	**1,597,087**	**1,545,758**	**1,597,087**	**1,545,758**

3 Other revenue

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Clinical Training Agency	9,762	9,201	9,762	9,201
Donations and bequests received	1,192	1,407	1,192	1,407
Rental revenue	585	621	585	621
Professional, training and research	3,752	3,368	3,752	3,368
Other revenue	11,509	10,722	11,509	10,722
Total other revenue	**26,800**	**25,319**	**26,800**	**25,319**

4 Personnel costs

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Salaries and wages	593,290	562,927	593,290	562,927
Contributions to defined contribution schemes	18,487	17,477	18,487	17,477
Increase/(decrease) in liability for employee entitlements	(7,769)	1,814	(7,769)	1,814
Total personnel costs	**604,008**	**582,218**	**604,008**	**582,218**

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

5 Capital charge

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six month actual closing equity balance. The capital charge rate for the period of first six months to 31 December 2016 was 7% (2016 : 8%). The rate for the period of second six months to 30 June 2017 was 6% (2016 : 8%).

6 Other expenses

		Group		Parent	
		Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Audit fees for Waitemata DHB financial statement audit		214	209	214	209
Audit fees (for subsidiary financial statements)		0	10	0	10
Operating lease expense		9,402	9,866	9,402	9,866
Impairment of debtors		1,611	1,473	1,611	1,473
Board members fees	23	365	360	365	360
Other expenses*		(1,173)	(808)	(140)	(48)
Total other expenses		**10,419**	**11,110**	**11,452**	**11,870**

*Includes Three Harbours Health Foundation net revenue

7 Cash and cash equivalents

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Cash at bank and on hand	67	18	0	0
Call deposits	1,750	2,033	0	0
NZ Health Partnerships Limited	17,812	53,631	17,812	53,631
Total cash and cash equivalents for the purposes of the statement of cash flows	**19,629**	**55,682**	**17,812**	**53,631**

7 Cash and cash equivalents (continued)

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 $1.817m (2016 : $2.051m) donated or bequeathed for a specific purpose. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Waitemata DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited and the participating DHBs. This Agreement enables New Zealand Health Partnerships Limited to 'sweep' DHB bank accounts and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZ Health Partnerships Limited, which will incur interest at on-call interest rate received by New Zealand Health Partnerships Limited plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST; for Waitemata DHB that equates to $58.112m (2016 : $55.803m).

8 Receivables

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Ministry of Health	29,101	23,421	29,101	23,421
Other receivables	11,946	10,020	11,298	9,922
Other accrued revenue	17,181	17,391	17,181	17,391
Less: Provision for impairment	(2,289)	(2,781)	(2,289)	(2,781)
Total receivables	**55,939**	**48,051**	**55,291**	**47,953**

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 2017			Group 2016		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	50,897	(76)	50,821	44,313	(57)	44,256
Past due 1-30 days	1,093	(244)	849	1,246	(269)	977
Past due 31-60 days	1,223	(169)	1,054	1,823	(207)	1,616
Past due 61-90 days	236	(320)	(84)	615	(536)	79
Past due > 90 days	4,779	(1,480)	3,299	2,835	(1,712)	1,123
Total	**58,228**	**(2,289)**	**55,939**	**50,832**	**(2,781)**	**48,051**

8 Receivables (continued)

	Parent 2017			Parent 2016		
	Gross	Impairment	Net	Gross	Impairment	Net
	$000	$000	$000	$000	$000	$000
Not past due	50,249	(76)	50,173	44,802	(57)	44,745
Past due 1-30 days	1,093	(244)	849	650	(269)	381
Past due 31-60 days	1,223	(169)	1,054	1,465	(207)	1,258
Past due 61-90 days	236	(320)	(84)	641	(536)	105
Past due > 90 days	4,779	(1,480)	3,299	3,176	(1,712)	1,464
Total	**57,580**	**(2,289)**	**55,291**	**50,734**	**(2,781)**	**47,953**

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

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

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

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Balance at 1 July	2,781	3,104	2,781	3,104
Additional provisions made	1,611	1,473	1,611	1,473
Receivables written off	(2,103)	(1,796)	(2,103)	(1,796)
Balance at 30 June	**(2,289)**	**(2,781)**	**(2,289)**	**(2,781)**

9 Investments

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,163	28,732	0	28,000
Total current portion	1,163	28,732	0	28,000
Non-current portion				
Term deposits with maturities greater than 3 months and remaining duration greater than 12 months	7,924	7,256	0	0
Total non-current portion	7,924	7,256	0	0
Total investments	**9,087**	**35,988**	**0**	**28,000**

9 Investments (continued)

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

The fair value of term deposits with a remaining duration greater than 12 months is $7.924m (2016: $7.256m). 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 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Pharmaceuticals	625	603	625	603
Surgical and medical supplies	6,927	6,011	6,927	6,011
Total inventories	**7,552**	**6,614**	**7,552**	**6,614**

The write-down of inventories held for distribution amounted to $nil (2016: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2016: $nil). However, some inventories are subject to retention of title clauses.

11 Investments in associates and joint ventures

	Interest held 30-Jun-17	Balance date
Investments in joint ventures		
healthAlliance N.Z. Limited – Class A shares	25%	30-Jun
New Zealand Health Innovation Hub Limited Partnership	25%	30-Jun
Investments in associates		
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	33.30%	30-Jun
South Kaipara Medical Centre	20%	30-Jun

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

Value of investments in associates, joint ventures and partnerships

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
healthAlliance N.Z. Limited	36,568	33,138	36,568	33,138
South Kaipara Medical Centre	88	88	88	88
McCrae Research	174	44	174	44
Total investments	**36,830**	**33,270**	**36,830**	**33,270**

There were no impairment losses in the value of associates and joint ventures assessed for 2017 (2016: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $36.568m (2016: $33.138m).

11 Investments in associates and joint ventures (continued)

Summary of financial information of joint ventures and associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2017					
healthAlliance N.Z. Limited	172,978	27,394	145,584	135,152	1,334
New Zealand Health Innovation Hub Limited Partnership	755	(2)	757	0	(303)
Northern Regional Alliance Ltd	10,923	9,380	1,543	14,469	28
South Kaipara Medical Centre	588	264	324	2,307	57
Total	**185,244**	**37,036**	**148,208**	**151,928**	**1,116**
2016					
healthAlliance N.Z. Limited	154,951	26,549	128,402	125,839	(900)
New Zealand Health Innovation Hub Limited Partnership	1,759	699	1,060	500	(602)
Northern Regional Alliance Ltd	10,556	9,041	1,515	15,377	5
South Kaipara Medical Centre	520	253	267	2,151	(21)
Total	**167,786**	**36,542**	**131,244**	**143,867**	**(1,518)**

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

	2017 $000	2016 $000
Share of surplus / (deficit) before tax:	282	(378)
Less: Tax expense	0	0
Share of surplus / (deficit)	**282**	**(378)**

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

12 Property, plant, and equipment

Parent and Group	Land $000	Buildings $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	$000
Cost or valuation							
Balance at 1 July 2015	185,560	390,162	112,073	29,319	4,068	19,898	741,080
Additions from WIP	9,428	24,691	4,294	1,389	11	(39,813)	0
Revaluation increase/(decrease)	29,322	76	0	0	0	0	29,398
Additions to WIP	0	0	0	0	0	71,624	71,624
Disposals	0	(414)	(417)	(337)	0	(752)	(1,920)
Balance at 30 June 2016	224,310	414,515	115,950	30,371	4,079	50,957	840,182
Balance at 1 July 2016	224,310	414,515	115,950	30,371	4,079	50,957	840,182
Additions from WIP	0	46,745	5,741	2,517	100	(55,103)	0
Revaluation increase/(decrease)	0	0	0	0	0	0	0
Additions to WIP	0	0	0	0	0	60,513	60,513
Disposals	0	0	0	(1,083)	0	(376)	(1,459)
Balance at 30 June 2017	224,310	461,260	121,691	31,805	4,179	55,991	899,236
Accumulated depreciation and impairment losses							
Balance at 1 July 2015	0	5,088	74,051	20,785	3,973	0	103,897
Depreciation expense	0	17,262	7,673	2,017	30	0	26,982
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	67	(614)	(339)	0	0	(886)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2016	0	22,417	81,110	22,463	4,003	0	129,993
Balance at 1 July 2016	0	22,417	81,110	22,463	4,003	0	129,993
Depreciation expense	0	18,241	7,370	2,201	36	0	27,848
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	(1,084)	0	0	(1,084)
Elimination on revaluation	0	(9)	0	0	0	0	(9)
Balance at 30 June 2017	0	40,649	88,480	23,580	4,039	0	156,748
Carrying amounts							
At 1 July 2015	185,560	385,074	38,022	8,534	95	19,898	637,183
At 30 June and 1 July 2016	224,310	392,098	34,840	7,908	76	50,957	710,189
At 30 June 2017	**224,310**	**420,611**	**33,211**	**8,225**	**140**	**55,991**	**742,488**

The net carrying amount of assets held under finance leases is $598k (2016: $862k) for clinical equipment.

IT assets in Work In Progress of $9.434m (2016: $4.153m) will be transferred to healthAlliance N.Z. Limited once completed.

Land

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

12 Property, plant, and equipment (continued)

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

The most recent valuation of land was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2016 and the land values were adjusted accordingly.

Buildings
Specialised hospital buildings and underground infrastructure are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.
Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

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

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

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

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

Parent and Group	2017 $000	2016 $000
Buildings	38,874	42,385
Clinical equipment	6,538	2,722
Other equipment	1,145	1,697
IT equipment	9,434	4,153
Total work in progress	**55,991**	**50,957**

Impairment
No impairment loss has been identified in property, plant and equipment in 2017 (2016 : nil).

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

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims has been estimated in the value of the land.

13 Intangible assets

Movements for each class of intangible assets are as follows:

Parent and Group	NOS Rights $000	Acquired Software $000	Total $000
Cost			
Balance at 30 June 2015	4,819	3,361	8,180
Additions from WIP	0	0	0
Additions to WIP	0	88	88
Balance at 30 June 2016	4,819	3,449	8,268
Additions from WIP	0	0	0
Additions to WIP	0	219	219
Balance at 30 June 2017	4,819	3,668	8,487
Accumulated amortisation and impairment losses			
Balance at 30 June 2015	0	3,067	3,067
Amortisation expense	0	190	190
Balance at 30 June 2016	0	3,257	3,257
Amortisation expense	0	159	159
Balance at 30 June 2017	0	3,416	3,416
Carrying amounts			
At 1 July 2015	4,819	327	5,146
At 30 June 2016	4,819	192	5,011
At 30 June 2017	**4,819**	**252**	**5,071**

The National Oracle Solution (NOS) is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL). During the year to 30 June 2017, Waitemata DHB had capitalised payments in respect of the NOS totalling $nil (2016: $nil). The total value of payments made by Waitemata DHB since the inception of the NOS to 30 June 2017 was $4.819m (2016: $4.819m).

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

The NOS rights have been tested for impairment at 30 June 2017, by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to WDHB's share of the DRC of the underlying NOS assets. No impairment charge has been recorded in the year to 30 June 2017 (2016: Nil).

14 Payables

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Creditors and accrued expenses	93,820	109,765	93,749	109,735
Revenue in advance	7,733	1,683	7,733	1,683
GST payable	7,389	6,640	7,389	6,640
Capital charge payable	0	202	0	202
Total payables	**108,942**	**118,290**	**108,871**	**118,260**

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

15 Borrowings

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Current portion				
Finance leases	256	339	256	339
Crown loans	0	25,710	0	25,710
Total current portion	256	26,049	256	26,049
Non-current portion				
Finance leases	342	523	342	523
Crown loans	0	250,996	0	250,996
Total non-current portion	342	251,519	342	251,519
Total borrowings	**598**	**277,568**	**598**	**277,568**
Borrowing facility limits				
New Zealand Debt Management Office loan facility limit for Crown Loans	0	277,820	0	277,820
Overdraft facility	0	0	0	0
Total borrowing facility limits for Crown Loans	**0**	**277,820**	**0**	**277,820**

Conversion of existing Crown loans to Crown equity
In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

15 Borrowings (continued)

The impact on Crown loans for the DHB is as follows:

Crown loans	Group		Parent	
	2016/17	2015/16	2016/17	2015/16
	$000	$000	$000	$000
Balance at 1 July	276,706	276,706	276,706	276.706
Conversion of loans to equity	(276,706)	0	(276,706)	0
Balance at 30 June	**0**	**276,706**	**0**	**276,706**
Represented by:				
Current portion	0	25,710	0	25,710
Non-current portion	0	250,996	0	250,996
Total Crown loans	**0**	**276,706**	**0**	**276,706**

The impact on Crown Equity is reflected in Note 18 Contributed Capital.

Finance leases

	Group		Parent	
	Actual 2017	Actual 2016	Actual 2017	Actual 2016
	$000	$000	$000	$000
Minimum lease payments payable:				
No later than one year	315	322	315	322
Later than one year and not later than five years	419	822	419	822
Later than five years	0	0	0	0
Total minimum lease payments	734	1,144	734	1,144
Future finance charges	(136)	(282)	(136)	(282)
Present value of minimum lease payments	**598**	**862**	**598**	**862**
Present value of minimum lease payments				
No later than one year	256	339	256	339
Later than one year and not later than five years	342	523	342	523
Later than five years	0	0	0	0
Total present value of minimum lease payments	**598**	**862**	**598**	**862**

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

Description of finance leasing arrangements

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

16 Employee entitlements

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Current portion				
Accrued salaries and wages	4,704	2,802	4,704	2,802
Annual leave	70,923	68,374	70,923	68,374
Sick leave	1,042	1,600	1,042	1,600
Sabbatical leave	3,855	3,620	3,855	3,620
Continuing medical education	6,418	7,915	6,418	7,915
Work related entitlements	153	1,913	153	1,913
Unpaid payroll	6,209	6,090	6,209	6,090
Payroll provisions	5,293	9,900	5,293	9,900
Unsettled CEAs	1,609	2,601	1,609	2,601
Accrued long service awards	3,305	3,261	3,305	3,261
Long service leave	671	461	671	461
Retirement gratuities	3,993	2,149	3,993	2,149
Total current portion	108,175	110,686	108,175	110,686
Non-current portion				
Continuing medical education	8,169	10,073	8,169	10,073
Long service leave	8,276	8,371	8,276	8,371
Retirement gratuities	18,205	19,149	18,205	19,149
Sick leave	2,685	5,000	2,685	5,000
Total non-current portion	37,335	42,593	37,335	42,593
Total employee entitlements	**145,510**	**153,279**	**145,510**	**153,279**

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

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

17 Provisions

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Current portion				
ACC Partnership Programme	1,051	704	1,051	704
Total current portion	1,051	704	1,051	704
Total provisions	1,051	704	1,051	704

Movements for each class of provision are as follows:

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Balance at 1 July	704	619	704	619
Movement in provisions	347	85	347	85
Amounts used	0	0	0	0
Balance at 30 June	**1,051**	**704**	**1,051**	**704**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2017. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 11% (2016: 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

- an average assumed rate of inflation of 1.7% (2016: 1.7%);
- a weighted average discount factor of 2.5% (2016: 2.5%) has been applied.

Insurance risk

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

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

18 Equity

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Contributed capital				
Balance at 1 July	103,015	103,015	103,015	103,015
Owner debt conversion to equity	276,706	0	276,706	0
Balance at 30 June	379,721	103,015	379,721	103,015
Accumulated surpluses/(deficits)				
Balance at 1 July	(40,936)	(42,785)	(40,936)	(42,785)
Surplus/(deficit) for the year	3,292	2,957	1,918	1,849
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(1,374)	(1,108)	0	0
Balance at 30 June	(39,018)	(40,936)	(39,018)	(40,936)
Revaluation reserves				
Balance at 1 July	273,891	244,493	273,891	244,493
Revaluations	(379)	29,398	(379)	29,398
Balance at 30 June	273,512	273,891	273,512	273,891
Revaluation reserves consist of:				
Land	209,414	209,396	209,414	209,396
Buildings	64,098	64,495	64,098	64,495
Total revaluation reserves	273,512	273,891	273,512	273,891
Trust funds				
Balance at 1 July	10,107	8,999	0	0
Movement	1,374	1,108	0	0
Balance at 30 June	11,481	10,107	0	0
Total equity	**625,696**	**346,077**	**614,215**	**335,970**

On 15 February 2017, the existing Crown loans held by the DHB were converted to Crown equity.

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

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Net surplus/(deficit)	3,292	2,957	1,918	1,849
Add/(less) non-cash items				
Depreciation and amortisation expense	28,007	27,173	28,007	27,173
Total non-cash items	28,007	27,173	28,007	27,173
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/ loss investments	0	0	0	0
Investments in associates – healthAlliance	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	0	0	0	0
Total items classified as investing or financing activities	0	0	0	0
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(1,289)	(9,236)	(1,289)	(9,491)
Inventories	(939)	(244)	(939)	(244)
Creditors and other payables	(21,747)	(7,405)	(20,139)	(6,586)
Provisions	0	85	0	85
Employee entitlements	(4,099)	5,075	(4,099)	5,075
Net movements in working capital items	(28,074)	(11,725)	(26,466)	(11,161)
Net cash flow from operating activities	**3,225**	**18,405**	**3,459**	**17,861**

20 Capital commitments and operating leases

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Capital commitments				
Property	2,793	25,597	2,793	25,597
Equipment	4,996	0	4,996	0
Total capital commitments	**7,789**	**25,597**	**7,789**	**25,597**

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

20 Capital commitments and operating leases (continued)

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 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Not later than one year	5,169	6,279	5,169	6,279
Later than one year and not later than five years	3,878	6,557	3,878	6,557
Later than five years	107	214	107	214
Total non-cancellable operating leases as lessee	**9,154**	**13,050**	**9,154**	**13,050**

The DHB leases a number of buildings under operating leases.

21 Contingencies

Contingent liabilities
Lawsuits against the DHB
Waitemata DHB and its associates have been notified of potential legal claims at 30th June 2017 which creates a contingent liability totalling approximately $670k (2016: approximately $230k).

At balance date, Unitec Institute of Technology have granted $348k (2016: $435k) towards the refurbishment of Awhina Health Campus which was completed on 2 November 2011. If certain conditions in the joint venture agreement are not fulfilled, Waitemata DHB would need to repay some, or all, of this amount.

22 Related party transactions

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

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

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $1.507b (2016: $1.455b) to provide health services in the Waitemata area for the year ended 30 June 2017.

Transactions with key management personnel

Key management personnel compensation	Actual 2017 $000	Actual 2016 $000
Board members:		
Remuneration	337	360
Full-time equivalent members	11	11
Salaries and other employee benefits of Executive Leadership Team	3,964	3,260
Full-time equivalent members	13	10
Total key management personnel remuneration	**4,301**	**3,620**
Total full-time equivalent personnel	**26**	**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.

22 Related party transactions (continued)

Key management personnel include the Chief Executive and the other twelve members of the management team (2016: ten members).

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2016: $nil).

23 Board member remuneration

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

	Actual 2017 $000	Actual 2016 $000
Dr Lester Levy (Chairman)	72	69
Prof Max Abbott	31	31
Edward Benson-Cooper	16	0
Sandra Coney	29	30
Kylie Clegg - Deputy Chairman from Dec 2016	32	18
Warren Flaunty	29	31
Dr James Le Fevre	28	27
Anthony Norman - Deputy Chairman to Dec 2016	16	36
Morris Pita	29	29
Christine Rankin – until 4 December 2016	13	30
Allison Roe	27	29
Gwen Tepania–Palmer - until 4 December 2016	11	30
Matire Harwood	15	0
Brian Neeson	17	0
Total board member remuneration	**365**	**360**

Co-opted committee members
Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $ 2k (2016 : $4k) - Norman Wong (Audit and Finance Committee), Rev Featunai Liuaana (CPHAC) and Prof Elsie Ho (CPHAC).

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

No Board members received compensation or other benefits in relation to cessation (2016 : $nil).

24 Employee remuneration

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

Total remuneration paid:

	Actual 2017	Actual 2016		Actual 2017	Actual 2016
$100,000 – 109,999	214	250	$340,000 – 349,999	12	15
$110,000 – 119,999	123	145	$350,000 – 359,999	8	7
$120,000 – 129,999	83	85	$360,000 – 369,999	8	7
$130,000 – 139,999	52	57	$370,000 – 379,999	8	6
$140,000 – 149,999	29	35	$380,000 – 389,999	7	8
$150,000 – 159,999	23	23	$390,000 – 399,999	1	6
$160,000 – 169,999	20	16	$400,000 – 409,999	4	3
$170,000 – 179,999	22	22	$410,000 – 419,999	3	3
$180,000 – 189,999	20	26	$420,000 – 429,999	1	1
$190,000 – 199,999	33	24	$430,000 – 439,999	3	3
$200,000 – 209,999	24	18	$440,000 – 449,999	3	0
$210,000 – 219,999	23	23	$450,000 – 459,999	2	0
$220,000 – 229,999	25	26	$460,000 – 469,999	0	1
$230,000 – 239,999	26	18	$470,000 – 479,999	0	0
$240,000 – 249,999	21	19	$480,000 – 489,999	2	2
$250,000 – 259,999	21	21	$490,000 – 499,999	0	0
$260,000 – 269,999	13	21	$500,000 – 509,999	0	0
$270,000 – 279,999	14	20	$510,000 – 519,999	0	1
$280,000 – 289,999	12	20	$520,000 – 529,999	0	0
$290,000 – 299,999	23	16	$530,000 – 539,999	0	0
$300,000 – 309,999	15	15	$540,000 – 549,999	0	0
$310,000 – 319,999	8	13	$550,000 – 559,999	1	1
$320,000 – 329,999	22	13	$580,000 – 589,999	1	1
$330,000 – 339,999	10	10	$1,020,000 – 1,029,999	1*	0
			Grand Total	**941**	**1,001**

* This payment relates to an individual whose role was disestablished. The amount includes normal salary payments, redundancy and associated end of employment payments.

During the year ended 30 June 2017 there were 106 (2016 : 129) employees who received compensation and other benefits in relation to cessation totalling $2.012m (2016 : $2.109m).

25 Events after the balance date

There were no significant events after the balance date.

26a Financial instrument categories

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

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Loans and receivables				
Cash and cash equivalents	19,629	55,682	17,812	53,631
Debtors and other receivables	55,939	48,051	55,291	47,953
Investments	9,087	35,988	0	28,000
Total loans and receivables	84,655	139,721	73,103	129,584
Financial liabilities measured at amortised cost				
Creditors and other payables (excl revenue in advance & GST)	93,820	109,967	93,749	109,937
Borrowings – NZDMO loans	0	276,706	0	276,706
Finance leases	598	1,144	598	1,144
Total financial liabilities measured at amortised cost	**94,418**	**387,817**	**94,347**	**387,787**

26b Financial instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits and NZDMO borrowings. The exposure on the on-call deposits and floating rate borrowings is not considered significant and is not actively managed.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Waitemata DHB had no direct exposure to foreign currency risk (2016 : nil).

Sensitivity analysis

As at 30 June 2017, 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.

26b Financial instrument risks (continued)

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

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor (approximately 33%). It is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services.

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

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

	Group		Parent	
	Actual 2017 $000	Actual 2016 $000	Actual 2017 $000	Actual 2016 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	151	157	0	0
AA -	3,081	21,649	0	18,000
A+	343	10,000	0	10,000
A	343	345	0	0
A-	218	194	0	0
BBB+	92	46	0	0
BB+	199	200	0	0
Total counterparties with credit ratings	4,427	32,591	0	28,000
Cash, cash equivalents	17,812	53,631	17,812	53,631
Investments	6,477	5,448	0	0
Total counterparties without credit ratings	24,289	59,079	17,812	53,631
Total cash, cash equivalents and investments	**28,716**	**91,670**	**17,812**	**81,631**
Debtors and other receivables				
Existing counterparty with no defaults in the past	55,939	46,051	55,291	45,953
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**55,939**	**46,051**	**55,291**	**45,953**

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

26b Financial instrument risks (continued)

Contractual maturity analysis of financial assets

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

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2016						
Cash on hand	53,649	53,649	53,649	0	0	0
On call deposits	2,033	2,033	2,033	0	0	0
Debtors and other receivables	48,051	48,051	48,051	0	0	0
Investments	35,988	35,988	28,732	5,666	314	1,276
Total	**139,721**	**139,721**	**132,465**	**5,666**	**314**	**1,276**

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2017						
Cash on hand	17,879	17,879	17,879	0	0	0
On call deposits	1,750	1,750	1,750	0	0	0
Debtors and other receivables	55,939	55,939	55,939	0	0	0
Investments	9,087	9,087	1,163	7,924	0	0
Total	**84,655**	**84,655**	**76,731**	**7,924**	**0**	**0**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2016						
Cash on hand	53,631	53,631	53,631	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	47,953	47,953	47,953	0	0	0
Investments	28,000	28,000	28,000	0	0	0
Total	**129,584**	**129,584**	**129,584**	**0**	**0**	**0**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2017						
Cash on hand	17,812	17,812	17,812	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,291	55,291	55,291	0	0	0
Investments	0	0	0	0	0	0
Total	**73,103**	**73,103**	**73,103**	**0**	**0**	**0**

26b Financial instrument risks (continued)

Contractual maturity analysis of financial liabilities

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

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2016						
Creditors and other payables	109,967	109,967	109,967	0	0	0
Finance leases	1,144	1,144	256	256	632	0
NZDMO loans	328,512	328,512	35,725	31,301	125,325	136,161
Total	**439,623**	**439,623**	**145,948**	**31,557**	**125,957**	**136,161**
2017						
Creditors and other payables	93,820	93,820	93,820	0	0	0
Finance leases	598	598	315	283	0	0
NZDMO loans	0	0	0	0	0	0
Total	**94,418**	**94,418**	**94,135**	**283**	**0**	**0**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2016						
Creditors and other payables	109,937	109,937	109,937	0	0	0
Finance leases	1,144	1,144	256	256	632	0
NZDMO loans	328,512	328,512	35,725	31,301	125,325	136,161
Total	**439,593**	**439,593**	**145,918**	**31,557**	**125,957**	**136,161**
2017						
Creditors and other payables	93,749	93,749	93,749	0	0	0
Finance leases	598	598	315	283	0	0
NZDMO loans	0	0	0	0	0	0
Total	**94,347**	**94,347**	**94,064**	**283**	**0**	**0**

27 Capital management

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

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

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

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

28 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary, Three Harbours Health Foundation (THHF). The DHB's investment in THHF is accounted at cost of $nil (2016 : $nil).

For the year ended 30 June 2017, THHF had total revenue of $1.462m (2016 : $1.376m) and a net surplus of $1.374m (2016 : $1.108m surplus). THHF had assets of $11.614m (2016 : $10.567m) and liabilities of $133k (2016 : $460k) as at 30 June 2017.

29 Patient trust monies and restricted funds

	Actual 2017 $000	Actual 2016 $000
Balance at 1 July 2016	73	75
Monies received	680	666
Payments made	(668)	(668)
Balance at 30 June 2017	**85**	**73**

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

30 Explanation of major variances against budget

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

- Total revenue for the year was $13.0m lower than budget due to reduced interest income, reduced revenue following the reduction in the capital charge rate and other income less than budgeted but in line with the 2016 other income
- Expenditure for the year was $11.8m lower than budget which was largely due to lower than anticipated interest expense and the reduced capital charge rate.

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

- Debtors and other receivables were higher than planned due to higher than anticipated levels of accrued revenue
- Investments were lower than plan due to the transfer of funds on deposit on maturity back to the sweep account
- Property, plant and equipment was lower than plan due to lower capital project spend than originally planned
- The significant movement in liabilities is due to the conversion during the year of Crown Debt to Crown Equity.

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

- Decreased operating cash flow of $29.4m due to the timing of revenue receipts in comparison to the budgeted receipts.

Independent Auditor's Report

To the readers of Waitemata District Health Board and group's financial statements and performance information for the year ended 30 June 2017

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

Opinion

We have audited:

- the financial statements of the District Health Board and group on pages 42 to 75, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, 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 District Health Board and group on pages 13 to 34 and information about the District Health Board's appropriation on page 39.

In our opinion:

- the financial statements of the District Health Board and group on pages 42 to 75:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; 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 Standards.
- the performance information of the District Health Board and group on pages 13 to 34 and information about the District Health Board's appropriation on page 39:
    - presents fairly, in all material respects, the District Health Board and group's performance for the year ended 30 June 2017, 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 31 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. 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.

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

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

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

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

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

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the District 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 District 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 District Health Board and group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the District Health Board and group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the District Health Board and group to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the District 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 District Health Board and 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 12, 35 to 39 and page 41, 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.

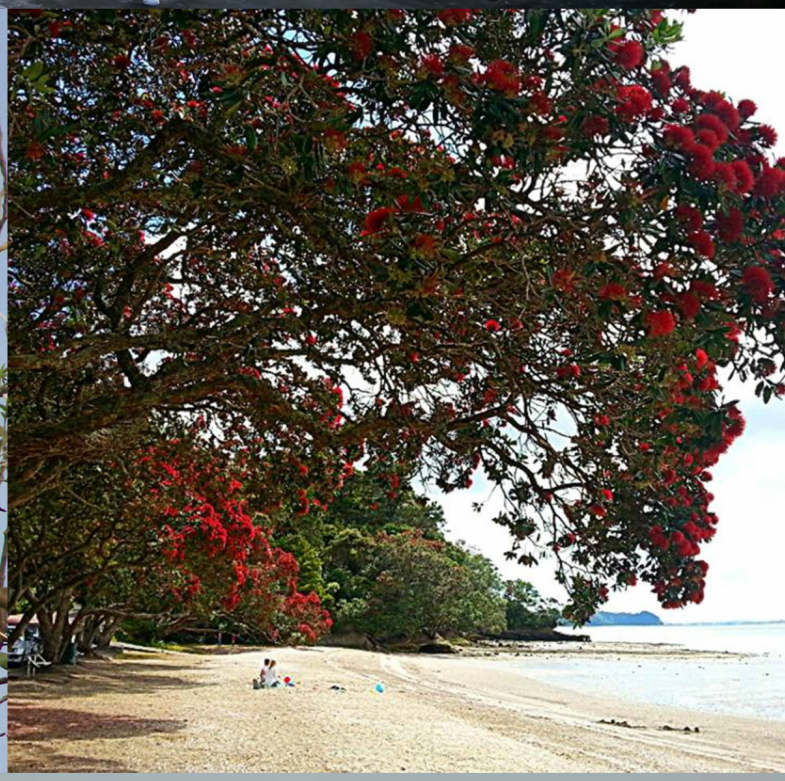
In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge 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.

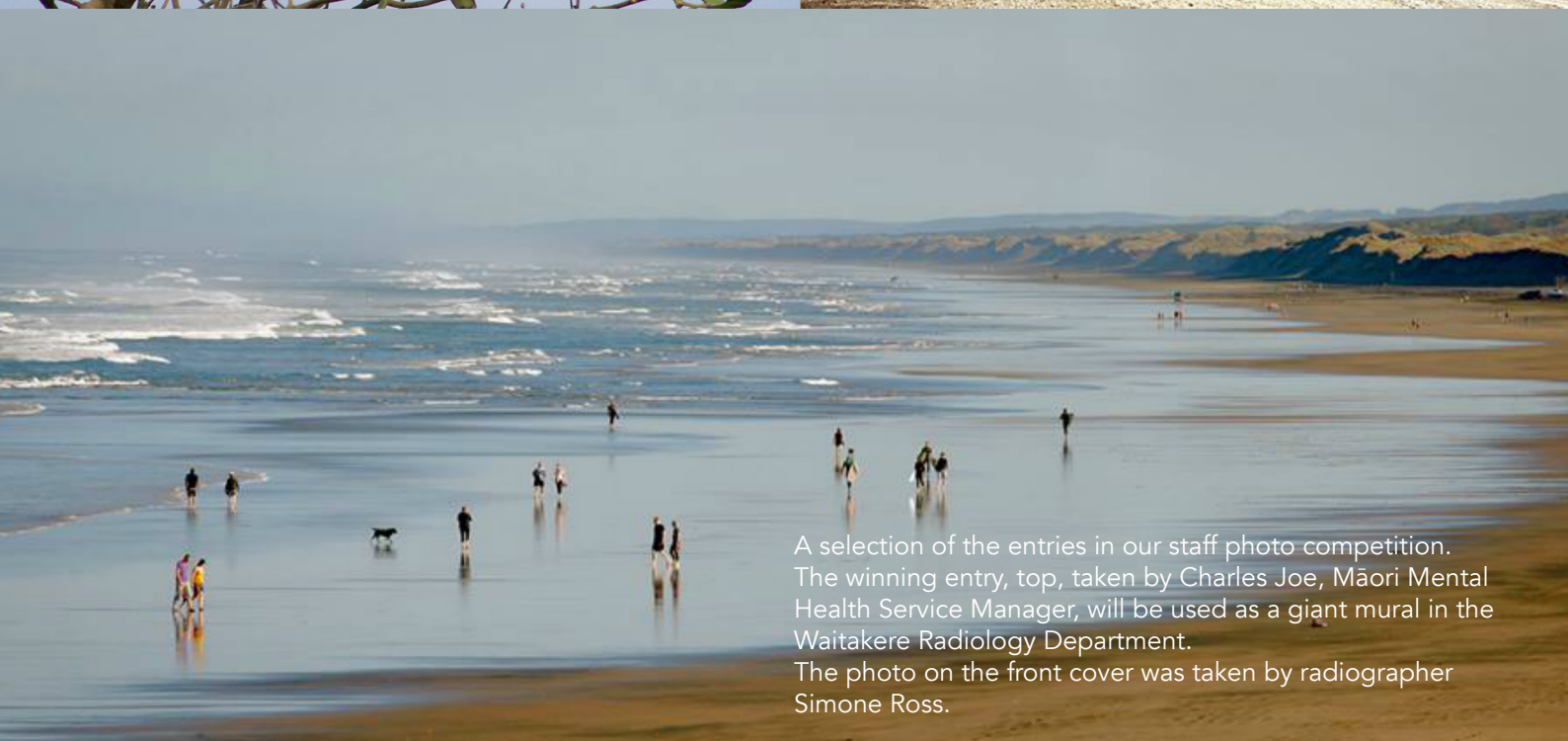
Independence

We are independent of the District 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(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

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





A selection of the entries in our staff photo competition. The winning entry, top, taken by Charles Joe, Māori Mental Health Service Manager, will be used as a giant mural in the Waitakere Radiology Department.
The photo on the front cover was taken by radiographer Simone Ross.

WAITEMATA DISTRICT HEALTH BOARD

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Best Care for Everyone

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