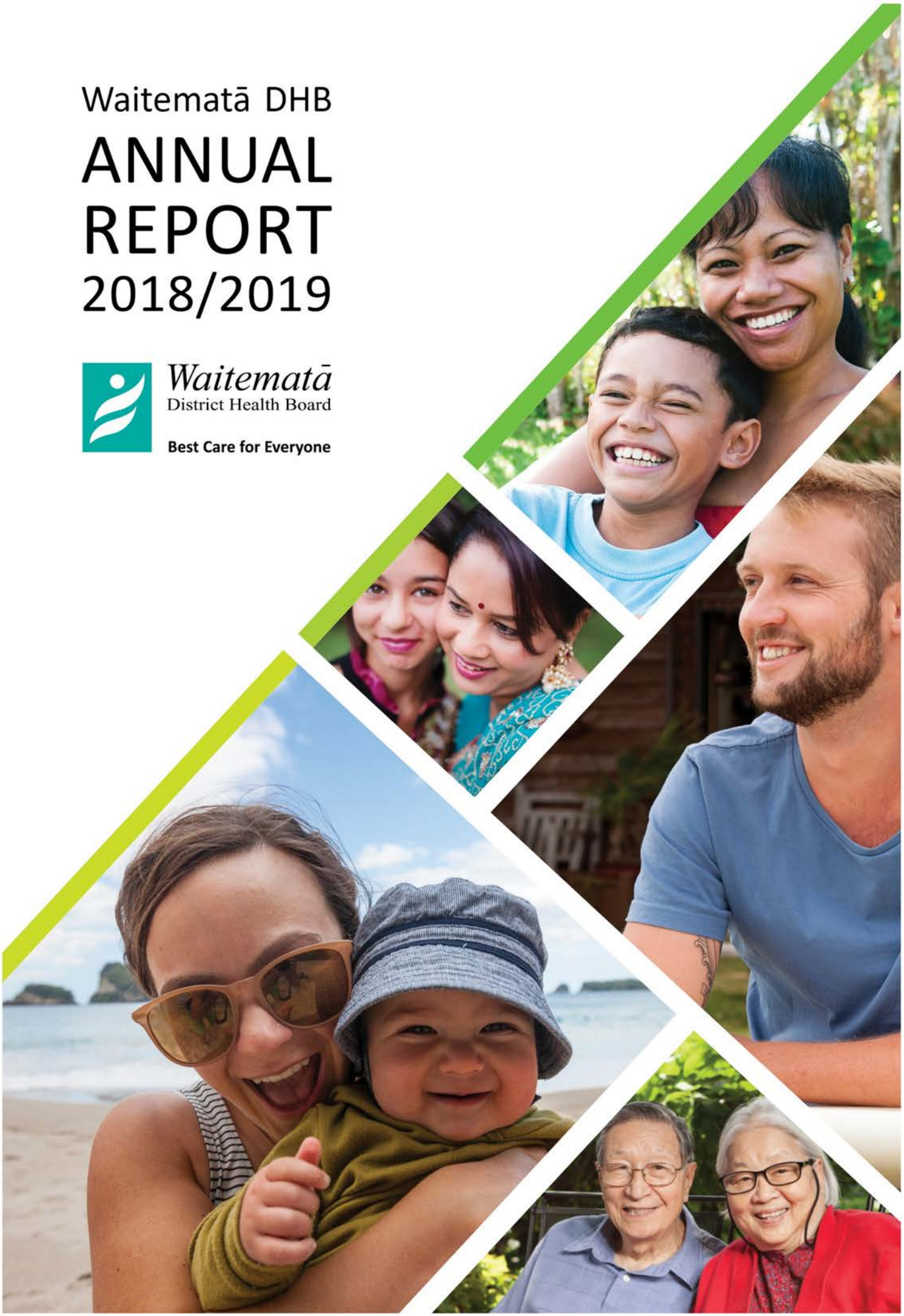
Waitematā DHB

ANNUAL REPORT 2018/2019

Waitematā
District Health Board

Best Care for Everyone



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

CONTENTS

2018/19 has seen a focus on the future

Professor Judy McGregor, CNZM
Chair

Dr Dale Bramley
Chief Executive Officer

We are expanding our services to deliver the 'best care for everyone' in our growing community and made progress reducing health inequities.

Significant site works on our Takapuna campus over the last twelve months are linked to the biggest expansion in our services and facilities since the opening of our North Shore Hospital tower in 1984.

A new four-storey hospital building is scheduled to open in 2023. It will cost over $240 million and will have capacity for four new wards, with 120 extra beds, four additional operating theatres and new endoscopy suites.

It is among a series of developments advanced or completed during the last year to help future proof our efforts to meet increasing demand and achieve better health outcomes for everyone: reducing health inequities, relieving suffering and promoting wellness.

Other developments in 2018/19 include:

- earthworks for a new $22 million, 15-bed medium-secure unit at our Regional Forensic Psychiatry Service, known as the Mason Clinic, in Point Chevalier
- progressing the purchase of additional land to expand our existing Mason Clinic site and meet increased demand for forensic services in the northern region for many years to come
- the start of work on an upgraded $6 million Waitakere Hospital Special Care Baby Unit (SCBU) that is due for completion in 2020
- the opening of Waitakere Hospital's new multi-faith spiritual centre, Wairua Tapu, Chapel of the Holy Spirit, to cater for the spiritual needs of patients, their families and whānau
- the advancement of plans to open a $16.7 million addiction treatment centre as part of Auckland City Mission's HomeGround precinct in 2020
- the opening of a new CT scanner at North Shore Hospital in refitted modern surrounds
- work to relocate our Diagnostic Breast Service to new rooms that will provide a more welcoming environment for patients at North Shore Hospital.

We are proactive in our efforts to keep people well and our Health Promotion Team works directly with high school students to teach them about bowel cancer and the importance of early detection through regular screening.

An artist's impression of the new hospital building currently under construction

Our Rural Point of Care Testing service (R-POCT) has enabled rural practices to test for suspected heart attacks, blood clots and blood infections in-practice and receive the results within 10 minutes, helping medical professionals clarify the best course of treatment and saving precious time and lives.

These initiatives contribute to an overall life expectancy for our population of 84.2 years, the highest in the country.

Our health and wellbeing initiatives are designed specifically to reduce health inequities, thereby contributing to our Māori life expectancy of 82.4 years. The gap in life expectancy between Māori and non-Māori has decreased year-on-year, and Māori life expectancy is now improving at twice the rate of non-Māori life expectancy. Life expectancy for our Māori population is now greater than the average overall life expectancy of all New Zealanders and is the highest Māori life expectancy in the country.

All of these achievements are made in a catchment that is home to the largest DHB population in New Zealand, with more than 627,000 people and expected to rise by over 100,000 in the next decade.

This growth drives our efforts to ensure our workforce better represents the population we serve, assisting in our ongoing work to improve equity of outcomes and enhance patient, family and whānau experience.

Multiple recruitment and mentoring initiatives continue to increase the number of Māori clinical personnel at our DHB and we have complemented this over the last year by offering all staff free te reo lessons, helping us to strengthen our connection with Māori patients and their whānau.

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

The many ethnicities represented by our staff on our wards and in the community continue to reflect the ever-changing face of Waitematā, providing a level of familiarity that helps put our patients and their families at ease in their times of need.

Diversity is also reflected in our newly appointed Waitematā DHB Consumer Council, whose members will help us better-understand the complex and varied needs of our multi-layered population in West Auckland, Rodney and the North Shore.

One of our organisational values is to be better, best and brilliant in all that we do and our staff have certainly lived up to that over the last 12 months, earning national and international acclaim across multiple platforms.

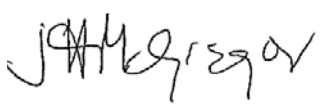
Among them were representatives of the Institute of Innovation and Improvement (i3), whose efforts resulted in our Leapfrog programme winning the Business Transformation through Digital and IT category of the 2019 CIO Awards.

Leapfrog is tasked with fast-tracking digital innovations that further modernise and enhance the services we offer.

An example is our development of the award-winning Qlik Data Discovery Programme, which provides real-time data that helps us plan better for the care of our patients, manage flow in our hospitals and continually strive for quality improvement.

This high-tech innovation makes us world-class when combined with the hard work of all our hospital and community-based staff.

Their tireless efforts truly make a difference in the lives of thousands of people every day and we take this opportunity to say a heartfelt thank you.



Professor Judy McGregor, CNZM

Chair
Waitematā District Health Board

Dr Dale Bramley

Chief Executive Officer
Waitematā District Health Board

Working together to achieve Māori health gain

Dame Rangimarie Naida Glavish, DNZM JP
Co-Chair, Te Rūnanga o Ngāti Whātua

Tū Tonu ngā Manaakitanga!

This whakatauākī represents the sacred obligation of Ngāti Whātua to manaaki, or care for, all of those within our tribal boundary. It is meant as an 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 in improving health outcomes among our whānau, in particular our tamāriki. The health and development of the most at-risk members of our whānau is crucial for the future of our communities. Significant work is being done by our primary and community care partners to ensure our tamāriki receive health services when and where they need them. The effort put in to immunisation, dental care and school health services has contributed to fewer Māori children being admitted to hospital for conditions that are potentially avoidable.

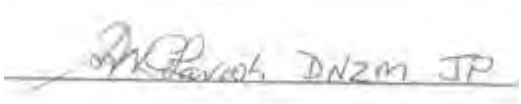
As we acknowledge all those who contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indicators in this report show that Māori often suffer disproportionately from health conditions or are not accessing important health services at the same rate as others in our community. One only needs to view life expectancy data to get a sense of the immense challenge of eliminating Māori health inequities.

For Māori, the life expectancy gap is largely due to avoidable deaths from cancers, in particular lung cancer, and chronic conditions, including cardiovascular disease (CVD). Smoking is a major contributing factor to these conditions, and has a detrimental effect on our tamāriki. The combined efforts of hospital-based services, primary care providers and community organisations contributed to a drop in the number of our whānau smoking. The burden of CVD weighs heavily on Māori. Waitematā DHB is helping those at risk of CVD and other chronic conditions make lifestyle changes to improve their wellbeing.

As the Tiriti o Waitangi partner, Te Rūnanga o Ngāti Whātua understands the importance of having a strong and trusting relationship with the DHB to achieve Māori health gain. The completion of the Auckland DHB and Waitematā DHB Māori Health Workforce Development Strategy is testament to our partnership. This strategy set the goal of increasing the Māori health workforce across the two DHBs to 13%. Although ambitious, this past year and all of 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 Waitematā 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. We all need to reflect on the role we play at all levels of the health system, and consider how we can improve the wellbeing of Māori, whether this is for the small whānau in front of you who are in need of your warmth and care, or you have the ability to influence the entire system so that the staff members, whānau and communities seeking leadership feel empowered to achieve wellbeing and their own tino rangatiratanga: how can you improve the wellbeing of Māori? Ask this question of yourself, and if you cannot find an answer, we will find it together in partnership.

Our Te Tiriti o Waitangi Partner
Te Rūnanga o Ngāti Whātua



Dame Rangimarie Naida Glavish DNZM JP
Chief Advisor Tikanga

Who we are and what we do

Waitematā DHB is the Government's funder and provider of health services to 627,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and one of the fastest growing DHBs in the country, and are expecting an extra 116,000 people by 2030.

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

More than 7,400 people are employed by Waitematā DHB.

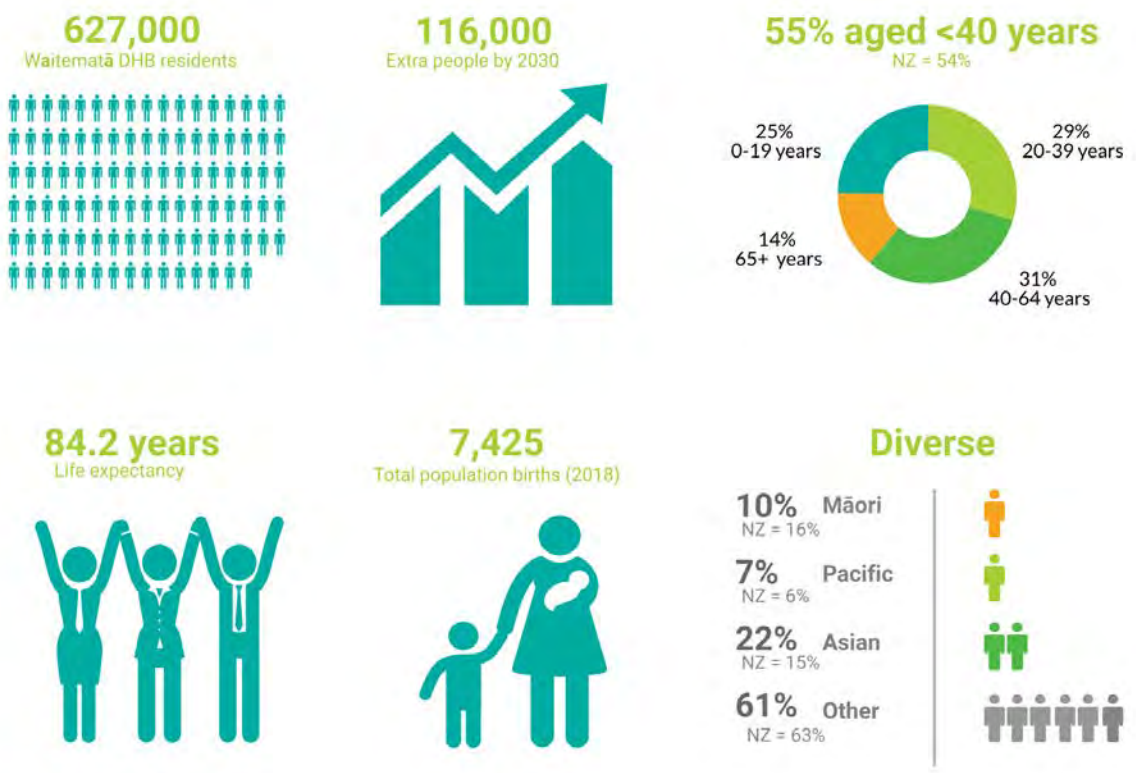
Waitematā DHB provides hospital and community services from 31 sites, including North Shore Hospital, Waitakere Hospital and the Mason Clinic.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the 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 2018/19 was $1.7 billion.

Our population in 2018/19



What are we trying to achieve?

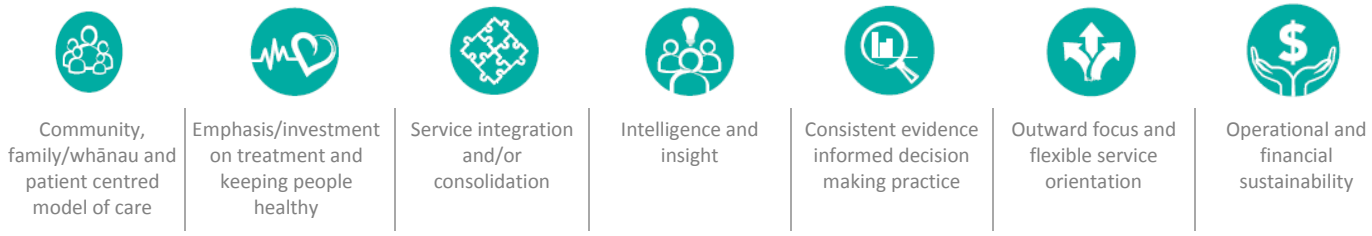
Best care for everyone

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

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

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

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



Health Equity

Waitematā DHB is committed to achieving health equity for all those in our community, in particular for Māori, who make up 10% of our population. The health status of the majority of our residents is very good and we are a relatively affluent population. However, some of our population does experience inequalities in health outcomes, with ethnicity the strongest equity parameter. Nearly one in five (17%) of our total population are Māori or Pacific, but 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. Individuals living in these areas tend to experience poorer health outcomes than those living elsewhere.

We are proud of our progress towards health equity, demonstrated by the increase in life expectancy observed for all population groups. Waitematā has the highest Māori life expectancy in the country, at 82.4 years; the rate of increase in Māori life expectancy is more than twice that of non-Māori life expectancy.

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

We want our patients to be cared for by a culturally aware workforce that reflects our communities. We implemented a Māori workforce development strategy that increased our total Māori workforce by 75% since 2015, to a current total of 509 Māori employees (6.9% of our workforce). By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population. In 2018, we launched te reo classes for staff and the Āke Āke app to help raise cultural awareness among our staff and community. Pronunciation of te reo Māori, cultural protocol and waiata are the main focus of the app.

A Māori Health Pipeline of projects was established, which focuses on identified areas to accelerate Māori health gain and reduce the life expectancy gap. The pipeline provides an opportunity to develop a more streamlined process for proposals, project implementation and robust evaluation. The pipeline work programme includes: lung cancer screening, alternative community cardiac and pulmonary rehabilitation prototypes, breast screening data match (the '500 Māori women campaign'), Māori provider and PHO data match, and targeted cervical cancer projects.

Delivering the best care for everyone

'Best care for everyone' is our promise to the Waitematā community and the standard for how we work together. 2018/19 saw some great examples of how we deliver the best care for everyone in line with our values.

New consumer council provides community voice

Thirteen people from the Waitematā community now have the opportunity to work alongside our CEO on a new Consumer Council designed to make a real difference in patients' lives.

The Council represents a broad cross section of our community. The Council includes people with strong connections to the local Māori, Pacific, Asian, disability and youth communities. All members have experienced Waitematā DHB within the last few years, either as patients or family and whānau, helping us to better understand the needs of the people we serve.

The Council will meet at least seven times a year, providing input towards the design, planning and delivery of accessible, safe and high quality health care services.

Hello, my name is … campaign

Waitematā DHB proudly supports the #hellomynameis campaign, which encourages all staff, regardless of their role, to always introduce themselves and their colleagues to the people they support.

Courtesy, communication and compassion are all vital parts of good clinical care. Good communication, including introducing oneself, ranks as one of the most important factors contributing to patient experience. As part of our values programme, the campaign's public communication and reach is one of the most successful social media campaigns at Waitematā DHB.

Extraordinary effort changes a life

A successful kidney transplant operation was made possible by the extraordinary efforts of staff at Waitakere Hospital.

West Aucklander Finau Veikoso, who had been on dialysis for eight years, was difficult to reach on the Saturday evening a kidney became available. Off-duty staff raced against the clock, going to enormous lengths to locate her and ensure that she received the life-changing transplant.

PHOTO: NZ HERALD

Dr Baskar Reddy and Dr Joanne O'Riordan helped Finau Veikoso (front left) receive a life-changing new kidney

Expansion of services at Waitakere Hospital

New services at Waitakere Hospital are designed to meet the demands of West Auckland's fast-growing population.

Specialist eye and dental care is now available closer to home with the launch of new surgeries at Waitakere Hospital. The procedures, previously only available at Greenlane, are performed by Auckland DHB clinicians and include dental surgery for children, and eye procedures.

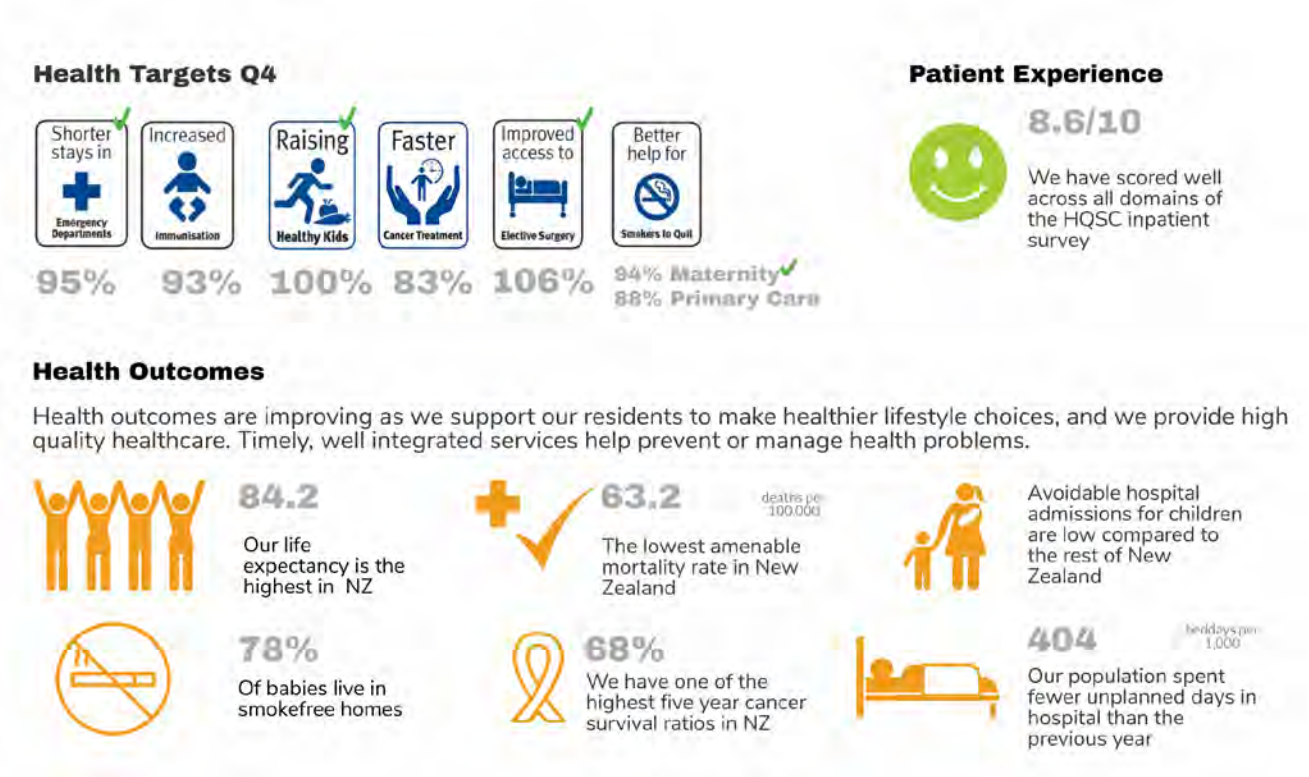
A new Radiology Department has doubled capacity and improved access. Demand for radiology at Waitakere Hospital has grown by 50% since 2010. Some people were receiving care at North Shore Hospital and other procedures were outsourced, but these patients can now be seen locally with shorter waiting times.

The year-long project included the installation of two new CT scanners to provide extra cardiac, brain and vascular imaging. The Radiology Department was extensively upgraded to accommodate the new scanners and includes better waiting areas for patients. Six extra staff were recruited to help operate the facility.

2018/19 achievements

Waitematā DHB is one of the healthiest communities in New Zealand and we performed well against our key indicators in 2018/19. The life expectancy of our population is the highest in New Zealand, and we achieved a number of the national Health Targets. Our achievements in 2018/19 include the below.

- Life expectancy continues to improve, reaching 84.2 years (2016-18), the highest in the country and an increase of 1.9 years since 2006-08. Significantly, life expectancy increased in our Māori population by 6.3 years over this same time period.
- Our smoking rate is one of the lowest in New Zealand at 12% (2013 Census) and 78% of babies live in smokefree homes at 6 weeks of age. We achieved the better help for pregnant smokers to quit Health Target, with 90% of pregnant smokers receiving brief advice on becoming smokefree.
- We achieved 100% against the raising healthy kids Health Target, meaning that all children identified as obese were referred for further support.
- We delivered 24,169 elective surgical procedures, exceeding the Health Target by 6%. We achieved the shorter waits in ED Health Target.
- We have one of the highest 5-year cancer survival rates in the country, and while short-term issues in Urology, Skin, and Head and Neck services meant that we did not achieve the faster cancer treatment Health Target in 2018/19, we are now back on track and achieved 90% compliance in June 2019.
- Amenable mortality has steadily declined over the past decade, and our rate is the lowest in New Zealand at 63.2 per 100,000 population.
- Our population is spending less time in hospital, with our acute bed day rate currently at 404 bed days per 1,000 population (standardised for age) compared with 398 per 1,000 population nationally, and a 15% reduction on the 2015/16 rate.
- We have lower rates of ambulatory sensitive hospitalisations (ASH) for children aged 0-4 years old than New Zealand as a whole.
- Our average score across the four domains of the Health Quality and Safety Commission (HQSC) inpatient survey improved, reaching 8.6/10.



Innovation and improvement

Institute for Innovation and Improvement (i3)

Established in December 2015, the i3 brings together clinicians, researchers, patients, whānau, our community and national and global leaders to design and apply innovative ways to improve health outcomes and patient experience.

Everything we do is underpinned by our three principles:

Person-centred design: keeping people at the centre of all of our design work.
Data driven: continuously using data to inform and improve.
Community and clinician led: supporting our community and clinicians to lead healthcare redesign and innovation.

Several of our work streams were recognised for their achievements in 2018/19.

Leapfrog Programme

Our Leapfrog Programme was recognised in the 2019 CIO Awards, winning the Business Transformation through Digital and IT category. The programme was also a finalist in the 2019 IDC Digital Transformation Awards.

Waitematā DHB's award-winning Leapfrog team

The Leapfrog Programme fast-tracks projects that will improve the delivery of care in the short-medium term. The programme supports the digital transformation of hospital-based services and aims to provide staff with access to information they need to do their jobs, whenever and wherever.

Through the Leapfrog Programme, we implemented multiple digital technologies that improve systems and processes, and give time back to our staff.

Patients' vital signs are now entered directly into their electronic health record via iPads and are accessible by doctors remotely. An electronic prescribing system makes 100% of prescriptions legible and improves safety. Our smartphone paging system allows wards to advise doctors on patients and resolve issues rapidly, and now all clinical notes are entered by staff electronically. We also integrated our patient survey system with electronic records so that patient surveys on quality of life and other health outcomes are available in real-time to support clinical decision-making.

http://i3.Waitematādhb.govt.nz/about/research-innovation/leapfrog/

eCALD®

Cultural diversity in the New Zealand population is growing, leading to increasing cross cultural interactions between clinicians and patients and between employees.

An innovative Waitematā DHB education programme to overcome cultural barriers in communication with patients was recognised at the 2018 Diversity Awards NZ.

Our national eCALD® digital cultural competency training programme was the winner for Cultural Celebration category at the 2018 Diversity Awards.

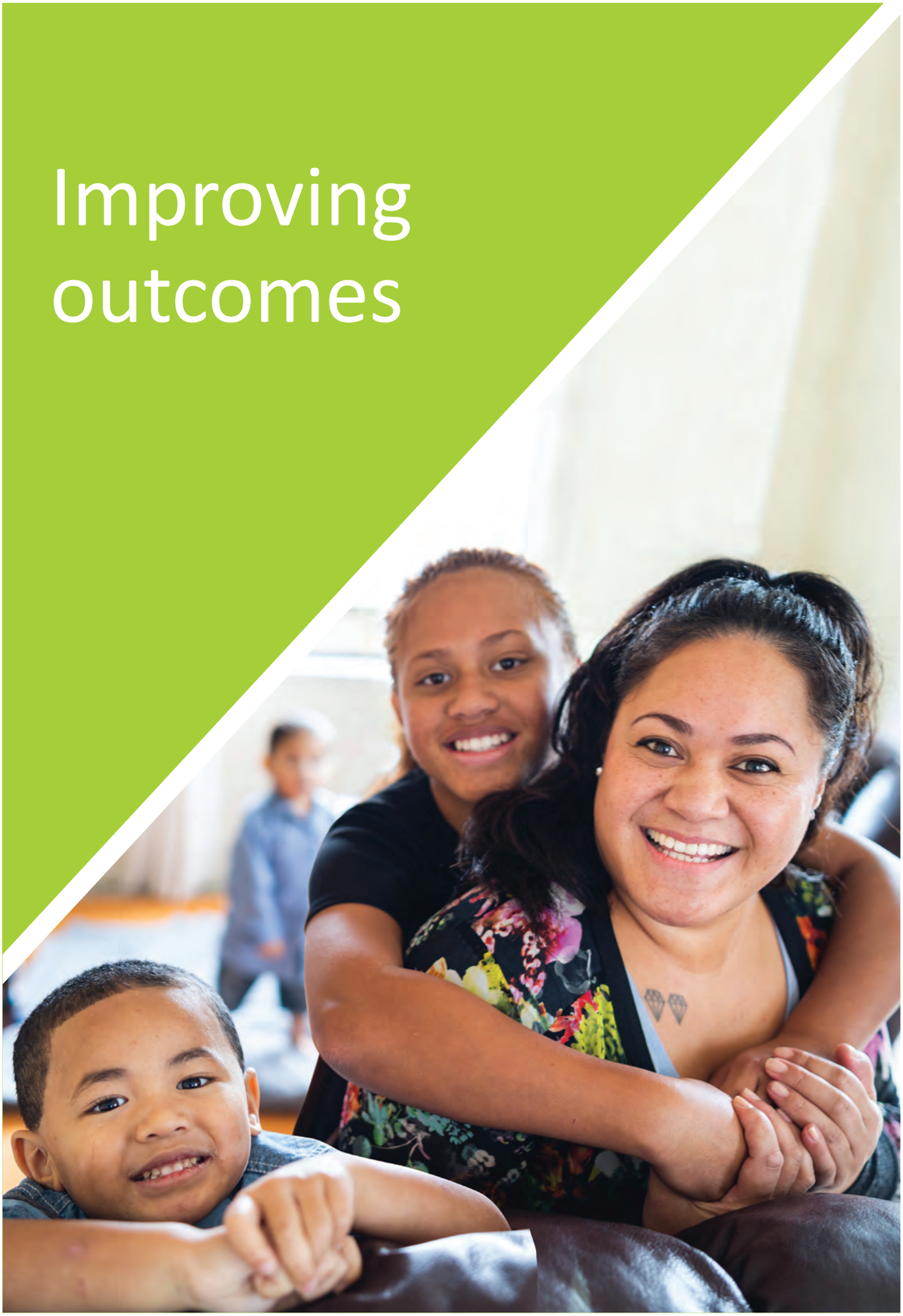
CALD refers to Culturally And Linguistically Diverse groups who are migrants and refugees from Asian, Middle Eastern, Latin American and African (MELAA) backgrounds.

The eCALD programme delivers online and face-to-face training across a range of areas including refugees, migrants, mental health and religion to improve understanding, and ultimately, communication with patients.

The eCALD® team provided education to over 33,000 health workers throughout New Zealand, with average evaluation scores for overall learning experience consistently over 85%. The website was accessed in 159 countries and over 13,000 people subscribe to the regular newsletter.

https://www.ecald.com/

Improving outcomes



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

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

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

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

The System Level Measures (SLMs) framework supports achievement of these overall goals. The SLMs in our performance framework are based on those set by the Ministry of Health, which align with the five strategic themes of the Health Strategy and other national strategic priorities. Our SLMs recognise that DHBs must work together with primary, secondary and community care providers to improve health outcomes. Improvement milestones were set to measure our progress in improving the SLMs.

Contributory measures report on the activities we are undertaking to help improve the SLMs and are front-line measurements of specific health processes or activity. The contributory measures included in our performance framework are based on the needs and priorities of our local communities and health services.

Performance against our SLM improvement milestones and contributory measures are reported in the following section. Movement against each indicator's baseline is shown in the highlight boxes. The baseline is generally December 2017 for SLM and contributory measures, and 2016/17 for other measures.

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

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

WAITEMATĀ DHB RESIDENTS HAVE THE HIGHEST LIFE EXPECTANCY IN THE COUNTRY, AT 84.2 YEARS

Our life expectancy continues to improve, reaching 84.2 years (2016-18), the highest in the country and an increase of 1.9 years over the last decade. Life expectancy for our Māori population increased by 6.3 years over the past decade and the gap in life expectancy continues to gradually close. Māori now have a life expectancy of 82.4 years. Life expectancy for Pacific remains significantly lower than other ethnicities, at 77.8 years.

OUR AMENABLE MORTALITY RATE REDUCED BY 15% OVER THE LAST 10 YEARS AND IS THE LOWEST IN NEW ZEALAND

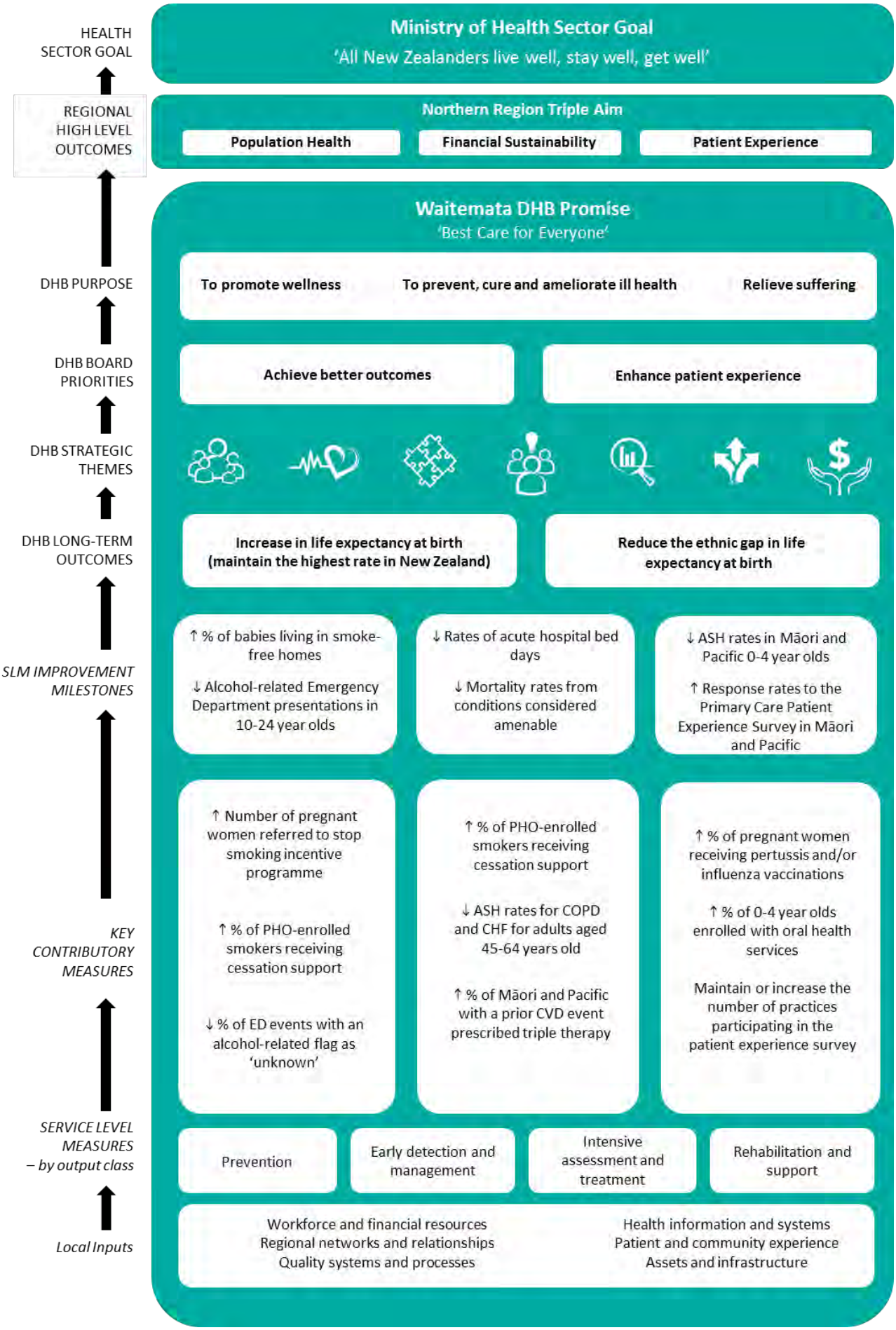
We have the lowest rate of amenable mortality (deaths potentially avoidable through healthcare intervention) in New Zealand. In 2016 (the latest available data), 63.3 deaths per 100,000 population were considered amenable, lower than the national rate of 87.6. An estimated 486 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were amenable in 2016.

OUR CHILDREN ARE STAYING OUT OF HOSPITAL WITH LOW ASH[1] RATES FOR THOSE AGED 0-4 YEARS

Our children are receiving a great start to life. The number of preschool children admitted to hospital for conditions that are potentially avoidable (ASH), such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall. Our rate for Māori children is similar to the national rate, although rates for Pacific children are twice as high as those for other ethnicities in Waitematā DHB.

[1] Ambulatory sensitive hospitalisations (ASH).

PERFORMANCE FRAMEWORK



Improving life expectancy for everyone

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

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

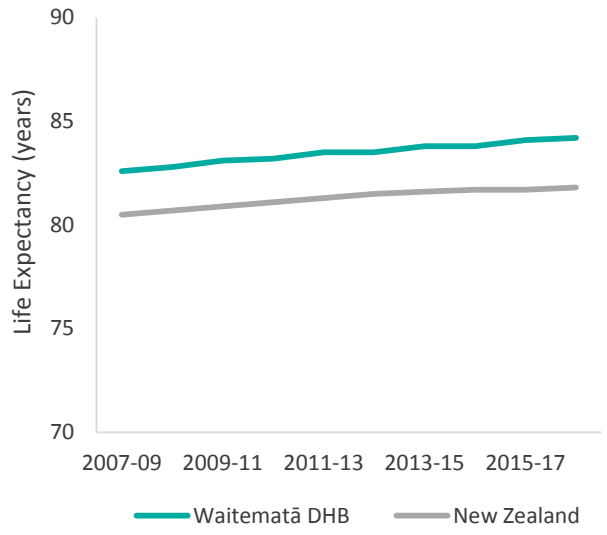
WE HAVE THE HIGHEST LIFE EXPECTANCY IN THE COUNTRY AT 84.2 YEARS, 2.4 YEARS HIGHER THAN NEW ZEALAND OVERALL

We have the highest life expectancy in New Zealand at 84.2 years (2016-18[2]), which is 2.4 years higher than New Zealand as a whole.

LIFE EXPECTANCY INCREASED BY 3.7 YEARS SINCE 2001

In Waitematā, life expectancy increased by 3.7 years since 2001, a greater increase than that for New Zealand as a whole (2.9 years).

LIFE EXPECTANCY AT BIRTH – 3 YEAR COMBINED ESTIMATE



Life expectancy differs significantly between ethnic groups in our district. Māori and Pacific people have a lower life expectancy than other ethnic groups, with a gap of 2.5 years for Māori and 7.1 years for Pacific.

INEQUALITIES ARE DECREASING - LIFE EXPECTANCY OF OUR MĀORI POPULATION INCREASED BY MORE THAN 6 YEARS OVER THE PAST DECADE

Life expectancy for our Māori population increased by 6.3 years over the past decade and the gap in life expectancy continues to gradually close. Māori now have a life expectancy of 82.4 years, only 2.5 years less than other ethnicities (excluding Pacific).

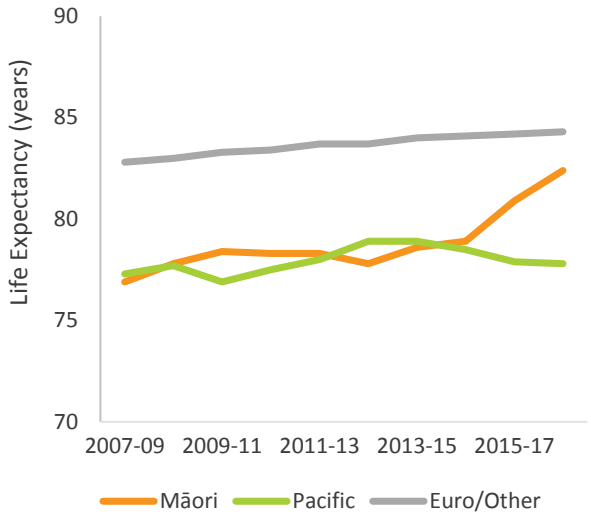
Life expectancy for Pacific remains significantly lower than other ethnicities at 77.8 years, and increased only slightly over the past decade.

Deaths from avoidable conditions account for around two-thirds of the 2.5-year life expectancy gap between Māori and other populations and around half of the 7.1-year gap between Pacific and other populations.

The life expectancy gap between Māori and other populations is largely due to mortality from cancers, in particular lung cancer, and chronic conditions, including cardiovascular disease. Smoking is a major contributory factor to these conditions, and the Māori smoking rate is more than double that of the total DHB rate (27% vs. 12%).

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

LIFE EXPECTANCY AT BIRTH, BY ETHNICITY – 3 YEAR COMBINED ESTIMATE



[2] The most recent life expectancy data available is for deaths occurring in the 2018 calendar year. Three-years combined estimates were produced to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

Healthy start

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

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

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

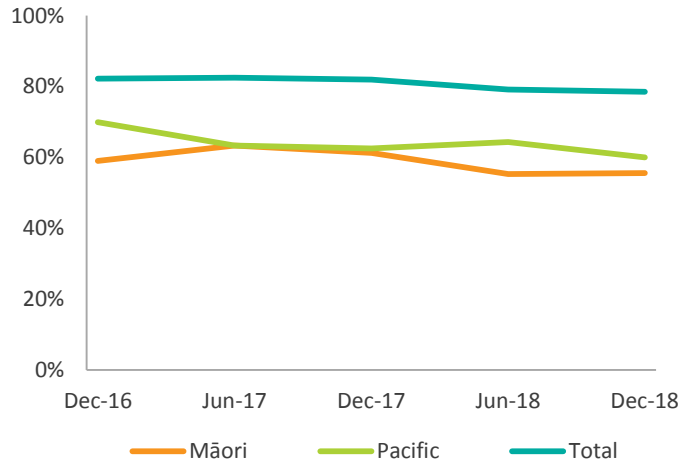
Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities. The rate of smoking in pregnancy, and worse pregnancy outcome for mothers and babies, is higher among Māori and Pacific women and those living in areas of high deprivation. In 2018/19, 165 women in our community smoked when first pregnant, and half of them were Māori.

More babies living in smokefree homes

78% OF BABIES LIVE IN SMOKEFREE HOMES AT 6 WEEKS OLD[3] — 3% ⬇

Well Child Tamāriki Ora (WCTO) service providers ask about smoking status at babies' 6-week postnatal check. In the 6 months to December 2018, 78% of 6 week old babies in our district lived in smokefree homes (i.e. no person ordinarily residing in the home is a current smoker).

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



This is a very slight decrease (3%) since December 2017, meaning we did not achieve our 2% improvement target.

More Māori and Pacific babies are exposed to smoking in their homes, with only 56% of Māori and 60% of Pacific babies living in smokefree homes.

Improvement activities

Pregnancy is a time when women are likely to be highly motivated to stop smoking themselves and to encourage their whānau to stop smoking. Evidence suggests that incentive-based smoking cessation programmes can reduce smoking rates during pregnancy and the incidence of low birth weight babies.

168 WOMEN WERE REFERRED TO OUR INCENTIVE-BASED SMOKING CESSATION PROGRAMME — 158% ⬆

Our Ready Steady Quit service helps expectant mothers and whānau quit, with a free 12-week programme providing support, quitting aids and up to $350 in shopping vouchers for those who are successful. Across Metro Auckland DHBs, 85 women who participated in the programme successfully quit smoking, validated by carbon monoxide testing.

In 2018/19, 168 Waitematā women were referred by healthcare providers to the programme. This was less than our target, but nearly three times as many as in the 12 months to March 2017. We are changing our referral processes to make it easier for GPs and midwives to refer women to the programme, including an opt-off approach, whereby women who smoke are routinely referred to the programme unless they specify an objection.

16,430 SMOKERS (34%) RECEIVED CESSATION SUPPORT FROM PRIMARY CARE — 16% ⬆

Offering cessation support is important to assist whānau members to become smokefree. Support includes referral to a smoking cessation programme, prescribing nicotine replacement therapy or other medicines, or providing behavioural support.

In the 15 months to June 2019, 34% of smokers received cessation support in primary care, exceeding our target of a 10% increase on the December 2017 baseline.

This contributory measure also sits under the amenable mortality SLM.

[3] The denominator for this measure is the total number of babies enrolled with WCTO providers. The 2019/20 methodology uses the total number of registered births as the denominator.

Working together to help whānau live smokefree

Waitematā DHB has several programmes dedicated to helping pregnant women and whānau become smokefree to create a healthier environment for babies.

Maternity Incentive Programme making a difference

The Ready Steady Quit stop smoking service, funded by Waitematā DHB and the Ministry of Health, extended its focus to providing dedicated support for pregnant women who want to start their smokefree journey.

The free Maternity Incentives programme provides support, including a post-partum visit and quitting aids for pregnant women and their whānau.

Enrolled pregnant women can obtain up to $350 in shopping vouchers over the 12-week programme if they successfully quit smoking. Whānau and others residing in the same household are encouraged to be part of the smokefree journey, with the potential to obtain up to $200 in vouchers through a shortened programme. QuitMist spray (oral nicotine replacement therapy spray) is also available.

Engagement in the service and outcomes improved dramatically since the introduction of the incentive programme. In 2018/19, 143 pregnant women across Auckland enrolled with the programme and 85 of those were smokefree (as measured by CO testing) four weeks after their quit date. This is more than double the number of women who successfully quit in the previous year.

Kara was expecting her third child when she was referred to the Ready Steady Quit Programme by her midwife. Kara is now smokefree thanks to the dedicated one-to-one help of her Ready Steady Quit Smokefree Practitioner Pep Tau.

“Having a Māori smoke free coach, Pep, come into my home made this journey much easier. Having her share a bit of her story meant there was no judgement” says Kara.

Kara knew she needed to give up smoking but was finding it hard. The programme taught her about her body’s response to nicotine and how to have a plan to help beat the cravings. The rewards gave her short-term goals to look forward to.

“Being part of the Hapu Mama programme has really helped give me motivation. My husband is so proud of me and has now asked for help to quit too.”

Smokefree homes key to keeping babies safe

Sudden unexpected death in infancy (SUDI) affects Māori families more than any other group in New Zealand. In 2015, there were 41 SUDI deaths in New Zealand, with three quarters occurring within Māori and Pacific families. Waitematā DHB is working to reduce these numbers.

A smokefree environment and safe sleeping practices are vital for every baby, and supporting Māori families to understand this message within a culturally appropriate setting is the focus of the new SUDI prevention programme.

When combined, smoking while pregnant and bed sharing increases the risk of SUDI by 32 fold.

The Waitematā DHB Te Aka Oranga Waikawa Wahakura weaving wānanga programme allows pregnant women and their whānau to weave a baby bed alongside expert harakeke (flax) weavers. Participants receive education on SUDI prevention, safe sleep practice as well as education on breastfeeding, healthy eating, exercise, healthy homes initiatives and stop smoking incentive programmes.

Melanie Nicholson, Waitematā DHB Safe sleep co-ordinator, with a client at the weaving wānanga

Since the national SUDI prevention programme began in June 2017, DHBs are better able to support safe sleep initiatives and resources, particularly for families most at risk. As a result of all DHBs’ ongoing efforts, the latest available combined national SUDI rate is 0.76 per 1,000 live births (2013-17 data), half that reported in 2000. The Waitematā DHB SUDI rate is considerably lower, at 0.28 per 1000 live births.

We hope to make further reductions with more programmes specific to Pacific families, showcasing community safe sleep champions and social media campaigns to improve community knowledge to ‘make every sleep a safe sleep’.

Keeping children out of hospital

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

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

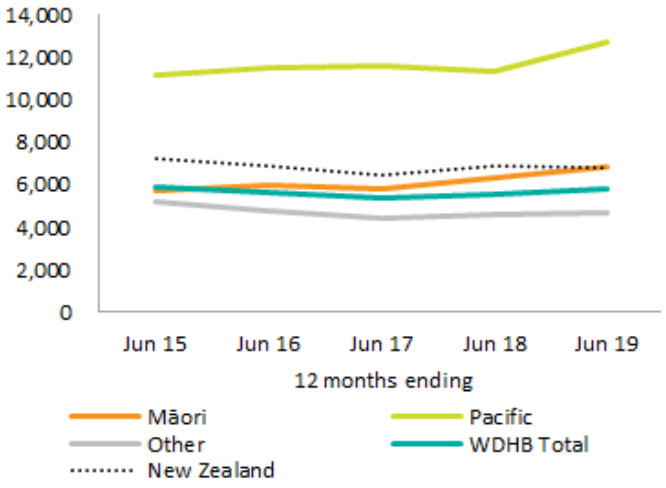
ASH rates are much higher for Māori and Pacific children. Primary health care access and quality, as well as underlying determinants of health (e.g. housing quality and crowding, exposure to second-hand cigarette smoke, poverty) may influence the incidence of ASH.

Fewer children are admitted to hospital with preventable conditions

5,822 AMBULATORY SENSITIVE ADMISSIONS PER 100,000 POPULATION **7% ⬆**

In the 12 months to June 2019, there were 5,822 admissions per 100,000 in our 0–4 year old population[4] (2,351 events) that were considered ambulatory sensitive, a 7% increase since December 2017. Pacific rates increased 18% and are now nearly three times as high as other ethnicities. In 2018/19, our efforts were focused on high need groups.

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



Improvement activities

Hospitalisations due to dental conditions make up around 8% of ASH admissions in 0-4 year olds, but are reducing (17% down since December 2017). Improving accessibility of oral health services will reduce the prevalence and severity of dental decay (caries), and those needing hospital treatment.

177 CHILDREN WERE ADMITTED TO HOSPITAL FOR DENTAL CONDITIONS (438 PER 100,000 POP) **17% ⬇**

The Auckland Regional Dental Service (ARDS) provides oral health promotion, education and treatment to over 300,000 children from birth to school year 8 across greater Auckland.

95% OF PRESCHOOLERS ARE ENROLLED WITH ORAL HEALTH SERVICES **1% ⬇**

To ensure that children are seen by ARDS, we have focused on early enrolment. At the end of December 2018, 95% of all pre-schoolers were enrolled with oral health services, meeting our target. This figure was much lower for Māori (71%). To make it easier for children and whānau to access dental care, ARDS is implementing an outreach programme and extending after hours clinics.

In 2018, 62% of all 5 year old children examined had no dental decay (caries free), with higher rates of decay seen for Māori (52% caries free) and Pacific (38% caries free) children. A change in practice to support high-risk children to be seen more frequently may have led to higher caries rates being observed in the examined population, but this process is expected to improve long-term outcomes for these children.

52% OF PREGNANT WOMEN RECEIVED PERTUSSIS VACCINATION DURING PREGANCY **30% ⬆**
AND 38% RECEIVED INFLUENZA VACCINATION **36% ⬆**

Respiratory conditions are the largest contributor to paediatric ASH rates in Waitematā DHB. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants, and can lead to further respiratory complications. Vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

For babies born in 2018/19, 52% of mothers had received pertussis vaccination during pregnancy, and 38% received influenza. While vaccination rates are lower for Māori and Pacific, they have nearly doubled since 2017.

Children who have been hospitalised for respiratory illness are offered influenza vaccination. In CY2018, 12% of eligible children received the vaccination. Although the overall uptake increased compared with the previous year, it was hampered by the national vaccine shortage.

[4] The population of all 0-4 year olds domiciled in Waitematā DHB is derived from Statistics NZ population projections using 2013 census data.

Healthcare at school for our children with the highest need

Awhi Tamariki is a new health screening and education programme to help all children start school healthy and ready to learn.

A new health assessment and education programme introduced into five low decile Waitematā DHB schools is giving public health nurses a holistic view of a child's health and a better chance at preventing common illnesses.

Awhi Tamariki is an early intervention health screening programme that will help to detect illnesses, such as Group A Streptococcal throat infections (which can lead to rheumatic fever), ear infections and dental issues, when children start primary school.

Public health nurses assess all new entrant children for issues with ears, skin, oral health and respiratory systems, picking up conditions which, left untreated, can result in hospital admission. The programme also includes education to children, teachers and whānau to help them identify health concerns and equip them with skills to prevent illness.

Awhi Tamariki builds on the previously established rheumatic fever screening programme and complements the current B4 School Checks programme, which focuses on meeting unidentified health need and behavioural and developmental progress.

Waitematā DHB unit manager for Child Health, Catherine Wightman, says Awhi Tamariki gives nurses the opportunity to take a holistic approach to a child's health.

"This enables us to get a better picture of the situation in order to come up with a thorough plan to tackling some commonly seen health issues for our most vulnerable school children," she says.

"Through Awhi Tamariki, we're able to put parents and caregivers at ease, knowing their child is in good health and physically ready to hit the ground running at school."

The five Waitematā DHB schools piloting Awhi Tamariki are Henderson South School, Pomaria Primary School, Ranui Primary School and Birdwood School in west Auckland, as well as Onepoto Primary School in Northcote.

A public health nurse will spend time in these schools to assess the health of five-year-olds as they begin school. The nurse will also be available on-site at set times to see older pupils for health-related issues, accompanied by a parent or caregiver.

Waitematā DHB public health nurse Maretta Hodgson is delivering the Awhi Tamariki programme at Henderson South School.

Youth are healthy, safe and supported

Promoting healthy behaviours during adolescence and taking steps to better protect young people from health risks are critical in preventing health problems and poor life outcomes in adulthood.

The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing: Youth experience of health system; Sexual and reproductive health; Mental health; Alcohol and drugs; and Access to preventative services. Waitematā DHB chose to focus on the impact of alcohol at both an individual and health system level.

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

Fewer young people seen in Emergency Departments because of alcohol

Identifying and monitoring alcohol-related emergency department (ED) presentations enables DHBs to better understand the impact excessive alcohol consumption has on young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals to primary care and community care.

In July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. The mandatory question is: 'Is alcohol associated with this event?' Possible answers are: Yes, No, Unknown and Secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved).

91% OF EMERGENCY DEPARTMENT PRESENTATIONS HAD 'UNKNOWN' RECORDED IN THE ALCOHOL-RELATED FIELD

Although this question was implemented in our patient management system, entering an answer was not made compulsory in our EDs until very recently, and alcohol data in our ED systems prior to July is erratic.

Our target in 2018/19 was to improve data collection to allow us to establish a baseline. Given our previous issues with data capture, we are currently unable to report the baseline number of young people admitted to ED because of alcohol.

We expect our data capture to improve in 2019/20 as it is now mandatory for the question to be answered. There is now also a focus on quality improvement for alcohol data collection across primary care and youth services.

Improvement activities

School-based health services offer easy, youth friendly, confidential access to health services, including support and education around alcohol and drug consumption. Eight nurses from school-based health services across Waitematā and Auckland DHBs have completed the Mental Health and Addictions Credentialing Programme in 2018. This programme aims to strengthen the capability of registered nurses to respond to mental health and addictions issues.

"The Mental Health Credentialing gave me skills to assess patients with various mental health presentations including anxiety, depression and AOD. As a practice nurse I then advocated for these patients, and was able to phone them weekly to case manage and review so that they could be encouraged to seek timely care if early warning signs were visible"

- Rebecca Williams, Youth Health Nurse for Alternative Education Unit in Waitematā DHB

99% OF LOW-DECILE STUDENTS RECEIVED HEEADSSS SCREENING **13%** ⬆

HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) Assessments are carried out by School Based Health Services nurses for Year 9 students in low decile schools. This allows for early identification of mental health, alcohol and drug issues and other information to assist young people in their development. In the 2018 school year, 99% of students at eligible schools received assessments.

4% OF 0-19 YEAR OLDS ACCESSED MENTAL HEALTH SERVICES **8%** ⬆

In the 12 months to June 2019, 4.0% of our population aged 0-19 years accessed mental health and addiction services. This is slightly higher than the national rate of 3.9%. The proportion of Māori youth receiving mental health support was much higher, at 5.6%.

4,153 ALCOHOL LICENCE APPLICATIONS WERE RISK ASSESSED **7%** ⬆

The Auckland Regional Public Health Service (ARPHS) has a statutory role in ensuring that the harms from excessive alcohol consumption are minimised in Auckland. In 2018/19 ARPHS reviewed and risk assessed 4,153 applications for new or renewed liquor licenses to ensure the safe and responsible sale, and consumption of alcohol.

Supporting young people with concerns about alcohol and drug use

Altered High works with young people and their families to reduce the risk and harm associated with alcohol and drug use.

The Altered High Youth Service is a team of health professionals that helps young people aged 13 – 19 years from all over the wider Auckland region with concerns regarding their own or someone else's alcohol or drug use. The service provides interventions to reduce the harm from alcohol or drug use and helps young people to stop using alcohol and/or drugs. Staff work with youth at their own pace and focus on what they want to achieve; a positive treatment experience achieves the best results. The service is confidential and can take an individual or family approach. The service is mobile and sees young people in a place that suits them, whether at school, in a community room or at home.

The service is based in Kingsland in central Auckland, but supports the whole Metro Auckland population. Anyone can refer patients to the service, although self-referrals are encouraged.

Substances and Choices Scale

The Substances and Choices Scale (SACS) is a questionnaire that Altered High workers routinely use with young people who attend the service. It is useful to help understand the range of difficulties young people might have with their alcohol and/or drug use. SACS is also used to measure progress. The test is available online if young people want to self-evaluate whether they have a serious alcohol or drug problem. A score of 3 or more indicates that further interaction might benefit and 5 or more might consider treatment. This test is available on a website called The Low Down, which is designed to help young New Zealanders to recognise and understand depression or anxiety.

Support groups

Altered High offers several support groups:

'Get with it' – alcohol and drug brief intervention group

This is a group for people aged 15-19 years who are using drugs and alcohol and:

- are concerned about or want to change their use
- need to access support after business hours
- have legal issues, such as diversion, probation, Police involvement.

The group aims to:

- explore beliefs regarding using substances
- help motivate youth to make changes
- look at ways to reduce the harms associated with using alcohol and other drugs.

Whānau Group

This group is for people who are concerned about a young person's alcohol or other drug use and would like information, advice or support. It provides an opportunity for parents/caregivers/whānau to talk about the impact of their teenager's substance use on their family, home life and themselves. Family can talk about the approaches they have tried and pressing concerns. It provides space to ask questions, gain knowledge on alcohol and drugs and youth development, and explore parenting approaches. The group has a focus on how family look after themselves and self-care skills.

Managing Moods Group

This is a group for people aged 16-19 years who would like to learn more about their emotions and strategies to help manage them.

Prevention and early detection

Preventative care is centred around keeping people healthy, identifying and treating problems quickly, and empowering people to manage their own health. Our aim is for fewer people to die from potentially avoidable conditions, such as cardiovascular disease, some cancers and diabetes.

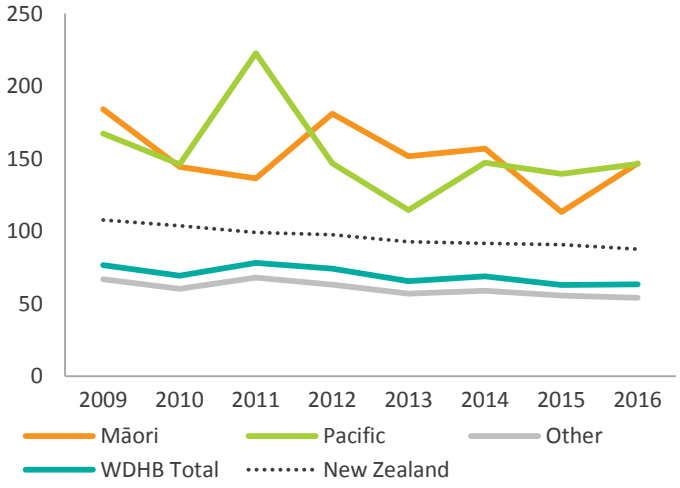
Amenable mortality rates measure the number of deaths that could be avoided through effective health prevention, detection and management interventions at an individual or population level. Amenable mortality rates are higher in Māori and Pacific people.

Fewer people die from preventable causes

OUR AMENABLE MORTALITY RATE WAS 63.3 PER 100,000 POPULATION — 3% ⬇

Our rate of amenable mortality is the lowest in New Zealand. In 2016, it is estimated that 486 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were potentially amenable – a rate of 63.3 deaths per 100,000 population.

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



The rate of amenable mortality is declining and we observed a 3% decrease on the 2013 baseline, but did not meet our target of a 4% reduction.

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

Improvement activities

Waitematā DHB has relatively low numbers of people WHO smoke, with only 12% of our adult population considered daily smokers, yet smoking remains the leading modifiable risk factor for many diseases. It is the leading cause of disparity in health outcomes, contributing to significant socioeconomic and ethnic inequalities in health.

16,430 SMOKERS (34%) RECEIVED CESSATION SUPPORT IN PRIMARY CARE — 16% ⬆

Offering cessation support is important to assist people to become smoke-free. Support includes referral to a smoking cessation programme, prescribing nicotine replacement therapy or other medicines, or providing behavioural support.

In the 15 months to June 2019, 34.4% of smokers received cessation support in primary care, exceeding our target of a ten percent increase.

This contributory measure also sits under the babies living in smokefree homes SLM.

83% OF ELIGIBLE MĀORI HAD THEIR CVD RISK ASSESSED — 5% ⬇

Cardiovascular disease (CVD) is largely preventable through early detection and effective management.

The CVD burden weighs more heavily on Māori than other ethnicities. By identifying those at risk of CVD early, lifestyle and drug interventions can reduce the risk and severity of further disease. As at June 2019, 83% of eligible Māori had received a CVD risk assessment in the last 5 years; the coverage rate for the overall Waitematā population was 86%.

Coverage rates have dropped slightly this year. This is due in part to the large numbers of people screened in 2014 (in a concerted effort to boost coverage) who are now due for re-assessment. The PHOs continue to actively work to achieve this target.

60% OF MĀORI AND PACIFIC PEOPLE WITH CVD WERE PRESCRIBED TRIPLE THERAPY MEDICATION — 2% ⬆

Where appropriate, people who experience a heart attack or stroke should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/ anticoagulant agent, a beta-blocker and a statin).

As at June 30 2019, 58% of all patients who had a previous CVD event were prescribed triple therapy. Rates for Pacific were higher than the total population at 66%, but Māori were slightly lower at 55%. Combined, there was an increase of 2% on the December 2017 baseline.

Small lifestyle changes bring big rewards

The solution to improved health often lies in simple, small lifestyle changes, and Green Prescription helps people make these changes.

What is Green Prescription (GRx)?

Being active and eating well are key to maintaining good health and a sense of wellbeing. Healthy lifestyles reduce the risk of a range of health conditions and help manage existing ones.

A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active and eat healthier, as part of the patient's overall health management. It is a smart and cost-effective way to help people stay healthy.

Harbour Sport delivers Green Prescription programmes in the Waitematā area. The initiative consists of two components: Active for Life (adults) and the Active Families programme, which aims to increase physical activity for children, young people and their families.

Many adult referrals for GRx are to support patients with chronic disease and long-term conditions (such as cardiovascular disease and diabetes) to better manage their conditions to improve their quality of life and prevent deterioration.

Health professionals refer patients to GRx for support to increase their physical activity and improve nutrition. GRx support staff assist patients to set achievable goals to be independently active. Participants are also supported to make healthy food choices and encouraged to attend local GRx exercise classes and education sessions.

In 2018/19, 5,340 Waitematā residents participated in GRx.

Support to make a change for good

Radio DJ Lee is a West Aucklander living in Ranui with his family. He was referred to the GRx Programme by his doctor as he was overweight and diagnosed with type 2 diabetes.

Together with his GRx Healthy Lifestyle Advisor, Lee set a goal of losing weight and returning to a good state of health. With support and encouragement from his advisor, Lee changed his eating habits and started to "eat for fuel, not for fun". Lee is now eating less and more healthily.

Lee's advisor helped him find the direction and motivation to start a daily exercise programme. Lee joined the West Wave leisure centre, where he uses the gym three days a week, and has built family walks into his exercise routine.
Since joining the GRx programme, Lee has turned his life around.

The increased motivation and enthusiasm from physical activity and healthy eating has resulted in a weight loss of 14.5 kg and incredibly, he has reversed his diabetes.

Lee said that the lifestyle change left him feeling more enthusiastic and open to physical activity. "I kicked diabetes in three months with the help of the Green Prescription," says Lee.

The introduction of family walks into his routine saw Lee spend more quality time with his family, which improved his overall wellbeing. The benefits of Lee's hard work paid off and his success was acknowledged by the wider community; Lee even appeared on The Project television programme to discuss his accomplishments.

Community exercise sessions are one of the services provided as part of Harbour Sport's Active for Life Green Prescription programme

Reducing his weight and managing his diabetes were Lee's main goals in joining the GRx programme.

With these initial goals achieved, Lee plans to continue his workouts three times a week and maintain his healthy eating plan to achieve a further 10 kg of weight loss.

Using health resources effectively

The demands on New Zealand's acute care services are increasing due to our growing and ageing population, and long-term conditions like cardiovascular disease and diabetes. We need to strengthen our ability to manage acute demand and deliver more planned care in the community, rather than unplanned care in hospitals, in order to more effectively use the available health resources.

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.

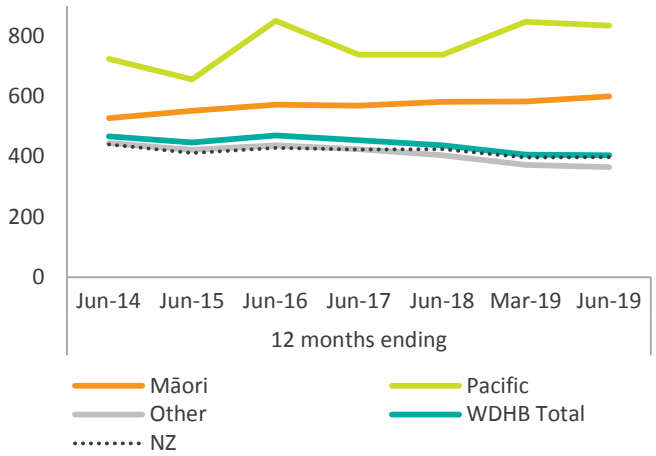
People spend less time in hospital

404 ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION — 1% ⬇

Although our standardised rate of acute bed days has slowly declined since 2014, it remains higher than the national rate (404 versus 398 per 1,000 population in the 12 months to June 2019).

The rate of acute bed day use is higher for Māori and Pacific people.

ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



Improvement activities

In 2018/19, we implemented targeted initiatives to improve the health status of our Māori and Pacific populations, as these groups are most likely to be admitted to hospital and focused on the prevention and treatment of conditions that contribute most to acute bed days. High priority conditions included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and cellulitis.

ASH ADMISSIONS PER 100,000 POPULATION -
197 COPD — 14% ⬇
113 CONGESTIVE HEART FAILURE — 8% ⬆

Congestive heart failure and COPD are long-term debilitating conditions that are responsible for a significant number of acute hospitalisations and overall bed days.

Both conditions can often be well managed with intensive treatment and follow-up in primary care along with patient and family education, potentially preventing the need for hospitalisation. Should hospitalisation be required, those receiving effective management in primary care can have a shorter length of stay and lower risk of readmission.

In the 12 months to June 2019, there were 197 admissions for COPD and 113 for CHF per 100,000 population (aged 45 to 64 years), which equates to 485 potentially avoidable hospitalisations.

131,625 EMERGENCY DEPARTMENT PRESENTATIONS, INCLUDING 11,513 SEEN AT URGENT CARE CLINICS — 5% ⬆

We are reducing the rate at which people present acutely to hospital, and the numbers seen in our emergency departments (EDs). In 2018/19, there were over 130,000 presentations at our EDs. This was an increase of 1.4% from the previous year, but less than the estimated population increase of 2.3%, and a considerable reduction on the 4% increase in ED attendances seen the previous year.

This number includes over 11,000 people who presented to our EDs and, after being triaged as clinically appropriate, were given a voucher for free care at an urgent care clinic (Shore Care and Whitecross). This significantly reduced the burden on our EDs and improved patient flow through the hospital.

We have a number of other programmes underway to reduce the volume of people requiring acute hospital care.

13,173 PEOPLE WERE REFERRED TO PRIMARY OPTIONS FOR ACUTE CARE — 23% ⬆

Primary Options for Acute Care (POAC) is a service providing healthcare professionals access to investigations, care, or treatment for patients in the community, preventing an ED attendance and possible hospital admission, and assisting earlier discharge. PHOs worked together with the POAC team to support GPs to better utilise POAC. In 2018/19, 13,173 patients were referred to POAC, significantly exceeding our target of around 10,800.

Transforming patient journeys through the hospital

The TransforMED programme began in 2017 and over the past two years has transformed the care provided by General Medicine across North Shore Hospital.

The Home-Based Ward System

Doctors have historically spread their efforts across all of the general medicine wards but are now assigned to one particular ward as part of TransforMED.

The home-based ward model of care allows ward-based medical teams to look after one ward, instead of having teams move between a number of wards. Doctors have more time for direct patient care, and get to work with the same staff all of the time. This allows for enhanced teamwork and communication between doctors, nurses and allied health teams, and more streamlined patient care.

The consultant-led teams review each patient daily so that management and discharge decisions can be made earlier and more efficiently.

Each ward has a daily meeting where the progress of each patient is discussed with the multidisciplinary team of doctors, nurses and allied health staff. Any delays to treatment are highlighted and addressed with the primary aim of reducing unnecessary waits for our patients and improving their journey of care.

Care is planned through the SAFER patient care bundle:

Senior review. All patients will be seen before midday by a clinician able to make management and discharge decisions.

All patients will have an expected discharge date and clinical criteria for discharge.

Flow of patients will commence early (by 10am) from assessment units to inpatient wards.

Eliminating Waiting = Early discharge. Wards that focus on improving processes end up with earlier discharges.

Review. Peer review and measurement for improvement. Systematic MDT review of patients with longer stays with a 'home first' mindset.

Since the model was implemented there has been a reduction in lengths of stay, improved utilisation of inpatient beds in medicine and enhanced timeliness of patient care. In total, over 3,000 bed days have been saved.

The home-based ward model has resulted in doctors having more time for direct patient care, improved support for junior doctors and enhanced team work and communication across the multidisciplinary team.

Trainee doctors have reported improved time management, teamwork and more regular access to training and teaching sessions.

Improved patient flow

A key part of the TransforMED initiative is the changes that have occurred within the Assessment and Diagnostic Unit. (ADU). There is now a daily floor manager and senior medical presence on ADU, this aligned with the times of peak patient presentation (12 to 8pm).

We have established a daily acute clinic where patients can be referred, in consultation with their GP, rather than attending the ADU. GPs can also contact Medical Consultants for admission and phone advice.

In partnership with the Emergency Department (ED) we have made changes to the Chest Pain Pathway. Very low risk patients are identified early, discharged home from ED and managed through outpatient clinics, reducing the number of patients referred from ED to Medicine.

The GP phone, the acute clinic and the changes to the chest pain pathway have helped us to manage our presentation rates. Presentations to General Medicine in 2018/19 were comparable to 2016/17 levels.

Implementation of Home-based wards will begin at Waitakere Hospital in December 2019.

A TransforMED team in action, Dr Indira Wickramasinghe, Dr Sheila Kaur, Dr Tina Chang, Consultant Physician Dr Steven Miller and registered nurse Kurt Navarro.

Person-centred care

Patient experience is a good indicator of the quality of health services, reflecting integration of health services, access to information and timely care. Positive patient experience is associated with adherence to recommended medication and treatments, engagement in preventive care (such as screening services and immunisations) and ability to use the health resources available effectively.

The primary care patient experience survey (PHC PES) was developed by the HQSC to provide new information about how people experience primary health care, and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

Enhancing patient experience of care

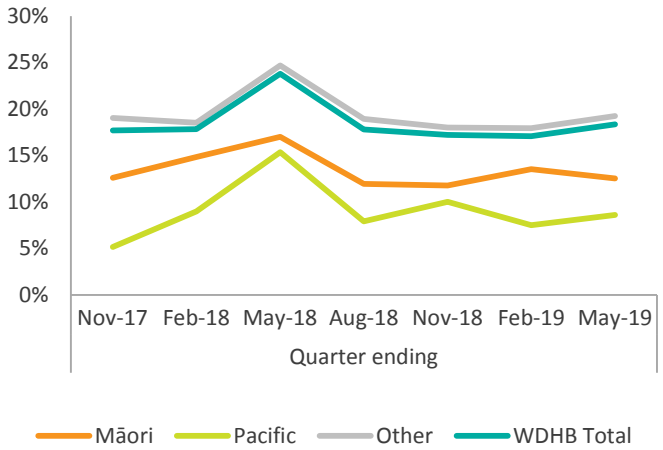
12.4% OF MĀORI AND 8.5% OF PACIFIC INVITEES RESPONDED TO THE PHC PES — 2% ↑

There has been a regional focus on improving response rates to the primary care survey to ensure that the perspective of all patients can be captured and the findings from the survey can be generalised to the patient population, particularly in Māori and Pacific patients.

In 2018/19, 6,541 Māori and Pacific people registered with Waitematā DHB PHOs were invited to participate in the primary care survey. Eleven percent responded, a 2% absolute increase on the December 2017 baseline. The Metro Auckland DHBs collectively achieved the 2% improvement targets for Māori and Pacific with response rates of 11.2% and 8.0%, respectively.

Feedback from primary care, focus groups, and research have highlighted that the electronic survey format is unlikely to engage Māori and Pacific participants. The principal reason is a preference for face-to-face discussion. Alternative ways to engage with Māori and Pacific are now being investigated.

PRIMARY CARE PATIENT EXPERIENCE SURVEY RESPONSE RATES



Improvement activities

88% OF PHO PRACTICES ARE PARTICIPATING IN THE PHC PES — 105% ↑

Participation in the PES by practices has increased significantly since it was implemented in 2017 as PHOs complete the developmental work required to successfully implement the survey, including infrastructure, practice engagement, capacity building, and patient communication.

As at June 2019, 88% of all Metro Auckland practices were participating in the survey, more than double the baseline result in November 2017 (43%) and exceeding our 50% target.

24% OF PHO-ENROLLED PATIENTS HAVE LOGIN ACCESS TO A PORTAL — 41% ↑

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 and patient-provider communication is improved.

At the end of June 2019, 67% of Metro Auckland practices had an online portal and 24% of all PHO-registered patients had signed up for access, exceeding our goals for the year.

WE SCORED AN AVERAGE OF 8.6/10 IN THE HQSC INPATIENT SURVEY — 4% ↑

Patient experience measures are now routinely in place for hospitals. Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their families.

A selection of adult patients who spent at least one night in hospital are sent an invitation via email or text to participate in the national survey on at least a quarterly basis. The survey covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.

Our average scores improved since the survey was implemented and are similar to New Zealand as a whole. For patients treated in May 2019, our scores were: Communication 8.7; coordination 8.5; partnership 8.5; and physical and emotional needs 8.6. The average score across all four domains is 8.6.

Improving patient experience for all

A good patient experience is made up of four domains: Communication, coordination, partnership and physical and emotional needs. In 2018/19 we focused on helping all our patients navigate the health system and enhancing the cultural competency of our staff.

Navigation support for mental health

We continue to expand services to support patients to navigate their way through the health system and other support agencies.

Awhi Ora is a community mental health support service provided by NGOs in partnership with general practice. 'Walk alongside' support helps people identify and work on the personal/practical challenges that are important to them. These needs commonly relate to physical and emotional health, problem drinking, drug use or gambling, and family and whānau, money, and housing problems. Support workers provide navigation support to connect people to services including health, accommodation and employment, as well as psychosocial support.

Hearts & Minds is a community development agency that provides support for patients with mental health concerns. Health and other support navigation is one of their key functions with support available in person and across digital platforms.

Cancer nurses supporting patients and whānau

Cancer Nurse Coordinators (CNCs) are clinical nurse specialists who coordinate care and provide support to patients with suspected or confirmed cancer. CNCs are an integral part of the multidisciplinary team and liaise with other healthcare professionals and agencies to improve the diagnosis and treatment process for patients. A key component of the CNC role is to act as a primary point of contact for patients and their families to provide clinical advice and emotional support.

Waitematā DHB has dedicated Māori and Pacific Cancer Nurse Coordinator roles. Māori and Pacific have worse cancer outcomes than other ethnicities, and this is in part due to issues accessing diagnosis and treatment. The CNCs ensure all patients receive early access to cancer services and experience optimal treatment pathways.

The Māori and Pacific CNCs identify strategic and operational gaps in the cancer pathway where service delivery can be improved, and work in partnership with the other CNCs to provide expert coordination and case management.

The Māori and Pacific CNCs also provide cultural advice and advocacy to support patients and whānau, and work closely with the Māori and Pacific community cancer navigators to support patients once they leave the hospital.

Te reo class and app for staff

Waitematā and Auckland DHBs have jointly launched free te reo Māori language classes and a mobile app, Āke Āke, for staff. These initiatives aim to raise cultural awareness in the workplace and improve how staff work with Māori patients and whānau.

The classes have been very popular, with more than 400 people wanting to participate.

Chief Advisor of Tikanga at Waitematā and Auckland DHBs, Dame Rangimarie Naida Glavish says, "There are inequities for Māori in our health system and barriers to treatment for some who need it most. We believe encouraging our staff to learn te reo is a move in the right direction towards bridging that gap".

The classes come after the successful launch of Waitematā and Auckland DHB's Āke Āke app in 2018. The mobile app promotes correct Māori pronunciation and tikanga (protocol).

Te reo classes have proved very popular with staff at Waitematā DHB

Kōrero Mai (talk to me) initiative

When a patient or their loved one is unwell, it can be difficult to communicate to hospital staff or staff may not understand the level of concern.

We introduced the Kōrero Mai system to help patients, family or whānau to escalate their concerns to staff, if they feel a patient's condition is deteriorating. We acknowledge that patients, families and their whānau know the patient best and are often able to recognise subtle signs of deterioration, even if the vital signs are normal.

Kōrero Mai is part of a 5-year National Patient Deterioration Programme, commissioned by the Health Quality and Safety Commission (HQSC).

Our people, our performance

Overview

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

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals set out in the Improving Outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitematā DHB population is now 84.2 years, an increase of 1.9 years over the last decade. The life expectancy gap is 2.5 years for Māori and 7.1 years for Pacific, compared with all other ethnicities.

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

Some 2016/17 baseline figures in the tables below differ to those included in the 2018/19 Annual Plan because the Annual Plan figures were incorrect or were not the most up-to-date result for 2016/17, but were what was available at the time.

Output class measures

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

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

The following tables include our output measures from the 2018/19 Statement of Performance Expectations by Output Class. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators do not have set quantitative targets, rather expected performance directions, and these have been assigned the below symbols in the target column.

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

Output Class 1: Prevention Services

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

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
HEALTH PROMOTION					
% of PHO-enrolled patients who smoke have been offered brief advice to quit in the last 15 months (C)	90%	89%	88%	90%	
% of PHO-enrolled patients who smoke who received cessation support (Q)	32%	32%	34%	32%	
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking (C)[5]	87%	90%	91%	90%	
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	New indicator	116 (CY2018)	168[6]	332	
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	100%	100%	100%	95%	
Number of clients engaged with Green Prescriptions (V)	New indicator	3,756 (76%)	5,340 (99%)	5,400	
IMMUNISATION[7]					
% of pregnant women receiving pertussis vaccination in pregnancy (C)	34%	44%	52%	50%	
Influenza vaccination coverage for children aged 0-4 years who are hospitalised for respiratory illness (C)					
- Māori	7%[8]	8%	8%[9]	15%	
- Pacific	7%	7%	11%[9]	15%	
- Total	10%[8] (CY2016)	11% (CY2017)	12%[9] (CY2018)	15%	
% of eight months olds will have their primary course of immunisation on time (C)					
- Total	92%	92%	92%	95%	
- Māori	86%	86%	86%[10]	95%	
Rate of HPV immunisation coverage (C)	60%	60%	56%[11]	75%	
POPULATION-BASED SCREENING					
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)	66%	65%	66%	70%	
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	74%	71%	70%[12]	80%	
% of 15-24 year olds tested for chlamydia (C)	12%	12%	11%[13]	15%	
% of 4-year-olds receiving a B4 School Check (C)	94%	90%	90%	90%	

[5] The Ministry states that this measure is still under development and reported results cover only a proportion of pregnant women who identify as smokers.
[6] See p13 for discussion of initiatives to improve uptake. Our 2019/20 target is reduced to 231 to reflect the lower number of women smoking when pregnant.
[7] The population data is sourced from the National Immunisation Register; babies are added onto this register at birth through the National Health Index system.
[8] 2016/17 baseline in 2018/19 Annual Plan incorrectly used CY2017 results, correct baseline should be CY2016 as used here.
[9] See commentary page 15.
[10] Nationally immunisation rates for Māori are falling. We are collaborating with PHOs to improve coverage and our Treaty partners to better engage Māori with immunisation. Co-designed posters with a Māori focus are being distributed to primary care practices. The collaboration with Plunket for an additional outreach immunisation service focusing on Māori and Pacific babies is extended to the end of 2019.
[11] Reporting methodology and parameters for HPV coverage were changed by the MoH for 2018/19. This new result varies substantially from our projected performance, which indicates an improvement on 2017/18 end-of-year performance. Other DHBs also report a discrepancy; the MoH is investigating this.
[12] We continue to see declining coverage, consistent with national declines in all ethnic groups over the past three years. We continue to work with primary health care to focus on improving screening coverage in women at greatest clinical risk.
[13] Dec-18 result (baseline Dec-17). We will further monitor this apparent drop to determine whether this is a data quality issue or a real decline. While the target of 15% coverage was not achieved for the total population in Metro Auckland DHBs, it was achieved for females alone, at 18%.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
Bowel cancer screening					
% of people aged 60-74 years invited to participate who returned a correctly completed kit (Q)					
- Māori	New indicator	New indicator	62%	60%	●
- Pacific			47%[14]	60%	●
- Other			60%	60%	●
% of individuals referred for colonoscopy following a positive iFOBT result and are offered their procedure within 45 working days (T)[15]	97%	93%	97%	95%	●
AUCKLAND REGIONAL PUBLIC HEALTH SERVICE (ARPHS)[16]					
Number of tobacco retailer compliance checks conducted (V)	316	372	432	300	●
Number of license applications and renewals (on, off club and special) received and are risk assessed (V)	3,870	2,112	4,153	Ω	N/A
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment (Q)	94%	95%	96%	90%	●
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	New indicator	80%	89%	85%	●

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 focussing on individuals and smaller groups. They support people to maintain good health, and through prompt diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes. These services also enable patients to maintain their functional independence and reduce complications or acute illness, reducing the need for specialist intervention.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
PRIMARY HEALTH CARE					
Rate of primary care enrolment (Māori) (C)	81%	83%	81%[17]	90%	●
Number of referrals to Primary Options for Acute Care (POAC) (V)	10,727	13,944	13,173	10,811	●
POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions (Q)	2.4%[18]	2.6%	2.7%[19]	3.0%	●
% of the eligible population who have had their CVD risk assessed in the last five years (Māori) (C)	87%	86%	83%[20]	90%	●
% of Māori patients with prior CVD who are prescribed triple therapy (Q)	57%[21]	58%	55%[22]	59%	●
% of Pacific patients with prior CVD who are prescribed triple therapy (Q)	63%[21]	63%	66%	66%	●
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds (Q)					
- Māori	7,460	7,081	8,319[23]	<7,311	●
- Pacific	10,850	10,474	12,264[23]	<10,633	●
- Chronic obstructive pulmonary disease (COPD)	173	171	197[24]	<170	●
- Congestive heart failure (CHF)	123	111	113	<121	●

[14] Promotional and education initiatives targeting Pacific communities continue to promote bowel screening, therefore we expect uptake to increase.
[15] The wording of this measure was incorrect in the 2018/19 annual plan.
[16] Services are delivered by ARPHS on behalf of the three Metro Auckland DHBs. Reported results are for all three DHBs.
[17] We are collaborating with Māori health providers, primary care, PHOs and Auckland DHB to develop a facilitated enrolment process for Māori hospital patients who are not enrolled with primary care.
[18] 12 months to Sep-17 result.
[19] 12 months to Mar-19 result.
[20] See page 19 for comment
[21] Result as at Jan-2018.
[22] The transition from Patient Management System to National Enrolment Service has led to data quality issues affecting the number records identifiable as prescribed triple therapy. PHOs are actively working to develop a resolution.
[23] We have multiple initiatives to target inequity in Māori and Pacific, including improving access to community-based acute care, better management of long-term conditions and preventative care, and improving the integration between primary care and other services to reduce rates in these populations.
[24] There were 50 more COPD admissions in 2018/19 than the previous year, due in part to a severe flu season. We continue to provide pulmonary rehabilitation for patients with COPD, one of the most clinically effective therapies to lower the risk of hospitalisation.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
% of PHO enrolled population who have login access to a portal (C)[25]	17%[26]	21%	24%	20%	
% of practices participating in Primary Care Patient Experience survey (C)[25]	43%	90%	88%	≥ Jun 2018 result	
Primary Care Patient Experience survey response rate (C)					
- Māori (based on DHB of practice)	7.9%[27]	15.2%	12.4%[28]	14.6%	
- Pacific (based on DHB of practice)	4.6%	9.6%	8.5%	7.2%	
PHARMACY					
Number of prescription items subsidised (V)	7,310,184	7,382,041[29]	7,545,871[29]	Ω	N/A
COMMUNITY-REFERRED TESTING AND DIAGNOSTICS					
Number of radiological procedures referred by GPs to hospital (V)	37,424	38,842	39,398	Ω	N/A
Number of community laboratory tests (V)	3,902,480	4,082,639	4,222,092[29]	Ω	N/A
ORAL HEALTH[30]					
% of preschool children enrolled in DHB-funded oral health services (C)	93%	96%	95%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.67	0.61	0.60	<0.61	
% of children caries free at five years of age (Q)	66%	67%	62%[31]	67%	

Output Class 3: Intensive Assessment and Treatment

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

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

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

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
ACUTE SERVICES					
Number of ED attendances (V)	124,867[32]	129,864	131,625	Ω	N/A
% of ED patients discharged admitted or transferred within six hours of arrival (T)	96.8%	96.6%	94.4%	95.0%	
% of ED admissions in 10-24 year olds where alcohol-related ED presentation status is 'unknown' (Q)	New indicator	83.2%	91%[33]	<10%	
% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks (T)	90%	94%	88%	90%	
% of eligible stroke patients thrombolysed (C)	8%	10%	8%[34]	10%	
% of ACS inpatients receiving coronary angiography within 3 days (T)	73%	72%	71%	70%	
MATERNITY					
Number of births in Waitematā DHB hospitals (V)	7,045	6,741	6,722	Ω	N/A

[25] Metro Auckland DHBs result.
[26] CY2017 result.
[27] 2016/17 baseline included in the 2018/19 Annual Plan was for a single quarter, figure included here is for full 2016/17 financial year
[28] This is a Metro Auckland DHB measure from the 2018/19 SLM improvement plan and the regional targets (10.5% for Māori, 7.4% for Pacific) were met.
[29] Results for 12 months ending in March.
[30] All results are for the calendar year prior to the end of each financial year.
[31] See comments page 15
[32] This was incorrectly reported in the 2018/19 Annual Plan; the correct result is included here.
[33] Result for 12 months to Mar-19. An answer to this question is now compulsory in our patient management system, which we expect will significantly improve our results. See p17.
[34] We are currently reviewing data accuracy as the supplied data may be an underrepresentation of the proportion of Waitematā DHB patients receiving thrombolysis due to the numbers diverted to Auckland City Hospital after hours.

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
ELECTIVE (INPATIENT/OUTPATIENT)					
Number of elective surgical discharges (V)	23,998 (111%)	24,027 (109%)	24,169 (106%)	22,073	
Surgical intervention rate (per 10,000 population) (C)[35]					
- Major joints	28.0	24.1	23.2	21.0	
- Cataracts	39.7	43.9	45.2	27.0	
- Cardiac surgery	6.1	5.7	5.7[36]	6.5	
- Angioplasty (PCR)	16.5	15.8	15.7	12.5	
- Angiogram	41.7	43.1	47.2	34.7	
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	92%	97%	98%	90%	
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	78%	71%	53%[37]	70%	
% of patients waiting longer than four months for their first specialist assessment (ESPI 2) (T)[38]	0.0%	0.0%	4.5%	0.0%	
% of accepted referrals receiving their scan within 6 weeks (T)					
- CT	96%	83%	70%[39]	95%	
- MRI	91%	78%	76%[40]	90%	
QUALITY AND PATIENT SAFETY					
% of opportunities for hand hygiene taken (Q)	86%	89%	89%	80%	
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.10	0.07	0.05[41]	<0.11	
% of falls risk patients who received individualised care plan (Q)	96%	97%	97%	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	5.77	9.71	12.48[42,43]	<8.4	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	95%	97%	97%[42]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	96%	97%	98%[42]	95%	
Surgical site infections per 100 hip and knee operations (Q)	1.61	0.63	0.52[42]	<0.93	
MENTAL HEALTH					
Percentage of population who access mental health services (C)					
- Age 0–19 years	3.7%	3.9%	4.0%	3.5%	
- Age 20–64 years	3.6%	3.6%	3.7%	3.4%	
- Age 65+ years	2.0%	2.1%	2.2%	2.0%	
% of 0-19 year old clients seen within 3 weeks (T)					
- Mental Health	71%	77%	70%[44]	80%	
- Addictions	89%	91%	93%	80%	
% of 0-19 year old clients seen within 8 weeks (T)					
- Mental Health	95%	95%	93%	95%	
- Addictions	98%	99%	99%	95%	

[35] These measures are discontinued by MoH; the latest available results (12 months to Mar-19) are shown.
[36] Auckland DHB is our service provider, who experienced high complexity and volumes; the MoH upper limit was not breached, no patients waited >120 days.
[37] Initiatives including improved booking and clinical planning, additional staff, e-referrals, nurse endoscopists and outsourcing will help improve performance.
[38] Assessment of performance is based on MoH criteria.
[39] The new CT scanner at North Shore Hospital will be fully commissioned by Aug-19. Additional staff are planned to start in the remaining months of 2019.
[40] Performance has improved with the target achieved in June. A service improvement programme is underway and outsourcing is planned, which factors in projected demand growth and is aimed at maintaining compliance with the target.
[41] Result for 11 months to May-19 as Jun-19 not available at the time of publication.
[42] Result for 12 months to Mar-19 as Jun-19 not available at the time of publication.
[43] The absolute numbers of falls are very small, therefore the rate is subject to large variations (n=13 for 2018/19, n=10 reported in 2017/18). Safety initiatives are in place to reduce falls.
[44] Long standing staff vacancies limit the service's ability to fully achieve targets. In particular, there is a 75% vacancy rate in psychiatry. The acute service is undergoing redesign for North and Rodney districts, with the goal of improving this target and retaining workforce.

Output Class 4: Rehabilitation and Support Services

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

Output measure	2016/17 baseline	2017/18 result	2018/19 result	2018/19 target	Rating
HOME-BASED SUPPORT					
% of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	98%	98%	98%	95%	●
PALLIATIVE CARE					
Proportion of hospice patient deaths that occur at home (Q)	33%	30%	35%	↑	●
% of acute patients who waited >48 hours for a hospice bed (T)	5%	16%	21%[45]	5.0%	●
RESIDENTIAL CARE					
ARC bed days (V)	915,023	966,718	974,841	Ω	N/A

[45] The result is primarily due to the closure of an inpatient unit. Patients are managed with a day stay and increased home care or transfer to another hospice. We plan to review this measure in 2019/20.

Cost of Service Statement – for year ended 30 June 2019

	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support		Total	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**205,133**	**557,716**	**1,534,681**	**984,923**	**25,753**	**28,988**	**71,626**	**219,115**	**1,837,193**	**1,790,743**
Expenditure										
Personnel	89,526	203,567	669,778	362,703	11,239	10,632	31,260	79,813	801,803	656,715
Outsourced Services	9,530	24,017	71,295	43,542	1,196	1,254	3,327	9,417	85,348	78,230
Clinical Supplies	14,231	38,876	106,466	70,131	1,787	2,031	4,969	15,243	127,452	126,281
Infrastructure and Non-Clinical Supplies	13,321	32,701	99,658	59,596	1,672	1,708	4,651	12,820	119,303	106,825
Payments to Providers	92,884	258,913	694,904	463,440	11,661	13,524	32,432	101,515	831,881	837,392
Total Expenditure	**219,492**	**558,074**	**1,642,100**	**999,412**	**27,555**	**29,149**	**76,640**	**218,808**	**1,965,788**	**1,805,443**
Net Surplus/ (Deficit)	**(14,359)**	**(358)**	**(107,420)**	**(14,489)**	**(1,802)**	**(161)**	**(5,014)**	**307**	**(128,595)**	**(14,700)**

The variance shown above are due to a change of classification methodology between preparing the Plan and year end reporting. Refer to the table below for the actual variances that arise where a consistent methodology is applied. The Net Deficit shown in the below table of $14.7m agrees to the Group's original Annual Plan total.

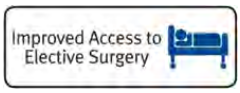
	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support		Total	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**205,133**	**200,866**	**1,534,681**	**1,502,754**	**25,753**	**25,217**	**71,626**	**70,136**	**1,837,193**	**1,798,973**
Expenditure										
Personnel	89,526	73,868	669,778	552,633	11,239	9,274	31,260	25,792	801,803	661,566
Outsourced Services	9,530	8,715	71,295	65,203	1,196	1,094	3,327	3,043	85,348	78,056
Clinical Supplies	14,231	14,107	106,466	105,540	1,787	1,771	4,969	4,926	127,452	126,344
Infrastructure and Non-Clinical Supplies	13,321	11,866	99,658	88,776	1,672	1,490	4,651	4,143	119,303	106,275
Payments to Providers	92,884	93,951	694,904	702,882	11,661	11,795	32,432	32,805	831,881	841,432
Total Expenditure	**219,492**	**202,507**	**1,642,100**	**1,515,033**	**27,555**	**25,423**	**76,640**	**70,709**	**1,965,788**	**1,813,673**
Net Surplus/ (Deficit)	**(14,359)**	**(1,641)**	**(107,420)**	**(12,280)**	**(1,802)**	**(206)**	**(5,014)**	**(573)**	**(128,595)**	**(14,700)**

An increase in the estimated cost to satisfy non-compliance with the Holidays Act of $114.3m has caused significant variances across output classes personnel expenditure compared to plan. From this $114.3m uplift in cost, relating to Intensive Assessment and Treatment and Early Detection and Management had the most significant impact ($95.5m and $12.8m respectively).

Excluding the impact of the non-compliance with the Holidays Act, Intensive Assessment and Treatment total revenue and expenditure vary from plan by $31.9m and $31.6m respectively. The Intensive Assessment and Treatment output class makes up a significant amount of the Group's revenue funding and expenditure. These variances are therefore mainly driven by the explanations provided in note 31 of the Financial Statements.

National Health Targets

2018/19 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show each quarter's and full year performance, where relevant. In quarter four, we achieved four of the seven Health Targets.

HEALTH TARGETS		2018/19 Q1	Q2	Q3	Q4	Full year
	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	92%	95%	96%	95%	94%
	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs), target = 22,718	104% (6,076)	105% (12,029)	106% (17,862)	106% (24,169)	106% (24,169)
	90% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment	95%	93%	88%	83%	88%
	95% of eight months olds will have their primary course of immunisation on time	92%	92%	92%	93%	92%
	90% seen in primary care provided with advice to help quit	88%	88%	87%	88%	88%
	90% of newly registered pregnant women provided with advice to help quit[46]	94%	90%	89%	94%	91%
	95% of obese children identified in the B4SC programme will be offered a referral to a health professional	100%	100%	100%	100%	100%

*The Ministry of Health are currently revising the National Health Targets

Health Quality and Safety Commission Markers

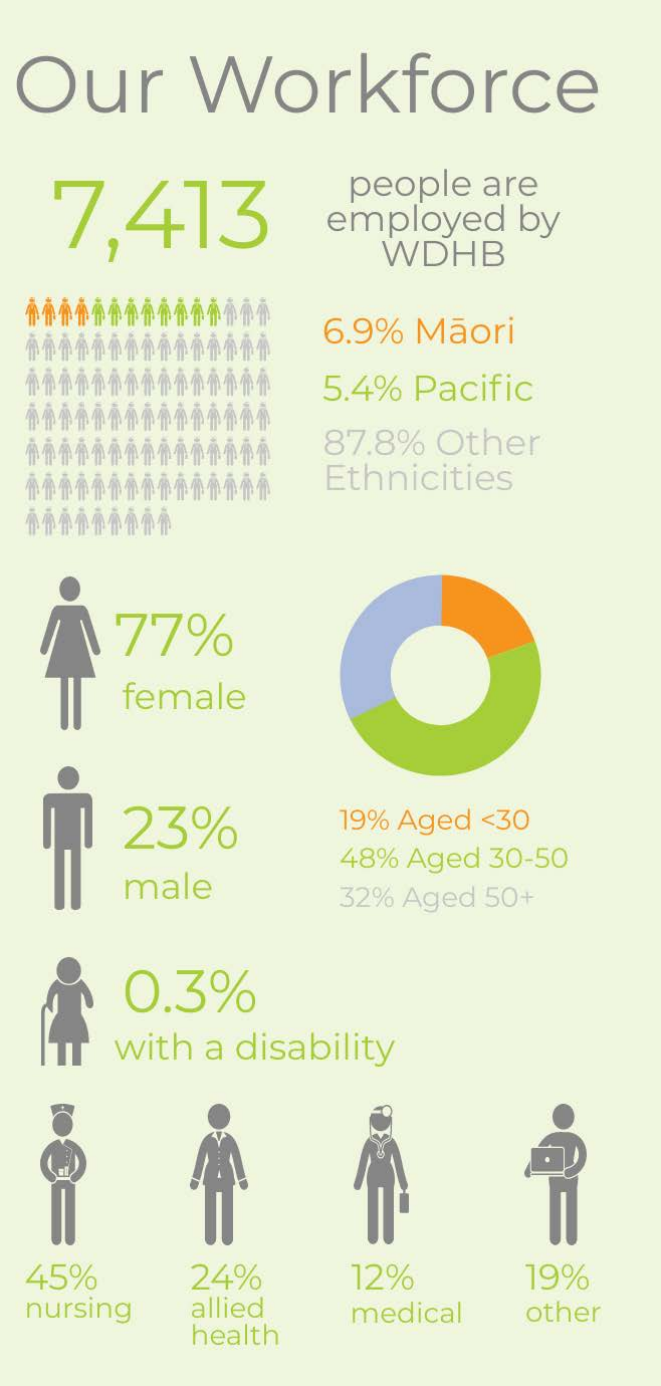
The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, Open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred. During 2018/19, we improved or maintained our compliance across most of the HQSM markers:

HEALTH QUALITY AND SAFETY MARKERS	Q4 2017/18	Q4 2018/19
80% compliance with good hand hygiene practice	90%	90%
90% of older patients assessed for risk of falling	95%	97%
% of patients assessed at risk of falling who received an individualised care plan	98%	99%
100% of hip and knee arthroplasty primary procedures given antibiotic in right time[47]	98%	97%
95% of hip and knee arthroplasty procedures given right antibiotic in right dose[47]	96%	97%
95% of audits of surgical safety checklist engagement score levels of 5 or higher	Sign in: 85% Time out: 92% Sign out: 95%	Sign in: 89%[47] Time out: 98% Sign out: 98%[47]

[46] The Ministry states that this measure is still under development and reported results cover only a proportion of pregnant women who identify as smokers.
[47] Q3 result for both 2017/18 and 2018/19 years.

Being a good employer

At Waitematā DHB, our promise is the best care for everyone. We believe that our patients receive the best care from our people when our people receive the best care from us as their employer. We are committed to being an Equal Employment Opportunities (EEO) employer through our organisation-wide good employer practices relating to the recruitment, development, management and retention of all staff. We have been an employer member of Diversity Works for the last eight years and received the 2018 Diversity Award for 'celebration culture' due to our national cultural competency training programme.



Our Good and Equal Employment Programmes

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

Staff experience, culture and values

Waitematā DHB is committed to fostering a positive culture and living our values every day. A key achievement in becoming a values-led organisation is to define the culture through the development of a shared set of values, standards and behaviours. Co-created with patients, their whānau, and staff, our values reflect what we want to see from each other and act as a guide for how we conduct our business.

The Values Programme is an ongoing commitment to our promise to provide the 'best care for everyone'. The aim of this programme is to foster a culture of compassion, connectedness and equity to improve health outcomes and patient experience. Programmes of work over the next 2 years will focus on: growing digital capability, culture and innovation; patient and staff experience; high performance ways of working; and health leadership.

Recruitment, selection and development

Waitematā DHB has a comprehensive training programme to equip new graduates with clinical and professional skills. Extensive coaching and teaching programmes to support the transition of post-graduate Allied Health, Nursing and medical staff from their student to intern year and into pre-registration training.

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

The DHB supports our Orderly, Cleaning, Therapy Assistants, Oral Health Assistants and Heath Care Assistant staff through NZQA accredited training via Careerforce, with more than 250 staff progressing through these programmes over the last 6 years.

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

Management and leadership development

The Fellows Programme enables service redesign and innovation by matching high performing individuals to areas of organisational need. Fellowships are 12-month roles that require completion of a project and a publication in areas, including: medical education and anthropology; health care design, innovation and management; health informatics; patient safety and services delivery. The Fellows programme was recognised in the 2018 IPANZ awards with Fellow Dr Eleri Clissold named as the 2018 IPANZ young professional of the year.

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

Health equity

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

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

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

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 receive summer work placements with Waitematā DHB.

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

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

Volunteers

We are assisted by approximately 300 volunteers who support our patients and their whānau. Volunteer groups include Volunteer Stroke Service, St Johns – Friends of Emergency and Ward 2, Hospital Auxiliary, Volunteer Chaplain Assistants, Front of House (Green Coats), ward volunteers, outpatient volunteers and Westlake Girls and Boys Schools. Our volunteers are highly valued by the organisation and our patients. They provide a friendly face to assist with way finding as visitors enter our hospitals and also provide support to patients on the ward in conversation and attending to their needs.

Front of House volunteers welcome and assist our patients and visitors to find their way around the hospital.

Other organisations assist with volunteering their time to our gardens. City Impact Church have led some garden improvement activities and the North Harbour Rose Society attend to our roses regularly at North Shore Hospital. Volunteers assisted the organisation during the nurses strike and also assist various services with patient feedback data collection by conducting surveys and interviews. Our volunteer programme continues to expand with an aim to have volunteers on all inpatient wards throughout the organisation.

Young volunteers from City Impact gave their time to tidy the Waitakere Hospital rose gardens

Remuneration and recognition

Waitematā 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 – awards provided to staff recognised for a specified activity or action that 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.

Florethel Aguirre Henderson, a cleaner at Waitakere Hospital, was one of 2019's Health Heroes. Ethel goes to great lengths to boost staff and patient spirits on Huia Ward, living our values of Everyone Matters and Connected.

Ethel Henderson, receiving her Health Hero award from CEO Dale Bramley

Long service awards – recognition of staff who have 15 years or more service with the DHB.

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

In Partnership with Unions

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

Workplace flexibility and design

A large facility development programme is underway across our sites, guided by the Northern Region Long-Term Investment Plan. 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 deliver contemporary patient care.

We offer our staff 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 work-life balance.

Policies

In 2018/19, we reviewed key people-based policies, including our recruitment policy and re-launching our anti-bulling and anti-harassment resources. Key employee policies are sent to union partners for their feedback and endorsed by our Executive Leadership Team.

Health, Safety and Wellbeing

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

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

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

A key work programme supports the wellbeing of our staff. This work, guided by the Te Whare Tapa Whā and World Health Organization Healthy Workplaces frameworks, includes providing debrief on site, wellbeing sessions for staff and fitness hubs.

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

Sustainability

Waitematā DHB's targets aim to address sustainable procurement, energy and carbon management, water efficiency, waste management and the built environment.

Waitematā DHB is completing its second and third Certified Emissions Measurement and Reduction Scheme (CEMARS) audit to verify its carbon emissions and plan for a stepped reduction in emissions. We are also Enviro-Mark Gold certified to verify that we take credible action for a better environment. The DHB is also a member of the Global Green and Healthy Hospitals, a worldwide network committed to reducing the health sector's environmental footprint and advocating for policies that promote environmental and public health.

Waitematā DHB has set annual targets to reduce our carbon footprint and put in place initiatives to achieve the target.

The average ambient temperature was 1°C lower in 2018/19, impacting on heat demand in summer and winter. Our overall electricity use decreased by 4.1% over the year to 34.1 GW. Gas use increased by 6.7% to 95.8 GJ.

Electricity savings were achieved with low-energy LED lighting retrofits as part of general maintenance, a 1°C increase in chiller temperature operation at North Shore Hospital over summer to maximise plant operating efficiency, and a PC sleep programme, which reduces energy costs by $140K per year. The increase in gas was due to blocked steam traps identified and cleared through routine maintenance.

Improvements were made in waste and recycling with general waste 60% (target 60%), medical waste 20% (target 15%) and recycling 20% (target 25%). While the international recycling market shrank dramatically (especially plastic, cardboard and paper) during 2018/19, new recycling initiatives began and include single-use scissors, forceps and tweezers, as well as Johnson & Johnson surgical instruments, batteries (significant increase in departments), unwanted furniture not reused internally (Junk Run pilot), and collection of compostable cups for composting at Envirofert Ltd.

Compostable cup collection in action

Travel advice was provided to 244 staff at North Shore Hospital, resulting in 69 staff trialling public transport, 24 carpooling, 13 staff trialling e-bikes and the remainder knowing their commute options.

Junk Run enables reuse or recycling of unwanted furniture

A sustainable building approach has been recommended for the design of our new hospital facility to achieve whole-of-life value. Initiatives such as energy efficiency, and increasing patient and staff comfort through improved indoor environment quality, will improve outcomes through an integrated design approach.

Waitematā DHB Board members

Professor Judy McGregor, CNZM, Chair

Sandra Coney QSO

Brian Neeson

Kylie Clegg, Deputy Chair

Warren Flaunty QSM

Morris Pita

Prof Max Abbott, CNZM

Dr James Le Fevre

Allison Roe MBE

Edward Benson-Cooper

Dr Matire Harwood

Statement of Waivers

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

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

The following waivers were given during the last year:

Ministerial Waiver August 2018

The Minister of Health considered a request for a waiver for the use of the EmergencyQ app, which is contracted to the DHB by Morris Pita's business Healthcare Applications Limited. The Minister was satisfied that the EmergencyQ app is in the interest of both the public and the DHB and therefore, under clause 37 of schedule 3 of the Act granted Mr Pita a waiver in respect of the 2016 pilot agreement and for future transactions provided an RFP process is undertaken and due process is followed in assessing any proposals received.

Meeting of the Waitematā DHB Board 19 December 2018

An item 'Sponsorship Agreements via the Well Foundation' was not provided to Board members Sandra Coney and Warren Flaunty due to their disclosed interests as a member of the Portage Licensing Trust and as a Trustee (Vice President) of the Waitakere Licensing Trust respectively. Having noted their interests, the Board were satisfied under Schedule 3, clause 36 (4) that Sandra Coney and Warren Flaunty could remain in the meeting for the discussion of the item, but neither participated in the voting of the item.

Meeting of the Waitematā DHB Board 06 March 2019

Both Warren Flaunty and Morris Pita noted their disclosed interests related to pharmacies and an item related to the 'Enhanced Residential Care Pharmacy Services Consultation'. Both Mr Flaunty and Mr Pita advised that neither had direct or indirect involvement with residential care pharmacy services. Having noted their interests, the Board were satisfied under Schedule 3, clause 36 (4) that Warren Flaunty and Morris Pita could remain in the meeting for the discussion of the item, but neither participated in the voting of the item.

Meeting of the Waitematā DHB Board 17 April 2019

Edward Benson-Cooper noted his disclosed interest related to a family member's employment with Intra Limited in relation to an item 'Advanced Interventional Radiology Outsourcing'. The Board noted this declaration and were satisfied under Schedule 3, clause 36 (4) that Edward Benson-Cooper could remain in the meeting for the discussion of this item, but not participate in the deliberations or voting of the item.

Meeting of the Waitematā DHB Board 29 May 2019

In relation to an item 'Expansion of the Special Care Baby Unit at Waitakere Hospital' both Sandra Coney and Warren Flaunty noted their disclosed interests as a member of the Portage Licensing Trust and as a Trustee of the Waitakere Licensing Trust respectively. Having noted their interests, the Board were satisfied under Schedule 3, clause 36 (4) that Sandra Coney and Warren Flaunty could remain in the meeting for the discussion and voting of the item.

Meeting of the Waitematā DHB Board 21 August 2019

James Le Fevre noted his disclosed interest as an Emergency Department doctor with regard to an item about the 'Holidays Act Estimated Provisions for Waitematā DHB'. The Board noted this declaration and were satisfied under Schedule 3, clause 36 (4) that James Le Fevre could remain in the meeting for the discussion of this item, but not participate in the voting of the item.

Trusts

Waitematā DHB controls the Three Harbours Health Foundation.

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

Waitematā 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 2018/19 financial year, or those that remain current, are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in Apr-14 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in Jul-08, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

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

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas. An assessment of what has been achieved with Waitematā DHB's 2018/19 appropriations is detailed below.

Appropriations allocated and scope

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

What is intended to be achieved with this appropriation?

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

How performance will be assessed and end of year reporting

Each DHB has a statutory responsibility to prepare:

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

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

Amount of appropriations

	2017/18		2018/19	
	Final Budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,450,808	1,450,808	1,531,538	1,531,538
Supplementary estimates		13,650		10,010
Total appropriation revenue	1,450,808	1,464,458	1,531,538	1,541,548

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

Asset performance

Introduction

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

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

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

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

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

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

Facilities Asset Portfolio

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

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
1.1	**Facility condition** Percentage of occupied buildings rated as 'poor' or 'very poor' condition *Assessment of facility condition based on visual inspection, reported as % of overall buildings value in 'poor' or 'very poor' condition (condition grading levels: very poor, poor, average, good, very good).*	Condition	<5%	3%	<5%	5%
1.2	**Facility utilisation based on bed occupancy** Average Medical/Surgical Bed occupancy *Average occupation of inpatient beds throughout the year. (Excluding short stay and ICU beds). The occupation of beds provides an indication of total utilisation across wards and surgical theatres. The target reflects the variation between peak winter and low summer demand.*	Utilisation	≥85%	87%	≥85%	84.4%
1.3	**Theatre utilisation** Elective Theatre Utilisation *Performance against annual production plan for elective theatre utilisation. This measures how well the theatre spaces are utilised (across all surgeries) based on the number of 4 hour lists completed.*	Utilisation	≥95%	97%	≥95%	95.4%

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
1.4	**Seismic compliance** Number of owned occupied buildings classed as 'potentially earthquake prone' *Number of owned occupied buildings with seismic state based on NBS of <34%. The target reflects the importance of having facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	0	0	n/a this was previously reported as the % of buildings as below	
1.5	**Seismic compliance** Number of owned occupied buildings classed as "Potentially Earthquake Risk" *Number of owned occupied buildings with seismic state based on NBS of between 34% and 67%. The target reflects the importance of having patient and staff facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	<14	10	n/a this asset performance measure was introduced on 1 July 2018	
1.6	**Car parking compliance** Mobility car park spaces as a percentage of total car park spaces to be greater than NZ Guideline 4121 *Percentage of mobility spaces at Waitakere and North Shore Hospitals as percentage of total spaces. The target is based on the NZ Standards 4121 and was approved by the Waitematā DHB Disability Advisory Committee as part of delivering the NZ Disability Strategy.*	Functionality (Fitness for Purpose)	>100%	171% (more mobility spaces than required in standards)	>100%	177% (more mobility spaces than required in standards)

Clinical Equipment Asset Portfolio

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

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
2.1	**CT Scanners Condition** Compliance with six monthly physics testing *Assessment of CT integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%	100%	100%
2.2	**MRI Condition** Compliance with annual physics testing *Assessment of MRI integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%	100%	100%
2.3	**CT Scanners Utilisation** Annual CT screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available and staffing resources within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	109%	≥100%	113%
2.4	**MRI Utilisation** Annual MRI screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	127%	≥100%	105%

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
2.5	**Clinical Equipment Functionality** Critical clinical equipment passing monthly "Functionality test" *Percentage of critical clinical equipment that is inspected and passes functionality test against schedule. The target reflects the importance of having high criticality equipment fit for purpose and available when required. Critical clinical equipment are those that are classed as having high consequences associated with failure.*	Functionality (Fitness for Purpose)	100%	99%	100%	100%
2.6	**Clinical Equipment Condition (Age Based)** Critical clinical equipment less than 3 years past End-of-Life *Percentage of critical clinical equipment that has not reached the end of its useful life, or is up to 3 years past the end of its useful life, where useful life is an assumed typical working life for each type of equipment. This is a new measure introduced on 1 July 2018. The target reflects current performance and is being actively increased over time.*	Condition	>70%	81%	n/a this asset performance measure was introduced on 1 July 2018	
2.7	**Clinical Equipment Maintenance** Number of non-scheduled maintenance visits/total number of maintenance visits (critical clinical equipment) *Based on the number of assets that are subject to non-scheduled corrective maintenance, or risk/incident management as a percentage of total maintenance visits (annual preventative maintenance plus non-scheduled maintenance). This is a new measure introduced on 1 July 2018.*	Functionality (Fitness for Purpose)	<30%	36%	n/a this asset performance measure was introduced on 1 July 2018	

ICT Asset Portfolio

Waitematā DHB's ICT asset portfolio is owned, managed and maintained by healthAlliance, the shared service company owned by the DHBs in the Northern Region. Waitematā DHB has been working with healthAlliance and Treasury to improve the level of reporting for critical ICT assets. Nine new asset performance measures were implemented during 2018/19 as reported below.

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
3.1	**ICT Tier 1 Applications Functionality** Availability of IT Services (Tier 1 Apps) *Measures the operational integrity, performance and stability of Tier 1 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.99%	99.8%	99.99%
3.2	**ICT Tier 2 Applications Functionality** Availability of IT Services (Tier 2 Apps) *Measures the operational integrity, performance and stability of Tier 2 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/Number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.99%	99.8%	99.99%
3.3	**End User Devices – Asset Age** Percentage of devices compliant with asset age replacement policy *The percentage of end user devices (excl. mobile & tablet) that comply with the asset age specified in the DHB replacement policy.*	Condition	>75%	78%	n/a this asset performance measure was introduced on 1 July 2018	
3.4	**End User Devices - Security** Percentage of devices compliant with security update policy *Measures the date of the last security patch of end user devices (excl. mobile & tablet), then determines how many devices expressed as a percentage comply with the DHB security update policy.*	Condition	>80%	100%	n/a this asset performance measure was introduced on 1 July 2018	

Measure		Indicator	2018/19 Target	2018/19 Actual	2017/18 Target	2017/18 Actual
3.5	**Software (Applications) - Condition** Percentage of applications with installed version number older than n-1 *Shows which applications are either at the current version or are one version behind the current version.*	Condition	>55%	58%	n/a this asset performance measure was introduced on 1 July 2018	
3.6	**Software (Applications) – Service Interruptions** % of applications not experiencing Service Level Agreement (SLA) breaches (service interruptions) *Measures the percentage of applications that do not show as 'SLA breached' (service interruptions) on a per monthly count over a 12-month period.*	Functionality (Fitness for Purpose)	>80%	100%	n/a this asset performance measure was introduced on 1 July 2018	
3.7	**Software (Applications) – Redundancy or Resiliency** Percentage of applications architected for redundancy or resiliency *Percentage of Top 55 Tier 1 applications that are deployed on corresponding Tier 1 architecture at the end of the reporting period. Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).*	Functionality (Fitness for Purpose)	>30%	27%	n/a this asset performance measure was introduced on 1 July 2018	
3.8	**Software (Applications) – Supportability** Percentage of assets supportable under Tier 1 Service Level Agreement (SLA) guidelines *Percentage of Top 55 Tier 1 applications that are labelled 'supportable to Tier 1' at the end of the reporting period. Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).*	Functionality (Fitness for Purpose)	>31%	42%	n/a this asset performance measure was introduced on 1 July 2018	
3.9	**Technology Platforms (Physical and Virtual) – Condition** Percentage of windows systems that have been checked and patched, across all production and non-production environments. *Measures the percentage of systems that are captured and updated under the recently implemented rolling 13 week programme for server patching.*	Condition	>75%	100%	n/a this asset performance measure was introduced on 1 July 2018	
3.10	**Technology (Tier 1 and Tier 2 systems) – Service Interruptions** Number of Service Level Agreement (SLA) breaches (service interruptions) recorded against application asset over 12 month period. *Measures the count of unplanned service interruptions.*	Condition	<20	4	n/a this asset performance measure was introduced on 1 July 2018	
3.11	**Technology (Remote Platform) Utilisation** Percentage of staff able to access clinical/non-clinical system platforms remotely. *Measures the percentage of unique user's activity against the total users.*	Utilisation	>35%	41%	n/a this asset performance measure was introduced on 1 July 2018	

Financial statements

FINANCIAL STATEMENTS

Statement of Responsibility

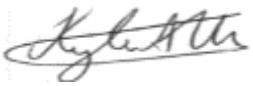
We are responsible for the preparation of the Waitematā District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waitematā District Health Board for the year ended 30 June 2019.

Signed on behalf of the Board:



Professor Judy McGregor, CNZM
Chair

Dated: 31 October 2019

Kylie Clegg
Deputy Chair

Dated: 31 October 2019

Statement of comprehensive revenue and expense for the year ended 30 June 2019

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Revenue						
Patient care revenue	2	1,804,618	1,688,957	1,804,618	1,759,818	1,688,957
Interest revenue		2,408	2,417	2,016	1,552	2,063
Other revenue	3	32,527	33,441	30,559	29,373	31,488
Total revenue	31	1,839,553	1,724,815	1,837,193	1,790,743	1,722,508
Expenditure						
Personnel costs	4	801,803	641,786	801,803	656,715	641,786
Depreciation and amortisation expense	13,14	30,229	29,608	30,229	30,882	29,608
Outsourced services		85,346	74,166	85,346	78,230	74,166
Clinical supplies		118,879	115,538	118,879	118,846	115,538
Infrastructure and non-clinical expenses		49,452	52,228	49,452	34,669	52,228
Other district health boards		309,105	299,498	309,105	313,818	299,498
Non-health board provider expenses		522,731	479,415	522,731	523,574	479,415
Capital charge	5	36,415	36,679	36,415	36,947	36,679
Other expenses	6	11,882	10,682	11,828	11,762	10,617
Total expenditure	31	1,965,842	1,739,600	1,965,788	1,805,443	1,739,535
Surplus/(deficit)		**(126,289)**	**(14,785)**	**(128,595)**	**(14,700)**	**(17,027)**
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations	19	0	15,938	0	0	15,938
Total other comprehensive revenue and expense		0	15,938	0	0	15,938
Total comprehensive revenue and expense		**(126,289)**	**1,153**	**(128,595)**	**(14,700)**	**(1,089)**

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

The accompanying notes form part of these financial statements.

Statement of changes in net assets/equity for the year ended 30 June 2019

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Balance at 1 July		626,849	625,696	613,126	608,935	614,215
Equity injections		2,200	0	2,200	0	0
		629,049	625,696	615,326	608,935	614,215
Comprehensive Income						
Surplus/(Deficit)		(126,289)	(14,785)	(128,595)	(14,700)	(17,027)
Prior year adjustments		(463)	0	(463)	0	0
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations		0	15,938	0	0	15,938
Total comprehensive revenue and expense for the year		**(126,752)**	**1,153**	**(129,058)**	**(14,700)**	**(1,089)**
Balance at 30 June	19	**502,297**	**626,849**	**486,268**	**594,235**	**613,126**

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

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2019

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Assets						
Current assets						
Cash and cash equivalents	7	41,053	32,534	36,685	13,719	29,077
Receivables	8	56,357	55,362	55,685	57,245	55,179
Investments	9	750	1,126	0	1,426	0
Inventories	10	8,256	7,933	8,256	8,629	7,933
Prepayments		931	759	931	1,259	759
Assets held for sale	11	21,600	0	21,600	0	0
Total current assets		128,947	97,714	123,157	82,278	92,948
Non-current assets						
Investments	9	10,713	8,922	0	9,918	0
Investments in associates and joint ventures	12	40,091	39,782	40,091	40,086	39,782
Property, plant and equipment	13	713,965	751,150	713,965	732,149	751,150
Intangible assets	14	15,064	3,730	15,064	3,881	3,730
Total non-current assets		779,833	803,584	769,120	786,034	794,662
Total assets		**908,780**	**901,298**	**892,277**	868,312	**887,610**
Liabilities						
Current liabilities						
Payables	15	113,522	105,795	113,048	101,674	105,830
Borrowings	16	60	256	60	256	256
Employee entitlements	17	122,059	120,060	122,059	123,006	120,060
Provisions	18	4,776	4,653	4,776	2,263	4,653
Total current liabilities		240,417	230,764	239,943	227,199	230,799
Non-current liabilities						
Borrowings	16	0	86	0	22	86
Employee entitlements	17	166,066	43,599	166,066	46,856	43,599
Total non-current liabilities		166,066	43,685	166,066	46,878	43,685
Total liabilities		**406,483**	**274,449**	**406,009**	274,077	**274,484**
Net assets		**502,297**	**626,849**	**486,268**	594,235	**613,126**
Equity						
Contributed Capital	19	381,921	379,721	381,921	379,721	379,721
Accumulated surpluses/(deficits)	19	(185,103)	(56,045)	(185,103)	(72,721)	(56,045)
Property Revaluation Reserves	19	289,450	289,450	289,450	287,235	289,450
Trust funds	19	16,029	13,723	0	0	0
Total equity		**502,297**	**626,849**	**486,268**	**594,235**	**613,126**

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

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2019

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Budget 2019 $000	Actual 2018 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,772,663	1,675,846	1,772,663	1,761,370	1,675,846
Other		61,865	39,490	60,954	29,373	37,850
Interest received		2,267	2,076	2,267	1,552	2,076
Payments to suppliers		(1,088,796)	(1,017,136)	(1,088,796)	(1,080,374)	(1,017,136)
Payments to employees		(677,605)	(624,385)	(677,605)	(656,715)	(624,385)
Payments for capital charge		(36,415)	(36,679)	(36,415)	(36,947)	(36,679)
GST (net)		(159)	1,523	(159)	0	1,523
Net cash flow from operating activities	20	33,820	40,735	32,909	18,259	39,095
Cash flows from investing activities						
Purchase of property, plant and equipment		(26,215)	(24,878)	(26,215)	(34,533)	(24,878)
Acquisition of investments		(1,286)	(2,952)	(1,286)	0	(2,952)
Net cash flow from investing activities		(27,501)	(27,830)	(27,501)	(34,533)	(27,830)
Cash flows from financing activities						
Capital contributions from the Crown		2,200	0	2,200	0	0
Net cash flow from financing activities		2,200	0	2,200	0	0
Net (decrease)/increase in cash and cash equivalents		**8,519**	**12,905**	**7,608**	**(16,274)**	**11,265**
Cash and cash equivalents at the start of the year		32,534	19,629	29,077	29,993	17,812
Cash and cash equivalents at the end of the year	7	**41,053**	**32,534**	**36,685**	**13,719**	**29,077**

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

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1 Statement of accounting policies for the year ended 30 June 2019

Reporting entity

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

The consolidated financial statements of Waitematā DHB for the year ended 30 June 2019 comprise Waitematā DHB and its subsidiaries (together referred to as the "Group"). The Group consists of the controlling entity, Waitematā District Health Board and Three Harbours Health Foundation.

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

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

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

The financial statements for the DHB and the Group are for the year ended 30 June 2019, and were approved for issue by the Board on 31 October 2019.

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, except where otherwise stated below.

Statement of compliance

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

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

Measurement base

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

Presentation currency and rounding

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

Changes in accounting policies and disclosures – New and amended standards and interpretations

The Group applied PBE IFRS 9 for the first time and transitional provisions were applied in adopting PBE IFRS 9. The nature and effect of the changes as a result of adoption of this new accounting standard are described below. Several other amendments and interpretations apply for the first time in 2018/19, but do not have an impact on the consolidated financial statements of the Group. Aside from PBE IFRS 9, the Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. When applied, this standard supersedes parts of PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Compared with PBE IPSAS 29, PBE IFRS 9 introduces a number of changes to the recognition and measurement of financial instruments. The DHB and Group has not applied PBE IFRS 9 retrospectively.

PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. However, all entities who report their financial statements (actuals and forecasts) in accordance with Crown accounting policies are required to adopt the new accounting standard PBE IFRS 9 at the same time as the for-profit sector, for annual periods beginning on or after 1 January 2018.

The main changes under PBE IFRS 9 that are relevant to The DHB and Group 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 is prescribed based on expected credit losses rather than previously incurred losses. Therefore it is no longer necessary for a trigger event to have occurred before recognising credit losses.

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

The effects of the implementation of PBE IFRS 9 are as follows:

- The classification of Financial Assets was revised. There was no material impact arising as a result of remeasurement of financial assets that have been classified differently under PBE IFRS 9.
- The expected credit loss model has been applied as outlined by the standard. This has impacted the valuation of both the current year and prior year receivables balances through the provision for impairment. Following application of PBE IFRS 9, there is a $463,000 increase in credit loss between the previous carrying amount of receivables in the 2017/18 financial statements ($2.27 million) and the carrying amount at the beginning of the 2018/19 reporting period ($2.74 million). This has been recognised in opening accumulated funds, as shown in the statement of changes in equity.
- The financial effects on other financial assets are not material and the balances are not adjusted. While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the expected credit loss is trivial.
- The requirements of PBE IFRS 29 for classification and measurement of financial liabilities were carried forward in PBE IFRS 9, so the Group's accounting policy with respect to financial liabilities is unchanged.

Standards issued and not yet effective, and not early adopted

PBE IPSAS 34 *Separate Financial Statements*; PBE IPSAS 35 *Consolidated Financial Statements*; PBE IPSAS 36 *Investments in Associates and Joint Ventures*; PBE IPSAS 37 *Joint Arrangements* and PBE IPSAS 38 *Disclosure of Interests in Other Entities*

The NZASB issued these standards to incorporate the equivalent standards issued by the IPSASB into PBE Standards. These standards replace PBE IPSAS 6, PBE IPSAS 7 and PBE IPSAS 8 and are effective for annual periods beginning on or after 1 January 2019. Early application of these standards is permitted, as long as all the standards are applied at the same time.

The key changes introduced by the new standards that are expected to impact the DHB and Group are as follows.

(a) Control: The new standards introduce an amended definition of control including extensive guidance on this definition. The DHB does not expect the new standards to result in the consolidation of additional entities.

(b) Joint arrangements: PBE IPSAS 37 Introduces a new classification of joint arrangements, sets out the accounting requirements for each type of arrangement (joint operations and joint ventures), and removes the option of using the proportionate consolidation method. The DHB will not reclassify any joint arrangements under the new standards, and will continue to account for this interest using the equity method in the consolidated financial statements of the Group and at cost in the DHB's separate financial statements.

(c) Disclosures on interests in other entities: The standards disclosure of information about their interests in other entities, including some additional disclosures that are not currently required under PBE IPSAS 6, 7 and 8.

This will result in additional disclosures for the Group and DHB regarding controlled entities, associates and joint arrangement.

Waitematā DHB is not early adopting these standards.

PBE IPSAS 39 Employee Benefits

PBE IPSAS 39 replaces the current standard on employee benefits, PBE IPSAS 25 Employee Benefits. PBE IPSAS 39 is based on IPSAS 39, which was issued by the IPSASB to update its standards for the amendments to IAS 19 by the IASB during the 2011-2015 period.

The new standard could impact the DHB and Group in relation to the classification of employee benefits as either short-term or other long-term employee benefits. The standard is effective for annual periods beginning on or after 1 January 2019. In general, entities must apply PBE IPSAS 39 retrospectively.

The new standard also changes the accounting for defined benefit plans as follows:

- Removes the option to defer the recognition of certain actuarial gains and losses arising from defined benefit plans (the "corridor approach");
- Eliminates some of the presentation options for actuarial gains and losses arising from defined benefit plans;
- Introduces the net interest approach, which is to be used when determining the defined benefit cost for defined benefit plans; and
- Structures the disclosures for defined benefit plans according to explicit disclosure objectives for defined benefit plans.

The new standard will have the following impact on the DHB's financial statements.

The DHB's current treatment of defined benefit plans is to treat them as defined contribution schemes. This is due to insufficient information being available to use defined benefit accounting as outlined in the Superannuation schemes accounting policy. The DHB's treatment of the defined benefit plans would remain the same when adopting PBE IPSAS 39.

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

Subsidiaries
Subsidiaries are entities in which Waitematā 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 Waitematā DHB and its subsidiaries, the acquisition of which are accounted for using the acquisition method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In Waitematā DHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

Joint 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 DHB 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.

Revenue from exchange transactions
MoH population-based revenue
The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Waitematā region. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

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

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

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

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

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

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

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

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

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

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

Leases
Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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

Foreign currency transactions
Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into 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.

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

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

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

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

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

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

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

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

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

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

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

Financial liabilities at amortised cost
Initial recognition and measurement
Financial liabilities are classified, at initial recognition, as financial liabilities at fair value through surplus or deficit, or at amortised costs, as appropriate. All financial liabilities are recognised initially at fair value and, in the case financial liabilities at amortised cost, net of directly attributable transaction costs. The DHB's and Group's financial liabilities include trade creditors and other payables, borrowings including an overdraft facility which are classified at amortised cost. The DHB has not classified any financial liabilities as financial liabilities through surplus or deficit. Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

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

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

Derecognition
A financial liability is derecognised when the obligation under the liability is discharged or cancelled or expires.

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

Inventories
Inventories held for distribution at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

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

- Land
- Buildings (including fit outs and underground infrastructure)
- Clinical Equipment
- IT Equipment
- Other Equipment and Motor Vehicles.

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

Revaluations
Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value at the reporting date. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

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

Additions
The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost less impairment, and is not depreciated. In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction it is recognised at fair value as at the date of acquisition.

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

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

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:

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

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

Finance, Procurement and Information Management System (formerly National Oracle Solution)
The Finance, Procurement and Information Management System (FPIM) (previously part of the National Oracle Solution programme), is 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. Waitematā DHB holds an asset at cost of capital invested by the DHB in FPIM. This investment represents the right to access the FPIM assets and is considered to have an indefinite life. DHBs have the ability and intention to 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.

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

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.

Make Good Lease Provision

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

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

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

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

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

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

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

Goods and services tax
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

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

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

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

Cost allocation
The DHB has determined the cost of outputs using the cost allocation system outlined below. Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output. There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

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

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

1 Statement of accounting policies for the year ended 30 June 2019 (continued)

Land and building revaluations
Note 13 provides information about the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads. The significant assumptions applied in determining the fair value and buildings are disclosed in note 13.

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

Holiday Pay Provision
Refer to Note 17 for details on the exposure in relation to the estimates and uncertainties surrounding holiday provisions.

Provision for expected credit losses
The Group uses a provision matrix to calculate ECLs for trade and other receivables and contract assets. The provision rates are based on days past due. The ECL calculation is initially based on the Group's historical observed default rates. The Group will adjust the historical credit loss experience with forward-looking information. For instance, if forecast economic conditions are expected to deteriorate over the next year, the historical default rates are adjusted. At every reporting date, the historical observed default rates are updated and changes in the forward-looking estimates are analysed. The assessment of the correlation between historical observed default rates, forecast economic conditions and ECLs is a significant estimate. The amount of ECLs is sensitive to changes in circumstances and of forecast economic conditions. The Group's historical credit loss experience and forecast of economic conditions may also not be representative of customer's actual default in the future. The information about the ECLs on the Group's trade receivables and contract assets is disclosed in Note 8.

Critical judgements in applying accounting policies
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 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 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Health and disability services (MOH contracted revenue)	1,677,063	1,585,840	1,677,063	1,585,840
ACC contract revenue	11,700	10,775	11,700	10,775
Inter district patient inflows	84,384	80,691	84,384	80,691
Revenue from other district health boards	7,393	5,852	7,393	5,852
Other patient sourced revenue	24,078	5,799	24,078	5,799
Total patient care revenue	**1,804,618**	**1,688,957**	**1,804,618**	**1,688,957**

3 Other revenue

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Clinical Training Agency	9,868	9,674	9,868	9,674
Donations and bequests received	604	753	604	746
Rental revenue	941	915	941	915
Professional, training and research	5,167	4,565	4,537	3,464
Other revenue	15,947	17,534	14,609	16,689
Total other revenue	**32,527**	**33,441**	**30,559**	**31,488**

4 Personnel costs

	Notes	Group		Parent	
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Salaries and wages		656,165	604,263	656,165	604,263
Contributions to defined contribution schemes		21,172	19,374	21,172	19,374
Increase/(decrease) in liability for employee entitlements		124,466	18,149	124,466	18,149
Total personnel costs		**801,803**	**641,786**	**801,803**	**641,786**

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

5 Capital charge

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six month actual closing equity balance. The capital charge rate for the year ended 30 June 2019 was 6% (2018: 6%).

6 Other expenses

		Group		Parent	
		Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Audit fees for Waitematā DHB financial statement audit		232	219	232	219
Audit fees (for subsidiary financial statements)		0	0	0	0
Operating lease expense		8,891	8,480	8,891	8,480
Impairment of debtors		2,310	1,578	2,310	1,578
Board members fees	24	359	343	359	343
Other expenses		90	62	36	(3)
Total other expenses		**11,882**	**10,682**	**11,828**	**10,617**

7 Cash and cash equivalents

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value.

Cash and cash equivalents include funds of $4.368m (2018: $3.457m) generated for specific purposes such as research. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

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

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Cash at bank and on hand	2,618	1,707	0	0
Call deposits	1,750	1,750	0	0
NZ Health Partnerships Limited	36,685	29,077	36,685	29,077
Total cash and cash equivalents for the purposes of the statement of cash flows	**41,053**	**32,534**	**36,685**	**29,077**

8 Receivables

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Ministry of Health	23,823	27,239	23,823	27,239
Other receivables	10,875	9,857	10,203	9,674
Other accrued revenue	24,899	20,539	24,899	20,539
Less: Provision for impairment	(3,240)	(2,273)	(3,240)	(2,273)
Total receivables	**56,357**	**55,362**	**55,685**	**55,179**

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 2019			Group 2018		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	51,097	(3)	51,094	48,132	0	48,132
Past due 1-30 days	3,159	(266)	2,893	5,394	(395)	4,999
Past due 31-60 days	1,329	(227)	1,099	985	(217)	768
Past due 61-90 days	290	(192)	98	274	(93)	181
Past due >90 days	3,725	(2,552)	1,173	2,850	(1,568)	1,282
Total	**59,597**	**(3,240)**	**56,357**	**57,635**	**(2,273)**	**55,362**

	Parent 2019			Parent 2018		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	50,425	(3)	50,422	47,949	0	47,949
Past due 1-30 days	3,159	(266)	2,893	5,394	(395)	4,999
Past due 31-60 days	,326	(227)	1,099	985	(217)	768
Past due 61-90 days	290	(192)	98	274	(93)	181
Past due >90 days	3,725	(2,552)	1,173	2,850	(1,568)	1,282
Total	**58,925**	**(3,240)**	**55,685**	**57,452**	**(2,273)**	**55,179**

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

PBE IFRS 9 was applied in determining the provision for impairment.

8 Receivables (continued)

Provision for impairment is calculated based on a review of significant debtor balances and an assessment of impairment using an "expected credit loss" model. The impairment assessment is based on an analysis of the likelihood to pay based on current circumstances and past collection history and write-offs.

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

	Group		Parent	
	2019 $000	2018 $000	2019 $000	2018 $000
Balance at 1 July	2,273	2,289	2,273	2,289
Additional provisions made	2,310	1,578	2,310	1,578
Receivables written off	(1,343)	(1,594)	(1,343)	(1,594)
Balance at 30 June	**3,240**	**2,273**	**3,240**	**2,273**

9 Investments

	Group		Parent	
	2019 $000	2018 $000	2019 $000	2018 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	750	1,126	0	0
Total current portion	750	1,126	0	0
Non-current portion				
Portfolio investments	10,713	8,922	0	0
Total non-current portion	10,713	8,922	0	0
Total investments	**11,463**	**10,048**	**0**	**0**

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

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

The fair value of portfolio investment with a remaining duration greater than 12 months is $10.713m (2018: $8.922m). 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 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Pharmaceuticals	787	721	787	721
Surgical and medical supplies	7,469	7,212	7,469	7,212
Total inventories	**8,256**	**7,933**	**8,256**	**7,933**

The write-down of inventories held for distribution amounted to $nil (2018: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2018: $nil). However, some inventories are subject to retention of title clauses.

11 Assets held for sale

Parent and group	Land $000	Buildings $000	Total $000
Balance at 1 July 2018	0	0	0
Transfer from Property, plant and equipment	12,212	9,388	21,600
Total assets held for sale	**12,212**	**9,388**	**21,600**

Assets held for sale relate to the planned sale of 44 Taharoto Road and are held as a current asset. As at balance sheet date, they are measured at the lower of their carrying amount and fair value less cost to sell.

12 Investments in associates and joint ventures

	Interest held 30 Jun 2019	Balance date
Investments in joint ventures		
healthAlliance N.Z. Limited – Class A shares	25%	30 Jun
New Zealand Health Partnerships Limited	5%	30 Jun
Investments in associates		
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	33.30%	30 Jun
South Kaipara Medical Centre	20%	30 Jun

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

Value of investments in associates, joint ventures and partnerships

	Group		Parent	
	2019 $000	2018 $000	2019 $000	2018 $000
healthAlliance N.Z. Limited	39,779	39,470	39,779	39,470
South Kaipara Medical Centre	88	88	88	88
McCrae Research	224	224	224	224
Total investments	**40,091**	**39,782**	**40,091**	**39,782**

There were no impairment losses in the value of associates and joint ventures assessed for 2019 (2018: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $39.779m (2018: $39.470m).

Summary of financial information of joint ventures and associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2019					
New Zealand Health Partnerships Limited	287,185	258,271	28,914	34,345	(38,029)
healthAlliance N.Z. Limited	212,822	31,312	181,570	155,895	291
Northern Regional Alliance Ltd	22,347	19,891	2,456	14,897	913
South Kaipara Medical Centre	512	221	291	2,299	68
Total	**522,926**	**309,695**	**213,231**	**207,436**	**(36,757)**
2018					
New Zealand Health Partnerships Limited	373,341	315,924	57,417	37,577	(4,263)
healthAlliance N.Z. Limited	191,996	31,337	160,659	136,513	(492)
New Zealand Health Innovation Hub Limited Partnership	573	47	526	56	(191)
Northern Regional Alliance Ltd	12,660	11,224	1,436	14,289	(107)
South Kaipara Medical Centre	484	261	223	2,216	(91)
Total	**579,054**	**358,793**	**220,261**	**190,651**	**(5,144)**

Waitematā DHB withdrew from New Zealand Health Innovation Hub Limited Partnership in July 2018 and transferred its equity to the other partners for no consideration.

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

	2019 $000	2018 $000
Share of surplus/(deficit) before tax:	(1,511)	(438)
Less: Tax expense	0	0
Share of surplus/(deficit)	**(1,511)**	**(438)**

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

13 Property, plant and equipment

Parent and Group	Land $000	Buildings $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Cost or valuation							
Balance at 1 July 2017	224,310	461,260	121,691	31,805	4,179	55,991	899,236
Additions from WIP	0	32,907	6,580	1,807	246	(41,540)	0
Revaluation increase/(decrease)	37,817	(75,251)	0	0	0	0	(37,434)
Additions to WIP	0	0	0	0	0	24,878	24,878
Disposals	0	0	0	0	0	(3,379)	(3,379)
Balance at 30 June 2018	262,127	418,916	128,271	33,612	4,425	35,950	883,301
Balance at 1 July 2018	262,127	418,916	128,271	33,612	4,425	35,950	883,301
Additions from WIP	0	10,874	9,412	3,870	456	(24,612)	0
Revaluation increase/(decrease)	0	0	0	0	0	0	0
Additions to WIP	0	0	0	0	0	22,267	22,267
Disposals	0	(476)	(268)	(1,023)	0	0	(1,767)
Transfer to intangible assets	0	0	0	0	0	(10,218)	(10,218)
Transfer to assets held for sale	(12,212)	(9,388)	0	0	0	0	(21,600)
Balance at 30 June 2019	249,915	419,926	137,415	36,459	4,881	23,387	871,983
Accumulated depreciation and impairment losses							
Balance at 1 July 2017	0	40,649	88,480	23,580	4,039	0	156,748
Depreciation expense	0	19,675	7,342	2,338	82	0	29,437
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	0	0	0	0
Elimination on revaluation	0	(54,034)	0	0	0	0	(54,034)
Balance at 30 June 2018	0	6,290	95,822	25,918	4,121	0	132,151
Balance at 1 July 2018	0	6,290	95,822	25,919	4,121	0	132,151
Depreciation expense	0	17,015	7,435	2,220	231	0	26,901
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	55	(94)	(996)	0	0	(1,035)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2019	0	23,360	103,163	27,143	4,354	0	158,017
Carrying amounts							
At 1 July 2017	224,310	420,611	33,211	8,225	140	55,991	742,488
At 30 June and 1 July 2018	262,127	412,626	32,449	7,694	304	35,950	751,150
At 30 June 2019	249,915	396,566	34,252	9,316	529	23,387	713,965

The net carrying amount of assets held under finance leases is $60k (2018: $342k) for clinical equipment. IT assets in Work In Progress of $360k (2018: $12.073m) 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 were made to the 'unencumbered' land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership. The most recent valuation of land and buildings was only desktop and is not reflected in the numbers. This revaluation confirmed the carrying value of land and buildings at 30 June 2019 still approximates fair value at this time.

Buildings

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

- the replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity
- the replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information
- the remaining useful life of assets is estimated and is adjusted where relevant for the condition of the asset, management's best estimates of future maintenance and replacement plans, and experiences with similar buildings

13 Property, plant and equipment (continued)

- straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset
- judgments were made on the extent to which infrastructure value is compromised based on the information available
- adjustments were made for the estimated capital costs to be incurred to maintain the continued function of buildings, as a deduction from the asset values.

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

Work in progress

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

	2019 $000	2018 $000
Buildings	19,474	17,198
Clinical equipment	1,943	5,348
Other equipment	1,610	1,331
IT equipment	360	12,073
Total work in progress	**23,387**	**35,950**

Impairment

No impairment loss has been identified in property, plant and equipment in 2019 (2018 : nil).

Restrictions on title

The DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold. Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981 and, in relation to some land, a right of first refusal in favour of Tamaki Makaurau pursuant to the provisions of a Deed of Settlement with the Crown in relation to Treaty of Waitangi claims. Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims has been estimated in the value of the land.

14 Intangible assets

Movements for each class of intangible assets are as follows.

Parent and Group	FPIM Rights $000	Acquired Software $000	Work in Progress $000	Total $000
Cost				
Balance at 30 June 2017	4,819	3,668	0	8,487
Additions from WIP	0	152	0	152
Impairment	(1,323)	0	0	(1,323)
Balance at 30 June 2018	**3,496**	**3,820**	**0**	**7,316**
Additions to WIP*	976	0	15,310	16,286
Additions from WIP	0	10,218	(10,218)	0
Impairment	(1,623)	0	0	(1,623)
Balance at 30 June 2019	2,849	14,038	5,092	21,979
Accumulated amortisation and impairment losses				
Balance at 30 June 2017	0	3,416	0	3,416
Amortisation expense	0	170	0	170
Balance at 30 June 2018	**0**	**3,586**	**0**	**3,586**
Amortisation expense	0	3,329	0	3,329
Balance at 30 June 2019	0	6,915	0	6,915
Carrying amounts				
At 1 July 2017	4,819	252	0	5,071
At 30 June 2018	**3,496**	**234**	**0**	**3,730**
At 30 June 2019	**2,849**	**7,123**	**5,092**	**15,064**

*This includes transfer from PPE WIP

14 Intangible assets (continued)

Finance, Procurement and Information Management System (FPIM); previously known as the National Oracle Solution (NOS)
The FPIM rights were tested for impairment at 30 June 2019 by comparing the carrying amount of the intangible asset to its recoverable service amount. For the year ended 30 June 2019, the following impairment indicators were determined to exist:

- there was a delay in government's decision on the business case
- 10 of the 20 DHBs decided not to continue participating in the programme
- the project's scope was further reduced and is expected to result in a revised level of economic benefits or service potential.

The process to determine the recoverable service amount of the assets related to the project involved:

- derecognising components of the asset that are no longer expected to be used by reviewing the cost of each work stream and activity that has been previously capitalised
- determining the revised recoverable service amount of the remaining assets based on the re-scoped project and writing the carrying value down to that value.

To support the estimate of the Optimised Depreciated Replacement Cost of the programme assets, the estimated present value of benefits the remaining DHBs expect to generate from the programme once it is completed and fully implemented has been determined. It has been concluded that a further impairment of $1.624m (2018: $1.323m) of the FPIM carrying amount was required for the year ended 30 June 2019. In July 2019 the Minister of Health confirmed that the FPIM preferred option business case presented to Cabinet in June 2019 was approved to proceed for 10 DHBs (including Waitematā DHB). The Ministry of Health will assume interim responsibility for the programme, and the programme will transfer to another entity or entities on a permanent basis (from NZHPL) by the end of 2019.

15 Payables

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Creditors and accrued expenses	99,432	93,045	98,958	93,080
Revenue in advance	5,338	3,837	5,338	3,837
GST payable	8,752	8,913	8,752	8,913
Capital charge payable	0	0	0	0
Total payables	**113,522**	**105,795**	**113,048**	**105,830**

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

16 Borrowings

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Current portion				
Finance leases	60	256	60	256
Non-current portion				
Finance leases	0	86	0	86
Total borrowings	60	342	60	342
Borrowing facility limits				
Overdraft facility	0	0	0	0
Total borrowing facility limits	**0**	**0**	**0**	**0**

16 Borrowings (continued)

Finance leases	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Minimum lease payments payable				
No later than one year	60	315	60	315
Later than one year and not later than five years	0	105	0	105
Later than five years	0	0	0	0
Total minimum lease payments	60	420	60	420
Future finance charges	0	(78)	0	(78)
Present value of minimum lease payments	**60**	**342**	**60**	**342**
Present value of minimum lease payments				
No later than one year	60	256	60	256
Later than one year and not later than five years	0	86	0	86
Later than five years	0	0	0	0
Total present value of minimum lease payments	**60**	**342**	**60**	**342**

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 13.

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.

17 Employee entitlements

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Current portion				
Accrued salaries and wages	6,942	5,228	6,942	5,228
Annual leave	81,636	74,740	81,636	74,740
Sick leave	1,119	942	1,119	942
Sabbatical leave	150	138	150	138
Continuing medical education	6,162	8,197	6,162	8,197
Work-related entitlements	(136)	21	(136)	21
Unpaid payroll	6,972	6,266	6,972	6,266
Payroll provisions	6,593	10,205	6,593	10,205
Unsettled CEAs	3,959	6,781	3,959	6,781
Long service leave	2,886	2,675	2,886	2,675
Retirement gratuities	5,776	4,867	5,776	4,867
Total current portion	122,059	120,060	122,059	120,060
Non-current portion				
Holiday pay provision	124,800	10,500	124,800	10,500
Continuing medical education	7,843	5,036	7,843	5,036
Long service leave	8,172	6,972	8,172	6,972
Sabbatical leave	2,823	2,507	2,823	2,507
Retirement gratuities	19,766	16,276	19,766	16,276
Sick leave	2,662	2,308	2,662	2,308
Total non-current portion	166,066	43,599	166,066	43,599
Total employee entitlements	**288,125**	**163,659**	**288,125**	**163,659**

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

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

17 Employee entitlements (continued)

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the Waitematā DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

Waitematā DHB also had its sampling strategy and extrapolation reviewed by AON Limited, the DHB's actuarial advisor to provide comfort to the Board that the estimated liability is reliable, given the inherent uncertainty that still remains in considering this issue.

The amount provided in the Board's accounts as at 30 June 2019 is $124.8m, and includes an estimate of the administrative, and software update costs to complete this process. The provision has been based on the DHB's interpretation of the Holidays Act legislation, the MOU and current knowledge of the payroll system issues regarding application of the Act.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties around the quantum and timing of the eventual settlement.

In developing this provision we have made assumptions that the outcome of the sample tested is representative of the whole population, and because of the estimates and assumptions the actual liability could be significantly different to the $124.8m estimate. This will not be known until further work is completed next financial year.

18 Provisions

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Current portion				
ACC Partnership Programme	1,834	2,363	1,834	2,363
Make good provision	2,942	2,290	2,942	2,290
Total current portion	4,776	4,653	4,776	4,653

Movements for each class of provision	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Balance at 1 July	4,653	1,051	4,653	1,051
Movement in provisions	123	3,602	123	3,602
Amounts used	0	0	0	0
Balance at 30 June	**4,776**	**4,653**	**4,776**	**4,653**

18 Provisions (continued)

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2019. 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 8.1% (2018: 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 1.52% (2018: 1.7%)
- a weighted average discount factor of 1.83% (2018: 2.3%) was applied.

Insurance risk

The DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit. The DHB is responsible for managing claims for a period of up to 24 months following the lodgement date. At the end of 24 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

19 Equity

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Crown equity				
Balance at 1 July	379,721	379,721	379,721	379,721
Capital contributions from the Crown	2,200	0	2,200	0
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	381,921	379,721	381,921	379,721
Accumulated surpluses/(deficits)				
Balance at 1 July	(56,045)	(39,018)	(56,045)	(39,018)
Prior year adjustments	(463)	0	(463)	0
	(56,508)	(39,018)	(56,508)	(39,018)
Surplus/(deficit) for the year	(126,289)	(14,785)	(128,595)	(17,027)
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(2,306)	(2,242)	0	0
Balance at 30 June	(185,103)	(56,045)	(185,103)	(56,045)
Revaluation reserves				
Balance at 1 July	289,450	273,512	289,450	273,512
Impairment loss	0	0	0	0
Revaluations	0	15,938	0	15,938
Balance at 30 June	289,450	289,450	289,450	289,450
Revaluation reserves consist of:				
Land	247,275	247,275	247,275	247,275
Buildings	42,175	42,175	42,175	42,175
Total revaluation reserves	289,450	289,450	289,450	289,450
Trust Funds				
Balance at 1 July	13,723	11,481	0	0
Movement	2,306	2,242	0	0
Balance at 30 June	16,029	13,723	0	0
Total equity	**502,297**	**626,849**	**486,268**	**613,126**

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

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Net surplus/(deficit)	(126,289)	(14,785)	(128,595)	(17,027)
Add/(less) non-cash items				
Depreciation and amortisation expense	30,229	29,608	30,229	29,608
Total non-cash items	30,229	29,608	30,229	29,608
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/loss investments	1,624	1,323	1,624	1,323
Investments in associates – healthAlliance	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	(26)	0	(26)	0
	1,598	1,323	1,598	1,323
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(399)	(5,761)	(1,310)	(5,159)
Inventories	(323)	(380)	(323)	(380)
Creditors and other payables	4,683	9,728	6,989	9,728
Provisions	123	3,602	123	3,602
Employee entitlements	124,198	17,400	124,198	17,400
Net movements in working capital items	128,282	24,589	129,677	25,191
Net cash flow from operating activities	**33,820**	**40,735**	**32,909**	**39,095**

21 Capital commitments and operating leases

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Capital commitments				
Property	1,301	655	1,301	655
Equipment	2,107	2,095	2,107	2,095
Total capital commitments	**3,408**	**2,750**	**3,408**	**2,750**

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

Non-cancellable operating lease commitments as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Not later than one year	6,441	3,970	6,441	3,970
Later than one year and not later than five years	16,949	2,142	16,949	2,142
Later than five years	5,581	0	5,581	0
Total non-cancellable operating leases as lessee	**28,971**	**6,112**	**28,971**	**6,112**

The DHB leases a number of buildings under operating leases. There has been a significant increase in the DHB's operating lease commitments as lessee from 2018. The renewal or start of key leases during the year led to an increase in total commitments of $14.5m over the remaining term of their contracted periods. These leases include; Pitman House, Q4 Smales Farm, Hibiscus Coast Community Health, Community Dialysis Centre, 3 Shea Terrace and 37 Taharoto Road. The remainder of the variance is mainly attributable to a change in methodology which we do not consider to have a material impact on the disclosure.

22 Contingencies

Contingent liabilities

Lawsuits against the DHB

Waitematā DHB and its associates were notified of potential legal claims at 30th June 2019 which creates a contingent liability totalling approximately $180k (2018: approximately $40k). At balance date, Unitec Institute of Technology have granted $174k (2018: $261k) 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, Waitematā DHB would need to repay some, or all, of this amount.

23 Related party transactions

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

Significant transactions with government-related entities

The DHB has received funding from the Crown and ACC of $1.689b (2018: $1.597b) to provide health services in the Waitematā area for the year ended 30 June 2019.

Transactions with key management personnel

Key management personnel compensation	Actual 2019 $000	Actual 2018 $000
Board members:		
Remuneration	346	343
Full-time equivalent members	11	11
Salaries and other employee benefits of Executive Leadership Team	3,267	3,399
Full-time equivalent members	10	11
Total key management personnel remuneration	**3,613**	**3,742**
Total full-time equivalent personnel	**21**	**22**

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board Members. Key management personnel include the Chief Executive and the other nine members of the management team (2018: ten members). No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2018: $nil).

24 Board member remuneration

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

	Actual 2019 $000	Actual 2018 $000
Prof Judith McGregor (Chair)	60	3
Dr Lester Levy	0	45
Prof Max Abbott	27	28
Edward Benson-Cooper	28	27
Sandra Coney	27	28
Kylie Clegg	36	43
Warren Flaunty	30	28
James Le Fevre	29	28
Morris Pita	28	29
Allison Roe	27	28
Matire Harwood	26	27
Brian Neeson	28	29
Total board member remuneration	**346**	**343**

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to: $1k (2018: nil) – Anthony Norman (Audit and Finance Committee) and $12k (2018:$2k) – Norman Wong (Audit and Finance Committee).

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 (2018: $nil).

25 Employee remuneration

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

	Actual 2019	Actual 2018		Actual 2019	Actual 2018
$100,000 – 109,999	382	253	$340,000 – 349,999	13	16
$110,000 – 119,999	224	163	$350,000 – 359,999	14	9
$120,000 – 129,999	164	114	$360,000 – 369,999	9	9
$130,000 – 139,999	72	63	$370,000 – 379,999	11	16
$140,000 – 149,999	51	43	$380,000 – 389,999	5	10
$150,000 – 159,999	33	33	$390,000 – 399,999	8	6
$160,000 – 169,999	37	25	$400,000 – 409,999	10	5
$170,000 – 179,999	24	26	$410,000 – 419,999	6	8
$180,000 – 189,999	22	18	$420,000 – 429,999	12	7
$190,000 – 199,999	20	35	$430,000 – 439,999	5	3
$200,000 – 209,999	24	16	$440,000 – 449,999	6	3
$210,000 – 219,999	18	23	$450,000 – 459,999	4	2
$220,000 – 229,999	21	22	$460,000 – 469,999	6	1
$230,000 – 239,999	16	25	$470,000 – 479,999	5	1
$240,000 – 249,999	23	19	$480,000 – 489,999	2	2
$250,000 – 259,999	20	18	$500,000 – 509,999	1	0
$260,000 – 269,999	22	19	$510,000 – 519,999	1	1
$270,000 – 279,999	20	21	$520,000 – 529,999	0	1
$280,000 – 289,999	15	14	$530,000 – 539,999	2	1
$290,000 – 299,999	22	13	$580,000 – 589,999	1	1
$300,000 – 309,999	14	14	$600,000 – 609,999	1	0
$310,000 – 319,999	16	18	$630,000 – 639,999	1	0
$320,000 – 329,999	14	6	$670,000 – 679,999	1	1
$330,000 – 339,999	13	16			
			Grand Total	**1,411**	**1,120***

*The comparative figures have been restated to include the KiwiSaver contributions

During the year ended 30 June 2019 there were 100 (2018: 116) employees who received compensation and other benefits in relation to cessation totalling $1.657m (2018: $1.420m).

26 Events after the balance date

There were no significant events after the balance date.

27a Financial instrument categories

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

	Group		Parent	
Financial assets measured at amortised cost	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Cash and cash equivalents	41,053	32,534	36,685	29,077
Debtors and other receivables	56,357	55,362	55,685	55,179
Term investments	750	1,126	0	0
Financial assets measured at fair value through surplus or deficit				
Portfolio investments	10,713	8,922	0	0
Total financial assets	**108,873**	**97,944**	**92,370**	**84,256**
Financial liabilities measured at amortised cost				
Creditors and other payables (excl revenue in advance and GST)	99,432	95,335	98,958	93,080
Finance leases	60	342	60	342
Total financial liabilities measured at amortised cost	**99,492**	**95,677**	**99,018**	**93,422**

27b Financial instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

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

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Waitematā DHB had no direct exposure to foreign currency risk (2018: nil).

Sensitivity analysis

As at 30 June 2019, if the New Zealand dollar had weakened/strengthened by 5% against the US dollar with all other variables held constant, the surplus for the year would have seen an insignificant impact.

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss. Due to the timing of its cash inflows and outflows, surplus cash is held as demand funds with NZ Health Partnerships Limited who invest with registered banks. In the normal course of business, exposure to credit risk arises from demand funds with NZ Health Partnerships Limited, debtors and other receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor (approximately 30%). 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.

27b Financial instrument risks (continued)

	Group		Parent	
	Actual 2019 $000	Actual 2018 $000	Actual 2019 $000	Actual 2018 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	0	0	0	0
AA -	5,252	4,515	0	0
A	463	445		
A+	0	0	0	0
A	389	198	0	0
A-	411	338	0	0
BBB+	504	254	0	0
BB+	0	204	0	0
Total counterparties with credit ratings	7,019	5,954	0	0
Total counterparties without credit ratings				
Cash, cash equivalents	36,685	29,077	36,685	29,077
Investments	8,812	7,551	0	0
Total counterparties without credit ratings	45,497	36,628	36,685	29,077
Total cash, cash equivalents and investments	**52,516**	**42,582**	**36,685**	**29,077**
Debtors and other receivables				
Existing counterparty with no defaults in the past	56,357	55,362	55,685	55,179
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**56,357**	**55,362**	**55,685**	**55,179**

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.

27b Financial instrument risks (continued)

Contractual maturity analysis of financial assets

The table below analyses financial assets into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows. Investments on call are included under the 'Less than 1 year' category.

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2018						
Cash on hand	30,784	30,784	30,784	0	0	0
On call deposits	1,750	1,750	1,750	0	0	0
Debtors and other receivables	55,362	55,362	55,362	0	0	0
Investments	10,048	10,048	1,126	6,711	2,079	132
Total	**97,944**	**97,944**	**89,022**	**6,711**	**2,079**	**132**
2019						
Cash on hand	39,303	39,303	39,303	0	0	0
On call deposits	1,750	1,750	1,750	0	0	0
Debtors and other receivables	56,357	56,357	56,357	0	0	0
Investments	11,463	11,463	750	8,471	2,242	0
Total	**108,873**	**108,873**	**98,160**	**8,471**	**2,242**	**0**
Parent						
2018						
Cash on hand	29,077	29,077	29,077	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,179	55,179	55,179	0	0	0
Total	**84,256**	**84,256**	**84,256**	**0**	**0**	**0**
2019						
Cash on hand	36,685	36,685	36,685	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,685	55,685	55,685	0	0	0
Total	**92,370**	**92,370**	**92,370**	**0**	**0**	**0**

Contractual maturity analysis of financial liabilities

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

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2018						
Creditors and other payables	93,045	93,045	93,045	0	0	0
Finance leases	342	342	256	86	0	0
Total	**93,387**	**93,387**	**93,301**	**86**	**0**	**0**
2019						
Creditors and other payables	99,432	99,432	99,432	0	0	0
Finance leases	60	60	60	0	0	0
Total	**99,492**	**99,492**	**99,492**	**0**	**0**	**0**
Parent						
2018						
Creditors and other payables	93,080	93,080	93,080	0	0	0
Finance leases	342	342	256	86	0	0
Total	**93,422**	**93,422**	**93,336**	**86**	**0**	**0**
2019						
Creditors and other payables	98,958	98,958	98,958	0	0	0
Finance leases	60	60	60	0	0	0
Total	**99,018**	**99,018**	**99,018**	**0**	**0**	**0**

28 Capital management

The DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves, and trust funds. Equity is represented by net assets. The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that the DHB effectively achieves its objectives and purposes, while remaining a going concern. There were no material changes in DHB's management of capital during the period.

29 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary, Three Harbours Health Foundation (THHF). The DHB's investment in THHF is accounted at cost of $nil (2018: $nil).

Summary of financial information of Three Harbours Health Foundation

	Assets $000	Liabilities $000	Equity $000	Revenue $000
2018	13,886	163	2,307	2,242
2019	16,503	475	2,360	2,306

30 Patient trust monies and restricted funds

	Actual 2019 $000	Actual 2018 $000
Balance at 1 July 2018	98	85
Monies received	790	663
Payments made	(774)	(650)
Balance at 30 June 2019	114	98

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.

31 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 $48.8m greater than the budget, largely due to additional funding received for services from the Crown after finalisation of the budget. Additional funding was received for Care Capacity Demand Management (CCDM) recruitment and Multi-Employer Collective Agreement (MECA) payments. The increased revenue resulted in additional Personnel costs under Expenditure as a result of the CCDM and MECA agreements.
- Expenditure for the year was $160.3m higher than budget, which is mostly due to:
  - Personnel costs being higher due to the Holiday Pay provision being increased by $114.3m as explained in note 17
  - Personnel costs being $30.1m higher due to variations in expected MECA costs, unbudgeted FTE increases and strike related costs.
  - Outsourced services costs $7.1m higher due to additional MRI and ultrasound costs and to help fill unexpected vacancies.
  - Infrastructure and non-clinical costs were higher than budget by $14.8m, mainly due to budgeted saving initiatives not being met. This includes $6.1m planned income on the sale of assets held for sale and non-delivery of planned workforce savings.

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

- Assets held for sale not being budgeted as Plant, Property and Equipment; this impacted both accounts by $21m.
- Unbudgeted increase in intangible assets due to the finalisation of work in progress intangible assets.
- Employee entitlements provisions in total were $118.3m higher than budgeted. The main drive of this was the $114.3m Holiday Pay provision reassessment which is explained in note 17. The remainder of the variance is mainly due to

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

- Increased operating cash flows of $15.6m due to $43.8m higher than budgeted patient care revenue receipts and $20.9m higher than budgeted payments to employees.
- Increase in investing cash flow of $7.0m was mainly due to delayed timing of projects.

32 Compliance with Crown Entities Act 2004

The DHB submitted its draft Statement of Intent (SOI)/ Statement of Performance Expectations (SPE) to the Ministry of Health on 28 June 2019. The finalised SOI/SPE was approved by the Board on 18 October 2019 (prior to the approval of the DHB 30 June 2019 Annual report), following which it was submitted to the Minister of Health and House of Representatives. The DHB did not comply with the requirements of the Crown Entities Act 2004 to have complete SPE before 1 July each year and to have a complete SOI before the start of the first financial year to which the SOI relates.

33 Going concern

The going concern principle was adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2018/19 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption. The key considerations are set out below.

Operating and cash flow forecasts

The DHB forecasts a breakeven result for the 2019/20 year, as set out in the 2019/20 Annual Plan. The DHB's cash flow forecasts indicate there are sufficient funds to meet the forecast operating and investing cash flow requirements of the DHB for the 2019/20 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 17 within the period of one year from signing the 2018/19 financial statements, additional financial support would be needed from the Crown.

Letter of support

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

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

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 2019

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

We have audited:

- the financial statements of the Health Board and Group on pages 45 to 78, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 9 to 33 and 40.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the Health Board and Group on pages 45 to 78:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2019; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 9 to 33 and 40:
  - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2019, 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 2019.This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board and Group being reliant on financial support from the Crown. 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 qualified opinion

As outlined in note 17 on page 68 and 69, the Health Board and Group has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board and Group has estimated a provision as at 30 June 2019 of $124.8 million to remediate these issues. However,

until further work is undertaken by the Health Board and Group, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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 qualified opinion.

The Health Board and Group is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 33 on page 78 that explain Crown support would be required if the Health Board and Group was required to settle the estimated Holidays Act 2003 liability within the period of one year from approving the financial statements.

The Health Board and Group has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board and Group with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

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

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

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

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

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

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

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

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

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

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

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

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board 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 a significant doubt on the 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 Health Board and Group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the 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 8, 34 to 39, and 41 to 44, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

We are independent of the Health Board 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 Health Board and Group.

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


Health Care Assistant
Nurse
Waitemata
PONAM
Registered Nurse
Main Entrance
CCTV
Waitemata
LYNN
Volunteer
Waitemata
VOLUNTEER

best care for everyone

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

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

everyone matters

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

with compassion

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

connected

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

better, best, brilliant...

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

Waitematā
District Health Board

Best Care for Everyone

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