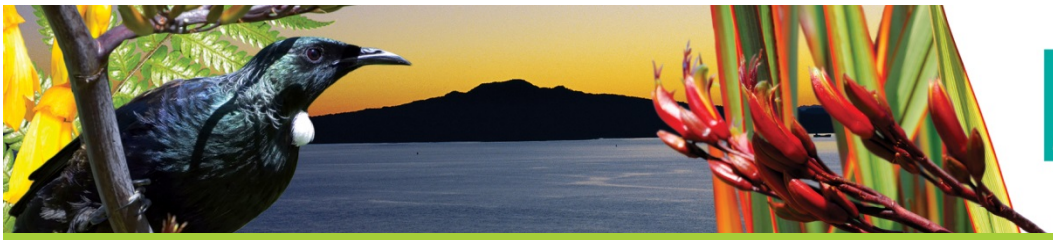


Waitematā
District Health Board
Best Care for Everyone

Annual Report 2019/20

Waitematā District Health Board

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

Contents

About Waitematā DHB

Who we are and what we do

Waitematā DHB is the Government's funder and provider of health services to 619,000 residents living in the areas of North Shore, Waitakere and Rodney, making us the largest DHB in the country by population.

Our population is diverse. 10% of Waitematā residents are Māori, 7% are Pacific, and 25% are Asian. We have a relatively affluent population, with a large proportion living in areas of low deprivation, and this is reflected in the health of our population. We have the highest life expectancy in New Zealand, at 83.9 years (2017-19), this is an increase of 3.3 years since 2001.

More than 8,600 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 all three Metro Auckland DHBs. We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, e.g. cardiac surgery and radiation oncology services, and have contracts with approximately 600 other community providers.

Our budget in 2019/20 was $1.8 billion.

Best care for everyone

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

Our **priorities** are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective services that are patient-focused and compassionate.

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 on-going 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.

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.

Equity

Waitematā DHB is committed to achieving health equity for all those in our community, in particular for Māori. Māori in our district generally have better health outcomes than Māori in other DHBs.

However, some of our population experience inequalities in health outcomes, and ethnicity is 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 second highest Māori life expectancy in the country, at 80.8 years; the rate of increase in Māori life expectancy is more than twice that of non-Māori life expectancy.

2019/20 achievements

Although many of our performance measures were adversely affected by COVID-19, Waitematā DHB remains one of the healthiest communities in New Zealand. We performed well against our key population health indicators achieving improved results for all our medium-term outcome measures in 2019/20.

Our achievements in 2019/20 include:

- Amenable mortality rates have more than halved for Māori over the past decade, and have reduced by 23% for our total population. We improved on our cancer, coronary angiography, urgent colonoscopy and MRI waiting times targets, meaning that people quickly receive the healthcare they need.
- Our children receive a great start to life. Our immunisation rates are among the highest in New Zealand and we exceeded our influenza vaccination target for children with respiratory illness. Nearly all pre-school children are enrolled with school dental services. More babies are growing up in smokefree homes, and increasing numbers of pregnant smokers are being helped to quit.
- Suicide rates have decreased and more people are able to access mental health services.
- People are spending less time in hospital and are receiving higher quality care. Acute bed days have reduced 10% since 2017/18, and we met nearly all of our HQSC quality and safety targets in 2019/20.

Our COVID-19 response

The novel coronavirus 2019 (COVID-19) pandemic had an immense impact on the way we plan and deliver services. Our on-going local and regional response work underscores the importance of flexibility, adaptability and rapid decision making. We responded quickly and effectively to the first outbreak, transforming our whole model of care over a very short timeframe and adapting swiftly to challenges as they arose, and were well prepared for the resurgence in August 2020.

Together with Northland and the other metropolitan Auckland DHBs, we are operating a regional response to the COVID-19 pandemic through the Northern Region Health Coordination Centre (NRHCC).

The NRHCC demonstrates how well we can address health protection, social welfare and cultural needs in a crisis.

In the metro Auckland region, testing for COVID-19 was established rapidly and early in the response. All testing is overseen by NHRCC.

A flexible model is in place that provides accessible testing in a range of settings. These include Community Testing Centres (CTCs), mobile testing units, general practice and urgent care clinics. We have additional Māori and Pacific mobile services providing augmented primary care, influenza vaccination and testing services.

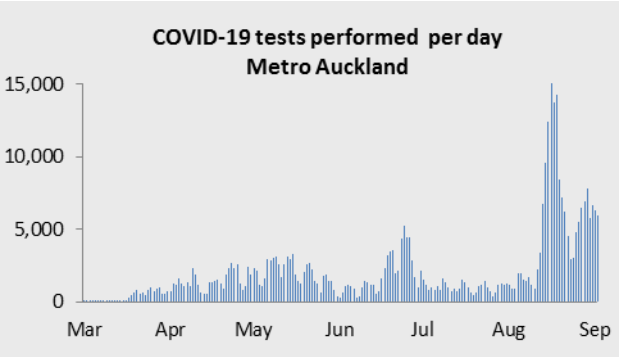
New Zealand reported its first case of COVID-19 on 28 February 2020. By 21 March (when there were 35 positive cases identified in the Northern region), 7 community testing centres (CTCs) were operating across the region. At the peak of the first outbreak, there were 14 CTCs in operation, and 6 mobile services providing testing for people who found it difficult to access CTCs or general practice. Community swabbing (in CTCs and primary care) peaked at around 2,500 tests per day in late April.

The testing model adapted rapidly to changing circumstances. Testing volumes are able to be quickly ramped up in response to Ministry of Health directives and heightened demand in the community, and capacity re-directed and service models altered as the focus shifted from symptomatic community cases to testing of returning New Zealanders in managed isolation facilities and surveillance testing in the community.

On August 11 2020, after 102 days with no community cases, a new outbreak was detected in Auckland. The NRHCC immediately increased testing capability across the region.

Within 24 hours, 16 new testing centres were opened across the Auckland region, with over 500 healthcare workers redeployed to support testing.

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



Testing capacity across Metro Auckland rapidly increased to meet demand

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

The August outbreak predominantly affected our Pacific (61% of cases) and Māori (22% of cases) communities living in less affluent areas of south and west Auckland. Housing and other adverse socioeconomic problems, along with a high prevalence of other health issues (e.g. diabetes and heart disease), combine to increase the risk of infection and death in these communities. Our Māori and Pacific teams played a significant role in limiting the outbreak by working with community leaders and healthcare and social service providers to provide equitable access to testing and wider support. Testing rates for Māori and Pacific are currently higher than those for the overall Waitematā DHB population.

COVID-19 tests for Waitematā DHB residents, as at 20 September 2020	
Total tests	102,267
Test rate per 1,000 people	161
Positive results	0.2%
COVID-19 test rates per 1,000 Waitematā DHB residents, by ethnicity, as at 20 September 2020	
Māori	184
Pacific	258
Asian	111
Other	180

A nurse performs a COVID-19 test on a patient at a community testing centre in Northcote.

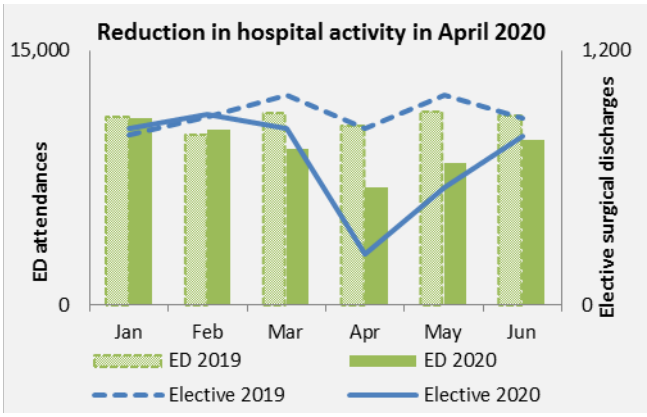
The NRHCC has assumed responsibility for the entire health component of the Managed Isolation and Quarantine (MIQ) system in the Northern Region and has robust procedures in place to ensure the safety of our workers, their families and our communities. The NRHCC also undertakes asymptomatic surveillance testing of border staff (airport and MIQ) as directed by the Ministry of Health testing strategy. Large programmes of asymptomatic testing through workplaces and the community were carried out to support New Zealand's COVID-19 elimination strategy.

Outbreaks of COVID-19 in aged residential care (ARC) facilities can be devastating. After a COVID-19 outbreak in a Waitematā DHB ARC facility, contingency planning for future outbreaks in ARC is now a priority. All ARC facilities have undertaken COVID-19 preparedness assessments and are being supported to address any identified issues.

An outbreak management process has been developed. This process includes an On-Call Response Team, which would manage the first 72 hours following a notification, and an Outbreak Management Team to support the facility throughout the outbreak.

Healthcare workers play an essential role in the pandemic response and our employee's health, safety and wellbeing is more important than ever. We developed a number of tools and services to help support ourselves and each other to manage uncertainty and anxiety.

The reduction in clinical activity as a result of restrictions under the Alert Level 3 and 4 lockdown period (late March to mid-May 2020), and the re-purposing of staff and facilities for COVID-19 functions, was immediate and dramatic. In both hospital settings and in primary care, significantly less care was able to be provided than expected under normal circumstances.



Elective surgery and emergency department attendances were significantly reduced during the lockdown period

The majority of routine elective surgeries were delayed during the lockdown period. Only around 30% of the expected number of procedures were carried out in April.

In late March, the Elective Surgery Centre was converted into a dedicated 51-bed ward and intensive care facility for COVID-19 patients. This doubled our intensive care capacity and meant that COVID-19 positive patients could be cared for in a separate building. Several elective operating theatres were converted into COVID-19 ready theatres, significantly reducing our elective surgery capacity.

The Elective Surgery Centre was transformed into a dedicated COVID-19 facility

Emergency department volumes decreased by one third in April 2020, compared with April 2019, and acute inpatient volumes showed a similar reduction.

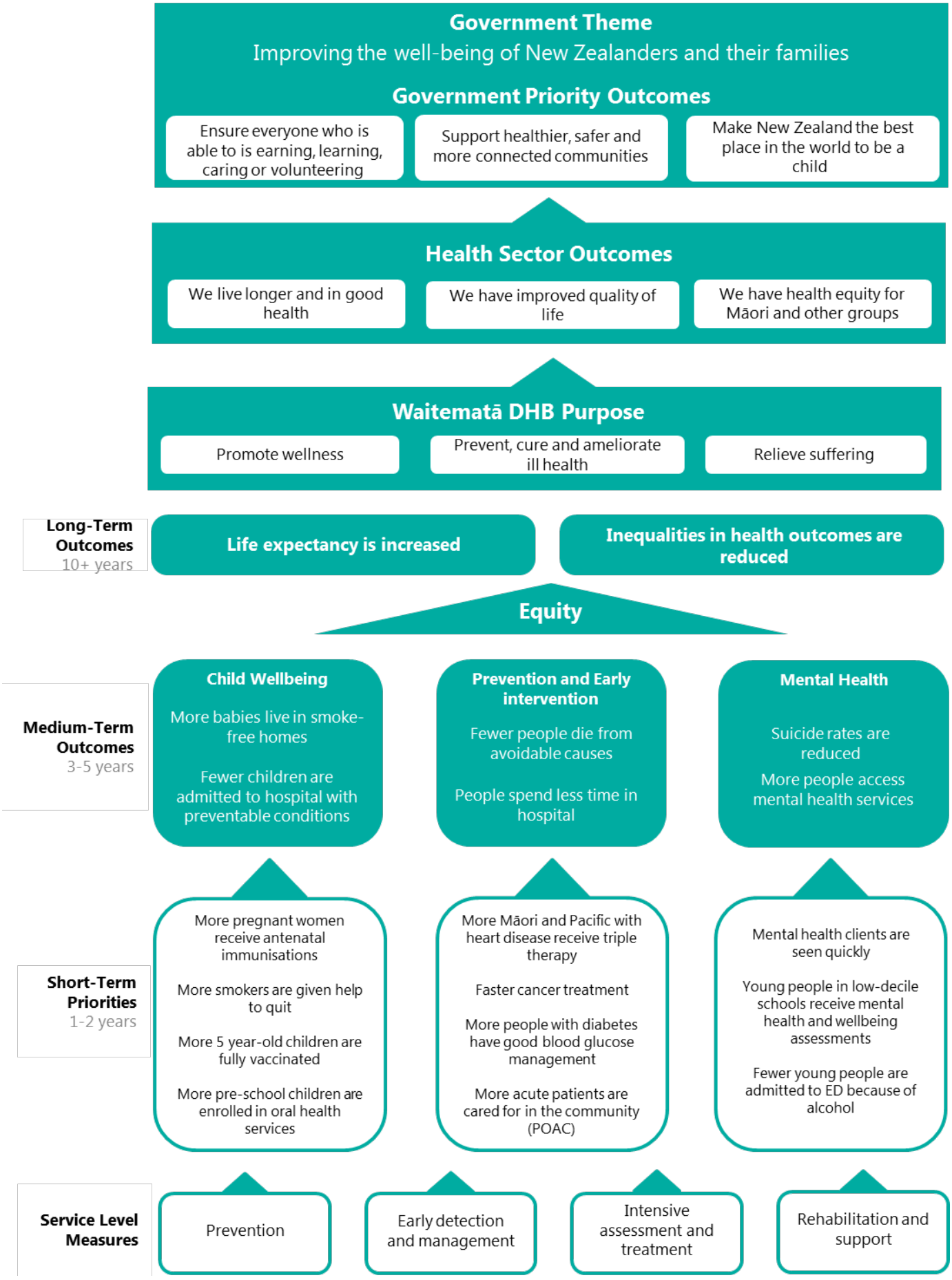
Outpatient activity was less affected as we moved rapidly to offer telephone and video consultations. Within four weeks, around 40% of specialist appointments were delivered by telehealth, increasing to 70% in seven weeks. During the August resurgence, we quickly transitioned to virtual appointments, where appropriate. Waitematā DHB is now working to support increased telehealth in the longer term by developing more electronic tools to assist with the delivery of virtual and paperless clinics.

New Zealand has been highly successful to date at limiting the direct impact of COVID-19 on the population compared with other OECD countries. This success has come with a significant financial cost to the country and Waitematā DHB. The estimated financial impact of COVID-19 on Waitematā DHB's statement of comprehensive revenue and expense for the year ended 30 June 2020 is a net cost of $26.8 million. The financial impacts of COVID-19 are detailed further in Note 31 of the Financial Statements.

In addition to the financial impacts, there were significant impacts on the ability of the DHB to meet our performance targets. These impacts are further detailed in the Statement of Performance.

Our focus is now on a sustainable, safe and equitable recovery. We are working to ensure our community has equitable and timely access to the services they need. We are engaged in significant programmes of work to clear the backlog of activity that was deferred during lockdown and return access and participation rates to levels seen prior to COVID-19.

Performance framework



Long-term outcomes

The long-term outcomes that we aim to achieve are to increase life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (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.

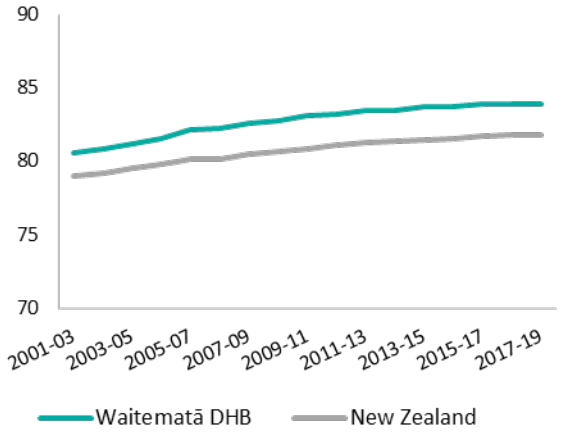
We have the highest life expectancy in New Zealand at 83.9 years (2017-19[1]), which is 2.1 years higher than New Zealand as a whole. Our life expectancy has increased by 3.3 years since 2001.

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 3.8 years for Māori and 6.8 years for Pacific.

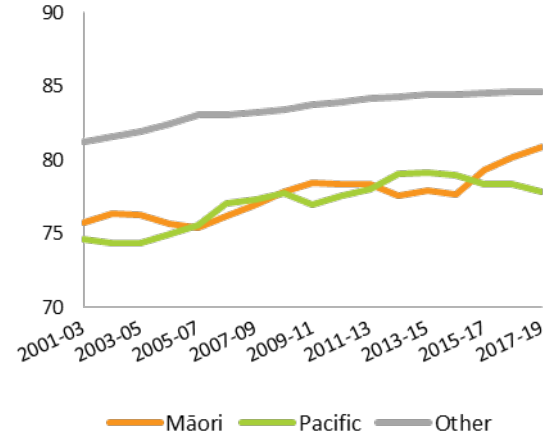
Life expectancy for our Māori population increased by 4 years over the past decade and the gap in life expectancy continues to gradually close. Māori now have a life expectancy of 80.8 years, but this is nearly 4 years lower than other ethnicities (excluding Pacific).

Life expectancy for Pacific remains significantly lower than other ethnicities at 77.8 years, and has shown only a slight increase over the past decade.

LIFE EXPECTANCY AT BIRTH – 3-YEAR COMBINED ESTIMATE



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



[1] The most recent life expectancy data available is for deaths occurring in the 2019 calendar year. Three-year combined estimates were produced to reduce the effect of year-to-year variations in death rates, which is particularly relevant due to smaller numbers seen at the ethnicity level.

Medium-term outcome measures

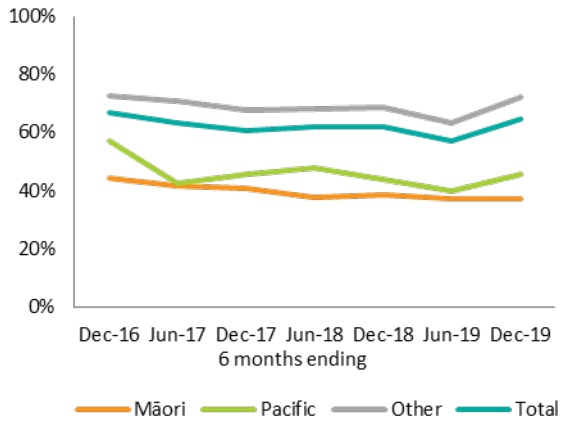
We performed well against our key population health indicators and achieved improvement in all of our medium-term outcome measures in 2019/20.

Measure	Prior year result[2]	Current year result[3]	% change
% of WCTO[4] registered babies living In smokefree homes at 6 weeks post-partum	60%[5]	65%[6]	8.3%
Ambulatory sensitive hospital admissions in those aged 0-4 years, per 100,000 population	5,564[7]	4,515	18.9%
- Māori	7,136[7]	5,519	22.7%
- Pacific	12,739[7]	8,968	29.6%
- Other	4,691[7]	3,664	21.9%
Mortality rate from conditions considered amenable, per 100,000 population	65.3[7,8]	65.0[8]	0.5%
Acute hospital bed days rate per 1,000 population	435[9]	403	7.4%
- Māori	625[9]	540	13.5%
- Pacific	809[9]	774	4.3%
- Other	396[9]	370	6.6%
Rate of suicide per 100,000 population	8.6[7,10]	8.6[10]	0%
Access rates to mental health services (in 0-19 year olds)	3.55%[7]	3.56%	0.3%

Note: a green % change indicates the result was better (or the same) in 2019/20 than in the previous year, a red % change indicates the result was worse than the previous year.

More babies live in smokefree homes

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



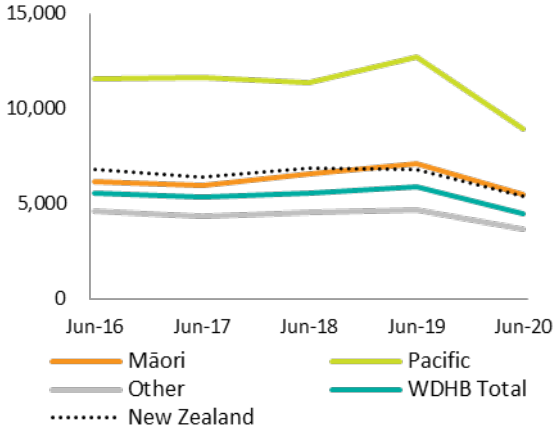
This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment and encouraging an integrated approach between maternity, community and primary care.

While the percentage of babies living in smokefree homes is improving generally over time, there is little improvement for Māori. Programmes like the maternal incentives smoking cessation programme aim to improve performance against this indicator and reduce the inequities for our Māori and Pacific populations.

[2] 2018/19 unless specified.
[3] 2019/20 unless specified.
[4] Well Child Tamariki Ora service.
[5] The denominator was changed in 2019/20 so the 2018/19 figure differs from that published in our previous Annual Report. The 2018/19 denominator is the total number of babies enrolled with WCTO providers, the 2019/20 denominator is the total number of registered births.
[6] Six months ending in December 2019 (the latest available data).
[7] Result updated in 2020 using the revised 2019 population projections, therefore it differs from the result published in the 2018/19 Annual Report.
[8] The 2018/19 result is the number of 2016 deaths; the 2019/20 result is the number of 2017 deaths.
[9] Updated using latest coded data and revised 2019 population projections, therefore this result may differ from that published in our 2018/19 Annual Report.
[10] The 2018/19 result is based on the number of 2012-16 deaths; the 2019/20 result is based on the number of 2013-17 deaths.

Fewer children are admitted to hospital with preventable conditions

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

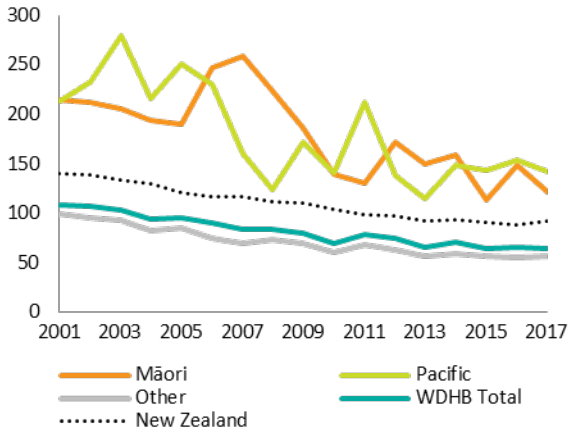


Ambulatory sensitive hospitalisations (ASH) are unplanned hospital admissions for a defined set of conditions that are potentially avoidable through prevention or management in primary care. In children, these conditions are primarily respiratory illnesses, gastroenteritis, dental and skin conditions. ASH rates are much higher for Māori and Pacific children. Access to primary and community health care programmes can help reduce ASH rates, but underlying determinants of health (e.g. housing, exposure to smoking and poverty) also influence the incidence of ASH.

During the COVID-19 lockdown period (Apr-May 2020), many people avoided seeking treatment at healthcare facilities, including hospitals, therefore lower rates of acute hospital admissions were observed during this period than expected. This included admissions for ambulatory sensitive conditions, impacting on performance for the last quarter of 2019/20 and appearing to improve performance when compared to the previous year. The incidence of some ASH conditions improved through the efforts to reduce the spread of COVID-19 – seasonal influenza and other respiratory infection rates dropped due to social distancing and good hygiene practices (as well as improved vaccination rates). Performance will need to be monitored over time to determine if this improvement is sustained.

Fewer people die from avoidable causes

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



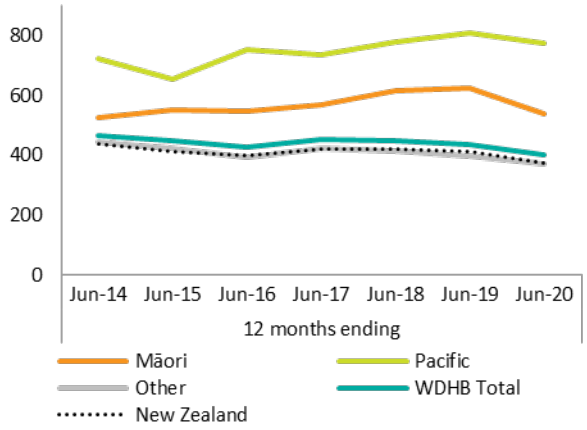
Amenable mortality is deaths in those aged under 75 that were potentially avoidable through healthcare intervention. Waitematā DHB has the second lowest rate of amendable mortality in New Zealand and is declining, however annual fluctuations are seen, especially when viewing the smaller numbers of deaths at ethnicity group level.

Since 2010 the rate of decline has slowed. This is largely due to an increasing number of deaths related to coronary disease, mainly in the 65+ age group.

In 2018 the Ministry of Health released a new cardio-vascular disease (CVD) risk assessment and management tool which aims to more accurately identify those that should be risk assessed, and better inform decision making around the treatment and management of CVD. Importantly, for Māori, Pacific and South Asian populations, risk assessment is now recommended to commence at a much earlier age than for other population groups.

People spend less time in hospital

ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



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

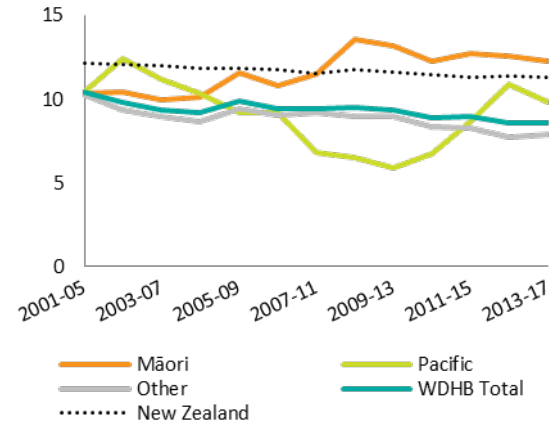
During the COVID-19 lockdown period many people avoided seeking treatment at healthcare facilities, including hospitals, therefore lower than usual rates of acute hospital admissions (thus bed days), were observed.

Efforts to reduce the spread of COVID-19 (social distancing, good hygiene) also reduced the rate of seasonal influenza (combined with increased vaccination rates) and other respiratory infections.

Performance is continuing to be monitored to determine if improvements will be sustained or if presentation for some conditions has been deferred.

Suicide rates are reduced

SUICIDE RATE - DEATHS FROM SUICIDE, PER 100,000 POPULATION



Note: The actual number of deaths from suicide is very small, therefore 3 years aggregated data is provided for each time point to reduce fluctuation

Suicide rates reflect the mental health and social wellbeing of the population. Reducing suicide requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress.

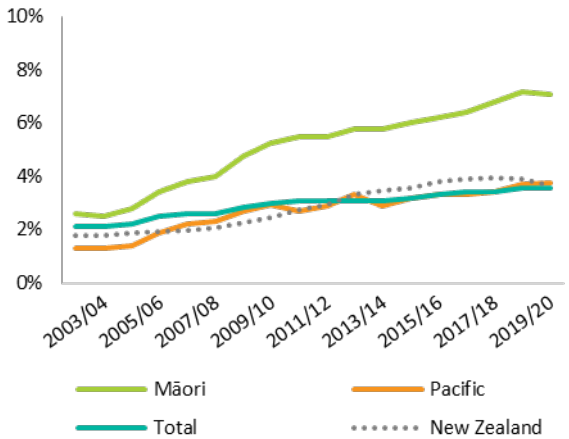
Although our suicide rates are lower than the national rate, there is a clear equity issue and a concerning increase among our Pacific population.

During Alert Level 4, there was speculation in the community around increased suicide numbers. To address this the Chief Coroner issued a statement on provisional suicide numbers confirming that suspected suicides during lockdown were lower than for the preceding month and lower than for the same period each year from 2008 to 2020 nationally, which is a trend we have observed for Waitematā and Auckland DHBs.

Our long term aim is for zero suicides.

More people access mental health services

MENTAL HEALTH ACCESS RATE – PROPORTION OF POPULATION ACCESSING MENTAL HEALTH SERVICES



While not all individuals with mental health and addiction challenges need, or will seek, support services, over time, more people should be able to access help. Accessible services mean people can obtain health care at the right place and right time taking account of different population needs.

Waitematā DHB access rates have steadily increased over time, with much higher rates for Māori.

Some mental health services were reduced or the method of delivery changed over the COVID-19 lockdown period.

Overview

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

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals, set out in the Improving Health Outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitematā DHB population is now 83.9 years, an increase of 1.3 years over the last decade. The life expectancy gap is 3.8 years for Māori and 6.8 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 2017/18 baseline results reported in the SP differ to those included in the 2019/20 Annual Plan because the Annual Plan figures were incorrect or were not the most up-to-date result for 2019/20, 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 2019/20 Statement of Performance Expectations by Output Class. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators expected performance directions rather than set quantitative targets, and these were assigned with the below symbols in the target column.

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

Population Projections

In February 2020, Statistics New Zealand released revised population estimates and projections, which included adjusted 2018 Census counts. This resulted in a 3% reduction in the projected 2019/20 population for Waitematā DHB, and changes between ethnic groups. This had a substantial impact on those measures that use DHB population as the denominator. Where possible, we recalculated our prior year's results using the revised population estimates to provide a more accurate comparator. This means some results will differ to those reported in our 2018/19 Annual Report. Any changes to previously reported results are disclosed in the footnotes.

Impact of COVID-19 on the services we provide

The reduction in clinical activity as a result of restrictions under the lockdown period, and the re-purposing of staff and facilities for COVID-19 functions, had a significant impact on our ability to meet performance targets. In both hospital and in primary care settings, our capacity to provide healthcare was significantly reduced than if we were operating under normal circumstances. The majority of the disruption occurred in April and May 2020, therefore, the quarter four results are the most affected. To demonstrate the impact of COVID-19 on our 2019/20 performance, we are reporting the cumulative Q1-3 'pre-COVID-19' result, the Q4 'COVID-19-affected' result, and the full year result for each indicator. For some measures, services could not be delivered, or data was not collected in Q4. Where this is the case, we rated our performance according to the Q1-3 result.

The operational impact of COVID-19 on our existing services include:

- In late March, the Elective Surgery Centre (ESC) was converted into an emergency COVID-19 facility, significantly reducing available Planned Care elective production. Two North Shore Hospital and one Waitakere Hospital elective operating theatres were converted into COVID-19-ready theatres. Normal elective surgery activity was resumed only in June 2020
- Emergency Departments (ED) experienced lower attendance rates during the lockdown period and acute inpatient numbers were significantly reduced from March to May
- Assessment, treatment and rehabilitation (AT&R) wards were closed during April to June, and staff were redeployed to other parts of our hospitals
- Gastroenterology reduced their outsourced volumes from March to May
- The Auckland Regional Dental Service carried out only essential emergency dental treatment during Alert Levels 4 and 3; no routine school dental care was provided
- Mental Health services continued some online consultations during lockdown, but at significantly reduced volumes.

New services introduced in response to COVID-19

A number of new services and/or an increase in existing services introduced in response to COVID-19, and include:

- Virtual/telehealth consultations
- New mental health approaches and pathways
- COVID-19-ready wards and associated services
- Aged residential care (ARC) facility outbreak management.

As part of the regional response work, we worked with the other Northern Region DHBs, Auckland Regional Public Health Service and the Ministry of Health, alongside other government agencies to set up and manage:

- Community testing centres, including mobile services and specific services for Māori and Pacific
- Border assessment and testing services
- Managed isolation facility assessment and testing services
- Personal protective equipment (PPE) logistics
- Intelligence and IT support services
- Welfare and wellness services
- Communication services, including non-English languages.

More detailed discussion of the scope and performance of our COVID-19 response is in the Introductory section.

Output Class 1: Prevention Services

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

Output measure	Previous years		2019/20				
	2017/18 baseline	2018/19	Q1-3	Q4 only	Full year	Target	Rating
HEALTH PROMOTION							
% of PHO-enrolled patients who smoke have been offered brief advice to quit in the last 15 months (C)	89%	88%	85%[11]	n/a[11]	79%[12]	90%	
% of PHO-enrolled patients who smoke who received cessation support (Q)[13]	32%	34%	31%[18]	n/a[18]	29%	n/a	n/a
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking (C)	90%	91%	86%[14]	98%	90%	90%	
No. of pregnant women smokers referred to the stop smoking incentive programme (Q)	116[15]	168	163	30	193[12]	231	
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional (Q)	100%	100%	100%	100%	100%	95%	
No. of clients engaged with Green Prescriptions (V)	3,756	5,340	3,805	1,095	4,900	4,861	
% of clients engaged with Green Prescriptions (C)							
Māori	*14%*	*16%*	*13%*	*13%*	*13%*	13%	
Pacific	*16%*	*19%*	*14%*	*15%*	*15%*	12%	
South Asian	*7%*	*8%*	*6%*	*5%*	*6%*[16]	9%	
IMMUNISATION							
% of pregnant women receiving pertussis vaccination in pregnancy (C)	50%[17]	52%	55%[18]	n/a[18]	54%	50%	
Māori	*29%*[17]	*32%*	*35%*[18]	*n/a*[18]	*32%*[19]		
Pacific	*30%*[17]	*33%*	*37%*[18]	*n/a*[18]	*39%*[19]		
Asian	*60%*[17]	*65%*	*67%*[18]	*n/a*[18]	*66%*		
% of pregnant women receiving influenza vaccination in pregnancy (C)[20]	30%	41%	*41%*[18]	n/a[18]	44%[19]	50%	
Māori	16%	*27%*	*27%*[18]	*n/a*[18]	*26%*[19]		
Pacific	20%	*34%*	*34%*[18]	*n/a*[18]	*39%*[19]		
Influenza vaccination for children aged 0-4 years who are hospitalised for respiratory illness (C)	15%[21]	12%[21]	n/a[21]	n/a[21]	18%[21]	15%	
Māori	*9%*[21]	*8%*[21]	n/a[21]	n/a[21]	*10%*[21,22]		
Pacific	*8%*[21]	*11%*[21]	n/a[21]	n/a[21]	*9%*[21,22]		
% of eight months olds will have their primary course of immunisation on time (C)[23]	92%	92%	93%	92%	93%	95%	
Māori	*86%*	*86%*	*89%*	*84%*	*87%*		
Pacific	*93%*	*96%*	*93%*	*87%*	*92%*		
% of five year olds will have their primary course of immunisation on time (C)[23]	85%	87%	88%	90%	89%	95%	
Māori	*81%*	*84%*	*86%*	*87%*	*86%*		
Pacific	*83%*	*85%*	*88%*	*88%*	*88%*		
Asian	*91%*	*92%*	*93%*	*93%*	*93%*		
Rate of HPV immunisation coverage (C)	60%[24]	56%[24]	n/a[24]	n/a[24]	68%[24]	75%	

[11] Rolling 15-months data. Q1-3 is rolling 15 months to March 2020; single quarter data is not available.
[12] Limited primary care activity took place in Q4 due to COVID-19 restrictions.
[13] Measure inadvertently left out of 2019/20 SPE, but is a Short Term Priority measure, so results included in SP. There is no set target for this measure.
[14] Does not include Q3 results; Ministry of Health is unable to provide Q3 data due to COVID-19 constraints.
[15] CY2018 result.
[16] The provider unsuccessfully tried to gain access to the South Asian community by engaging with the temple in West Auckland, and is now promoting their services through other South Asian hubs within Waitematā.
[17] Differs from results in the 2018/19 Annual Report, which are for the calendar year prior to the end of the financial year (FY); these results are for FY.
[18] Rolling 12-months data. Q1-3 is rolling 12 months to March 2020; single quarter data is not available.
[19] Antenatal immunisation coverage was impacted by COVID-19 as many clinic appointments were delivered virtually, removing the opportunity for vaccination. Health promotion campaigns were launched to raise awareness for Māori and Pacific pregnant mothers.
[20] Measure inadvertently left out of 2019/20 SPE, but is a Short Term Priority measure, so results included in SP.
[21] To align with the influenza season, all results are for the calendar year prior to the end of each financial year; quarterly results are not relevant.
[22] Lists of 0-4 year-olds eligible for funded influenza vaccine are provided to PHOs who are actively working with their practices on recalling these children. The impact of COVID-19 raised awareness of respiratory disease prevention and is likely to drive increased demand for the vaccine in the future.
[23] Population data sourced from the National Immunisation Register; babies are added onto this register at birth through the National Health Index system.
[24] To align with the school year, all results are for the calendar year prior to the end of each financial year; quarterly results are not relevant.

Output measure	Previous years 2017/18 baseline	Previous years 2018/19	2019/20 Q1-3	2019/20 Q4 only	2019/20 Full year	Target	Rating
POPULATION-BASED SCREENING							
% of women aged 50-69 years having a breast cancer screen in the last 2 years (C)[25]	65%[26]	66%[26]	68%[26,27]	n/a[27]	65%[28]	70%	
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	72%[26]	72%[26]	71%[27]	n/a[27]	69%[29]	80%	
HEEADSSS assessment coverage in DHB funded school health services (C)	88%[24]	90%[24]	n/a[24]	n/a[24]	90%[24]	95%	
% of 4-year-olds receiving a B4 School Check (C)	90%	90%	84%	20%	68%[30]	90%	
Bowel cancer screening							
% of people aged 60-74 years invited to participate who returned a correctly completed kit (Q)[31]	63%	63%	62%[27]	n/a[27]	61%	60%	
Māori	*60%*	*62%*	*63%*[27]	n/a[27]	*63%*		
Pacific	*46%*	*47%*	*49%*[27]	n/a[27]	*49%*[32]		
Asian	*55%*	*55%*	*55%*[27]	n/a[27]	*55%*[32]		
Other	*66%*	*66%*	*65%*[27]	n/a[27]	*64%*		
% of those with a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system (T)	93%	97%	95%	100%	95%	95%	
AUCKLAND REGIONAL PUBLIC HEALTH SERVICE (ARPHS)[33]							
Number of tobacco retailer compliance checks conducted (V)	372	432	183	1	184[34]	300	
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into (V)	2,112	3,010	3,091	534	3,625	Ω	n/a
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification (Q)[35]	New indicator	83%	94%	100%	95%	98%	
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	New indicator	89%	95%	100%	96%	95%	
% of compliance assessments conducted of large and medium networked drinking water supplies (Q)	100%	100%	100%	n/a[34]	100%	100%	

[25] Eligible women screened as at the end of the reporting period.
[26] Figure updated in 2020 using revised 2019 population projections, therefore may differ from result published in previous Annual Reports.
[27] Result as at the end of the reporting period; single quarter data not applicable.
[28] Screening services were halted during COVID-19 lockdown. Various initiatives to promote screening continues; improvements from a data-match campaign in Māori women will be reviewed for other ethnicities.
[29] Cervical screening coverage is declining nationally. Services were substantially reduced during COVID-19 lockdown, thus little gain was made in 2019/20. We continue to work with primary care to improve Māori and Pacific uptake. The planned HPV Primary Screening Programme will offer significant advantages for improving equity and coverage.
[30] Services ceased or were substantially reduced during COVID-19 lockdown.
[31] Proportion of people invited to take part in the programme who were screened during the two years prior to the end of the reporting period.
[32] Bowel screening rates for Pacific and Asian communities are historically lower than other ethnicities. We continue to engage with these groups to increase coverage.
[33] Services are delivered by ARPHS on behalf of the three Metro Auckland DHBs. Reported results are for all three DHBs.
[34] Service provision was significantly affected by the ARPHS response to the COVID-19 pandemic, which included redeploying many staff. Compliance activity will resume as capacity allows.
[35] This measure would more appropriately be classified as 'timeliness (T)'.

Output Class 2: Early Detection and Management

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

Output measure	Previous years		2019/20				
	2017/18 baseline	2018/19 result	Q1-3	Q4 only	Full year	Target	Rating
PRIMARY HEALTH CARE							
Rate of primary care enrolment (Māori) (C)	83%[26]	82%[26]	84%[27]	n/a[27]	83%	90%	
Number of referrals to Primary Options for Acute Care (POAC) (V)	13,944	13,173	7,260	1,790	9,050[36]	10,811	
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices who do not have an HbA1c recorded in the last 15 months (C)	13%	15%	11%[27]	n/a[27]	12%	<12%	
Māori	*16%*	*24%*	*17%*[27]		*19%*[37]		
Pacific	*13%*	*16%*	*13%*[27]		*14%*[37]		
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol (Q)	63%	59%	63%[27]	n/a[27]	63%	65%	
Māori	*49%*	*45%*	*49%*[27]		*49%*[37]		
Pacific	*53%*	*48%*	*49%*[27]		*49%*[37]		
% of Māori patients with prior CVD who are prescribed triple therapy (Q)	59%	55%	59%[27]	59%[27]	59%	62%	
% of Pacific patients with prior CVD who are prescribed triple therapy (Q)	64%	66%	67%[27]	67%[27]	67%	66%	
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds (Q)	4,371[26]	4,275[26]	4,106[18]	n/a[18]	3,908[38]	<4,271[39]	
Māori	*7,449*[26]	*8,454*[26]	*8,327*[18]		*7,472*	*<7,935*[39]	
Pacific	*11,256*[26]	*12,873*[26]	*11,061*[18]		*10,024*	*<11,947*[39]	
Average response score to the primary care survey question 'in the last 12 months, when you ring to make an appointment how quickly do you usually get to see your current GP?'[40] (T)	5.4	5.2	5.1[41]	n/a[41]	n/a[41]	6.0	n/a
PHARMACY							
Number of prescription items subsidised (V)	7,401,580	7,639,059	6,078,303	2,087,051	8,165,354	Ω	n/a
COMMUNITY-REFERRED TESTING AND DIAGNOSTICS							
Number of radiological procedures referred by GPs to hospital (V)	38,842	39,398	28,055	5,948	34,003	Ω	n/a
Number of community laboratory tests (V)	4,082,639	4,250,213	3,214,596	799,036	4,013,632	Ω	n/a

[36] Limited primary care activity took place in Q4 due to COVID-19 restrictions.

[37] Improving diabetes management for Māori and Pacific continues to be a focus. A co-design project with GP practices focused on equity to improve access to diabetic medications and dietitian and psychological services. COVID-19 affected primary care's ability to undertake routine diabetes care , but PHOs are working with their practices to re-engage patients.

[38] During the COVID-19 lockdown (Apr-May 2020), many people avoided seeking treatment at healthcare facilities, including hospitals, therefore lower rates of acute hospital admissions were observed than expected.

[39] Target recalcuted to reflect revised 2019 population projections, therefore differs to that published in 2019/20 Annual Plan.

[40] Answers are assigned a value ('over a week'= 0, 'within a week'= 3, 'next working day' = 7, 'same day' = 10) and summed, then divided by the total number of responses to give an average response score.

[41] The Primary Healthcare patient experience survey was halted at the end of Q2 2019/20 for review, therefore results are available only to Q2.

Output measure	Previous years 2017/18 baseline	Previous years 2018/19 result	2019/20 Q1-3	2019/20 Q4 only	2019/20 Full year	2019/20 Target	2019/20 Rating
ORAL HEALTH[42]							
% of preschool children enrolled in DHB-funded oral health services (C)	95%[26]	96%[26]	n/a	n/a	98%	95%	
Māori	*76%*[26]	*75%*[26]			*75%*[43]		
Pacific	*88%*[26]	*91%*[26]			*96%*		
Asian	*90%*[26]	*91%*[26]			*93%*		
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.61	0.60	n/a	n/a	0.61	<0.59	
Māori	*0.76*	*0.92*			*0.85*[43]		
Pacific	*0.89*	*0.82*			*0.79*[43]		
Asian	*0.65*	*0.61*			*0.63*		
% of children caries free at five years of age (Q)	67%	62%	n/a	n/a	58%[43]	67%	
Māori	*55%*	*52%*			*49%*[43]		
Pacific	*48%*	*38%*			*38%*[43]		
Asian	*58%*	*53%*			*47%*[43]		
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years (C)	68%[44]	68%[44]	n/a	n/a	68%[45]	85%	

[42] To align with the school year, aall results are for the calendar year prior to the end of each financial year. Because the 2019/20 full year result is actually for calendar year 2019, it is not necessary to show the impact of COVID-19.

[43] A significant work programme continues to support attendance and overall efficiency and effectiveness of dental services. The service is implementing topical fluoride application to pre-schoolers in early childhood education (ECE) centres, specifically targeting Kohanga Reo, Pacific language nests and ECE centres with high Māori or Pacific numbers. All Māori and Pacific children are appropriately assigned a 6-month recall to increase preventative approaches.

[44] Prior years' results have not been updated to reflect revised 2019 population projections.

[45] Engaging with secondary school students and their parents once the student has left ARDS continues to be difficult. Many methods were trialled to track these students and encourage them to attend, including using mobile dental providers and their school nurse/health worker/pastoral care.

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	Previous years		2019/20				
	2017/18 baseline	2018/19 result	Q1-3	Q4 only	Full year	Target	Rating
ACUTE SERVICES							
Number of ED attendances (V)	129,848	131,625	97,220	24,995	122,215	Ω	n/a
% of ED patients discharged admitted or transferred within six hours of arrival (T)	97%	94%	96%	96%	96%	95%	●
% of ED admissions (to Waitematā DHB facilities) in 10-24 year olds where alcohol-related ED presentation status is 'unknown' (Q)	65%	91%	55%[18]	n/a[18]	38%[46]	<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[47] (T)	94%	88%	89%	87%	89%	90%	●
% of eligible stroke patients thrombolysed (C)	10%	8%	9%	7%	8%[48]	10%	●
% of ACS inpatients receiving coronary angiography within 3 days[49] (T)	72%	71%	77%	75%	76%	70%	●
MATERNITY							
Number of births in Waitematā DHB hospitals (V)	6,741	6,722	5,108	1,519	6,627	Ω	n/a
% of babies exclusively breastfed on discharge (Q)	79%	78%	75%	76%	75%	75%	●
ELECTIVE (INPATIENT/OUTPATIENT)							
Number of planned care interventions (V)	New indicator	New indicator	25,701 (106%)	6,331 (83%)	32,032 (100%)	32,119[50]	●
Inpatient surgical discharges			*15,477*	*3,936*	*19,413*	*21,276*	*n/a*
Minor procedures			*9,619*	*3,000*	*12,619*	*10,729*	*n/a*
Non-surgical interventions			*0*	*0*	*0*	*114*	*n/a*
% of people receiving urgent diagnostic colonoscopy in 14 days[49] (T)	97%	98%	99%	100%	99%	90%	●
% of people receiving non-urgent diagnostic colonoscopy in 42 days[49] (T)	71%	53%	47%	28%	42%[51]	70%	●
% of patients waiting longer than four months for their first specialist assessment (ESPI 2) (T)	0.0%	4.5%	6.1%[27]	15.4%[27]	15.4%[30]	0%	●
% of accepted referrals receiving their scan within 6 weeks[49] (T)							
- CT	83%	70%	68%	65%	63%[52]	95%	●
- MRI	78%	76%	85%	67%	83%[52]	90%	●

[46] Our patient management system now requires an answer to be entered for this field and performance for this data quality indicator is steadily improving.
[47] Only includes patients who received their first treatment; patients who are still waiting at the end of the reporting period are not included in this result.
[48] Stroke patients thrombolysed at presenting DHB. After hours stroke patients are transferred to Auckland City Hospital for thrombolysis and are not counted towards this measure, thus under-representing the proportion of Waitematā stroke patients receiving thrombolysis.
[49] Patients still waiting at the end of the reporting period, who have waited less than the target waiting time, are counted as compliant at that point in time, even if they go on to breach the waiting time; patients who have waited longer than the target waiting time are counted as non-compliant. Once a patient is seen, their wait time will be be-recalculated based on their actual wait time.
[50] This target is updated from that published in the 2019/20 Annual Plan.
[51] All non-urgent procedures were delayed during March to June as a result of COVID-19 restrictions. Internal and outsourced production recommenced in late May, and the full planned production was achieved in June. Several initiatives are underway to support our recovery plan.
[52] Some procedures were delayed during March to June as a result of COVID-19 restrictions. We are undertaking additional after hours sessions and outsourcing scans to private providers to improve waiting times.

Output measure	Previous years 2017/18 baseline	Previous years 2018/19 result	2019/20 Q1-3	2019/20 Q4 only	2019/20 Full year	2019/20 Target	2019/20 Rating
QUALITY AND PATIENT SAFETY							
% of opportunities for hand hygiene taken (Q)	88%	89%	89%[53]	n/a[54]	n/a[54]	80%	
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days (Q)	0.06	0.05	0.08	0.14	0.09	<0.11	
% of older patients assessed for the risk of falling (Q)	97%	97%	98%	n/a[54]	n/a[54]	90%	
% of falls risk patients who received individualised care plan (Q)	97%	97%	99%	n/a[54]	n/a[54]	90%	
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions (Q)	12.6	12.48	11.29	13.65	11.8[55]	<8.43	
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision (Q)	96%	97%	99%	n/a[54]	n/a[54]	100%	
% of hip and knee procedures given right antibiotic in right dose (Q)	97%	98%	100%	n/a[54]	n/a[54]	95%	
Surgical site infections per 100 hip and knee operations (Q)	0.63	0.52	0.50	n/a[54]	n/a[54]	<0.93	
% occasions insertion bundle used in ICU (Q)	99%	99%	100%	100%	100%	90%	
% occasions maintenance bundle used in ICU (Q)	94%	96%	98%	91%	96%	90%	
% of 'yes, completely' responses to the national inpatient survey question 'did a member of staff tell you about medication side effects to watch for when you went home' (Q)	45%	47%	46%[56]	n/a[56]	n/a[56]	47%	n/a
% of patients audited for pressure injury risk who received a score (Q)	86%	86%	87%	n/a[54]	n/a[54]	90%	
% of patients with the correct pressure injury care plan implemented (Q)	78%	66%	68%[57]	n/a[54]	n/a[54]	90%	
MENTAL HEALTH							
% of population who access Mental Health services(C)							
- Age 0–19 years	3.92%[26]	4.02%[26]	3.81%[18]	n/a[18]	3.69%	3.49%[58]	
Māori	*5.24%*[26]	*5.72%*[26]	*5.20%*[18]	n/a[18]	*5.09%*	*4.70%*[58]	
- Age 20–64 years	3.74%[26]	3.86%[26]	3.78%[18]	n/a[18]	3.83%	3.43%[58]	
Māori	*8.37%*[26]	*8.80%*[26]	*9.46%*[18]	n/a[18]	*9.03%*	*7.80%*[58]	
- Age 65+ years	2.21%[26]	2.35%[26]	2.13%[18]	n/a[18]	2.19%	2.01%[58]	
Māori	*2.29%*[26]	*2.48%*[26]	*2.37%*[18]	n/a[18]	*2.40%*	*2.13%*[58]	
% of 0-19 year old clients seen within 3 weeks[49] (T)							
- Mental Health	77%	70%	68%[18]	n/a[18]	70%[59]	80%	
- Addictions	91%	93%	86%[18]	n/a[18]	81%	80%	
% of 0-19 year old clients seen within 8 weeks[49] (T)							
- Mental Health	95%	93%	92%[18]	n/a[18]	90%	95%	
- Addictions	99%	99%	98%[18]	n/a[18]	96%	95%	

[53] July 2019 to February 2020 result.
[54] In response to the COVID-19 pandemic, the Health Quality & Safety Commission temporarily suspended the requirement for DHBs to report on manually collected quality and safety marker measures from 23 March to 30 June 2020, therefore Q4 result are not available. Rating was applied to the Q1-3 result.
[55] The absolute number for falls is very small (*n* = 13 for 2018/19, *n* = 12 for 2019/20). A formal quality improvement plan is in place to reduce falls with harm.
[56] The Inpatient patient experience survey was halted at the end of Q2 2019/20 for review, therefore results are available only to Q2.
[57] Pressure injury prevention improvements are in place. We are currently using the NEWS data rather than audit.
[58] Target is based on old population projections.
[59] During COVID-19, many patients chose to delay appointments until lockdown was lifted; online and telephone appointments were offered. Referral rates from the summer months contributed to low referral rates; delayed appointments and staff shortages further compounded waiting times.

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for 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.

	Previous years		2019/20				
Output measure	**2017/18 baseline**	**2018/19 result**	**Q1-3**	**Q4 only**	**Full year**	**Target**	**Rating**
HOME-BASED SUPPORT							
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	98%	98%	99%	n/a[60]	n/a[60]	95%	●
PALLIATIVE CARE							
Hospice							
Total number of contacts in the community (V)	21,827	21,010	17,647	2,293	19,940	Ω	n/a
% of acute patients who waited >48 hours for a hospice bed (T)	16%	21%	1.6%	0.0%	0.5%	<5.0%	●
Hospital							
Total number of referrals (V)	New indicator	1,158	1,065	322	1,387	Ω	n/a
Average time to first contact with referrer (T)	New indicator	4.4h	10.5h	6.1h	7.6h[61]	≤6h	●
Average time from referral to first face-to-face patient assessment (T)	New indicator	8.55h	10.6h	4.3h	9.25h	≤24h	●
RESIDENTIAL CARE							
ARC bed days (V)	966,718	974,841	741,251	241,728	982,979	Ω	n/a

[60] Due to COVID-19, service provision was reduced to minimise transmission risk, and providers were switched to fixed funding rather than fee for service, which means accurate data for this measure is not available for Q4. Rating is applied to the Q1-3 result.

[61] The target was based on fewer referrals to the service that were often received later in hospital admission. A number of factors contributed to an increase in referrals leading to an increase in waiting time, including inconsistent data entry due to staff turnover, more referrals received earlier in hospital admission, particularly after hours when the service is unavailable, and periods of the service being under-staffed.

Cost of Service Statement – for year ended 30 June 2020

	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support		Total Excluding COVID-19	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**419,000**	**197,141**	**1,160,434**	**1,636,282**	**35,371**	**24,948**	**315,743**	**74,901**	**1,930,548**	**1,933,272**
Expenditure										
Personnel	82,346	73,357	652,113	608,870	10,182	9,283	33,405	27,871	778,046	719,381
Outsourced Services	11,393	8,798	73,579	73,024	1,282	1,113	5,746	3,343	92,000	86,278
Clinical Supplies	12,268	13,619	101,812	113,035	1,552	1,723	4,662	5,174	120,294	133,552
Infrastructure and Non-Clinical Supplies	10,419	8,765	102,477	72,751	1,440	1,109	2,878	3,330	117,214	85,955
Payments to Providers	300,726	92,602	278,431	768,602	21,163	11,719	264,072	35,183	864,392	908,105
Total Expenditure	**417,152**	**197,141**	**1,208,412**	**1,636,282**	**35,619**	**24,948**	**310,763**	**74,901**	**1,971,946**	**1,933,272**
Net Surplus/ (Deficit)	**1,848**	**0**	**(47,978)**	**0**	**(248)**	**0**	**4,980**	**0**	**(41,398)**	**0**

	Total Excluding COVID-19		COVID-19		Total	
	$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**1,930,548**	**1,933,272**	**6,957**	**0**	**1,937,505**	**1,933,272**
Expenditure						
Personnel	778,046	719,381	11,315	0	789,361	719,381
Outsourced Services	92,000	86,278	460	0	92,460	86,278
Clinical Supplies	120,294	133,552	5,134	0	125,428	133,552
Infrastructure and Non-Clinical Supplies	117,214	85,955	714	0	117,928	85,955
Payments to Providers	864,392	908,105	16,134	0	880,526	908,105
Total Expenditure	**1,971,946**	**1,933,272**	**433,757**	**0**	**2,005,703**	**1,933,272**
Net Surplus/ (Deficit)	**(41,398)**	**0**	**(26,800)**	**0**	**(68,198)**	**0**

The variances shown above are due to a change of classification methodology between preparing the Plan and year-end reporting. Refer to the next table for the actual variances that arise where a consistent methodology is applied. Break-even position shown in the next table agrees to the Group's original Annual Plan.

	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support		Total Excluding COVID-19	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**419,000**	**423,561**	**1,160,434**	**1,152,901**	**35,371**	**35,602**	**315,743**	**320,543**	**1,930,548**	**1,932,607**
Expenditure										
Personnel	82,346	75,943	652,113	595,030	10,182	9,342	33,405	31,239	778,046	711,554
Outsourced Services	11,393	11,021	73,579	67,157	1,282	1,209	5,746	5,830	92,000	85,217
Clinical Supplies	12,268	12,756	101,812	105,874	1,552	1,614	4,662	4,847	120,294	125,091
Infrastructure and Non-Clinical Supplies	10,419	9,054	102,477	93,385	1,440	1,285	2,878	2,208	117,214	105,932
Payments to Providers	300,726	314,787	278,431	291,455	21,163	22,152	264,072	276,419	864,392	904,813
Total Expenditure	**417,152**	**423,561**	**1,208,412**	**1,152,901**	**35,619**	**35,602**	**310,763**	**320,543**	**1,971,946**	**1,932,607**
Net Surplus/ (Deficit)	**1,848**	**0**	**(47,978)**	**0**	**(248)**	**0**	**4,980**	**0**	**(41,398)**	**0**

	Total Excluding COVID-19		COVID-19		Total	
	$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**1,930,548**	**1,932,607**	**6,957**	**0**	**1,937,505**	**1,932,607**
Expenditure						
Personnel	778,046	711,554	11,315	0	789,361	711,554
Outsourced Services	92,000	85,217	460	0	92,460	85,217
Clinical Supplies	120,294	125,091	5,134	0	125,428	125,091
Infrastructure and Non-Clinical Supplies	117,214	105,932	714	0	117,928	105,932
Payments to Providers	864,392	904,813	16,134	0	880,526	904,813
Total Expenditure	**1,971,946**	**1,932,607**	**433,757**	**0**	**2,005,703**	**1,932,607**
Net Surplus/ (Deficit)	**(41,398)**	**0**	**(26,800)**	**0**	**(68,198)**	**0**

Net Deficit for the year totals to $68.198m against a planned break-even position. It is mainly driven by $41.800m Holidays Act provision and $26.800m COVID-19 financial impacts.

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

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 nine years and were awarded the Accessibility Tick in December 2019.

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.

In 2020, we launched our staff experience programme 'Better, Together'. The programme was primarily a response to COVID-19 and outlines work that enables us to live our values through activities where we listen to, strengthen, support, engage, connect with and recognise each other. A key highlight so far is our appreciative inquiry and leader check-in sessions, which support local teams to reflect and create actions.

Health equity

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

To support our health equity efforts, we set and aligned employment growth targets to match Māori and Pacific working age district populations with levels of staff employment. Targets for 2019/20 were met through improved recruitment processes, providing 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.

Since 2009, we supported over 300 Māori and Pacific students through their tertiary study. Since 2017, 100% of scholarship graduates who applied for roles gained employment in the health sector.

Waitematā DHB runs up to two 4-week programmes per year to support Māori and Pacific candidates into Health Care Assistant (HCA) roles. The 'New to HCA' programme was a finalist in the 2018 Diversity Awards NZ.

Recruitment, selection and development

Last year, a Māori recruitment consultant joined the team, bringing a kaupapa Māori approach to our recruitment processes. As well as working alongside Māori candidates, the consultant provided individual guidance on Māori interview practises to over 100 hiring managers.

The focus on identifying and addressing cultural awareness and competency within Services aims to both strengthen the recruitment experience for Māori applicants and our promise of best care to everyone, by keeping safe mana motuhake for existing staff.

We commissioned the Blind Foundation to review our recruitment website, providing valuable feedback on layout, size and colours that are accessible to candidates with visual and hearing impairments.

Building Capability

Waitematā DHB is committed to growing our digital capability. Last year, we launched our first digital academy to develop clinical staff to design people-centred solutions. The success of the programme saw an increase in trainees in our second cohort in 2020.

We have 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.

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

We support our Orderly, Cleaning, Therapy Assistants, Oral Health Assistants and HCA staff through NZQA accredited training via Careerforce, with more than 300 staff progressing through these programmes in the last 7 years.

Waitematā 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.

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

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, patients and visitors. They provide a friendly face to assist with way finding as visitors enter our hospitals, help with patient feedback data collection and provide support to ward patients in conversation and attending to their needs.

Other organisations assist with volunteering their time to our gardens include City Impact Church and the North Harbour Rose Society.

Remuneration and recognition

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

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

Living within our means is central to our success as an organisation. We actively participate in national bargaining, establishing parameters to ensure bargaining will deliver organisational and sector expectations. Any agreements negotiated nationally or locally are approved by the Ministry of Health 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 regular bipartite committees, both nationally and locally. This allows us to have dialogue about programmes of work, such as our health, safety and wellbeing risks and strategies, 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 Health Services Plan. Staff are involved in planning discussions about construction and design to enable accessible workplaces and future-proofed spaces that are safe and deliver contemporary patient care.

We offer our staff flexible hours, as 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 2019/20, we reviewed key people-based policies, including our recruitment and education policies. 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.

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

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

Waitematā DHB Board members

Professor Judy McGregor, CNZM, Chair

Sandra Coney QSO

Allison Roe MBE

Kylie Clegg, Deputy Chair

Warren Flaunty QSM

Renata Watene

Edward Benson-Cooper

John Bottomley

Hon Chris Carter

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.

Ministerial Directions

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

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in Apr-14 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in Jul-08, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF
- The direction from the Minister of Health on COVID-19 Response 2020 issued on 17 March 2020 pursuant to Section 32 of the New Zealand Public Health & Disability Act 2000 and section 103 of the Crown Entities Act 2004, continues to apply.

Statement of Waivers

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

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

The following waivers were given during the last year:

Meeting of the Waitematā DHB Board 21 August 2019

- James Le Fevre noted his disclosed interest as an Emergency Department Doctor for two items: 'Holidays Act Memorandum of Understanding' and 'Safe Transfer of Patients to Urgent Care Clinics'. The Board noted his declarations and were satisfied under Schedule 3, clause 36 (4) that James Le Fevre could remain in the meeting for the discussion of this item.

Meeting of the Waitematā DHB Board 02 October 2019

- Due to his disclosed pharmacy related interest, Warren Flaunty was not provided with an item for 'Community Pharmacy: Audit Policy Update'. The Board noted this declaration and was satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of the item, but could not participate in the voting of the item.

Meeting of the Waitematā DHB Board 18 December 2019

- Warren Flaunty noted his disclosed pharmacy related interest in relation to an item 'Evergreen agreements for community pharmacy and aged residential care services'. The Board noted this declaration and were satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of this item, but not participate in the decision making of the item.

Meeting of the Waitematā DHB Board February 2020

- Warren Flaunty noted his disclosed interest for the Waitakere Licencing Trust in relation to items 'Position Statement: Reducing Harms from Hazardous Alcohol Use in our Communities' and 'Waitakere –Hospital Special Care Baby Unit'. The Board noted his declarations and were satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of this information item.
- Warren Flaunty noted his disclosed pharmacy related interest in relation to an item 'Evergreen agreements for community pharmacy and aged residential care services'. The Board noted this declaration and were satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of this item, but not participate in the voting of the item.

Meeting of the Waitematā DHB Board 27 May 2019

- John Bottomley noted his disclosed interest as a Consultant Interventional Radiologist for Waitematā DHB in relation to an item 'Radiology Outsourcing post COVID-19 Lockdown'. The Board noted this declaration and were satisfied under Schedule 3, clause 36 (4) that John Bottomley could remain in the meeting for the discussion of this item, but not participate in the decision making of the item.

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

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas. An assessment of what has been achieved with Waitematā DHB's 2019/20 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

	2018/19		2019/20	
	Final Budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,531,538	1,531,538	1,622,080	1,622,080
Supplementary estimates		10,010		30,390
Addition to the supplementary estimates				3,988
Total appropriation revenue	1,531,538	1,541,548	1,622,080	1,656,458

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

Waitematā DHB is required to report on the technical performance of its three main asset portfolios (facilities, clinical equipment and Information Communications Technology (ICT)) to meet mandatory asset reporting requirements as set out in the Cabinet Office Circular CO (19) 6: Investment Management and Asset Performance in the State Services. The Circular gives effect to Cabinet's intention that there is active stewardship of government resources, and strong alignment between individual investments and the government's long-term priorities.

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

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.

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	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 Actual
1.1	**Facility condition** Percentage of occupied buildings rated as 'poor' or 'very poor' condition *Assessment of facility condition based on visual inspection, reported as % of overall buildings value in 'poor' or 'very poor' condition (condition grading levels: very poor, poor, average, good, very good).*	Condition	<5%	2.6%	<5%	3%
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%	86%	≥85%	87%
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%	80%	≥95%	97%
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	0	0

Measure		Indicator	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 Actual
1.5	**Seismic compliance** Number of owned occupied buildings classed as "Potentially Earthquake Risk" *Number of owned occupied buildings with seismic state based on NBS of between 34% and 67%. The target reflects the importance of having patient and staff facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	≤10	10	<14	10
1.6	**Seismic status of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is known *The current seismic status of some leased buildings is unknown as assessments have either not been carried out by landlords, or the information has not been provided by landlords.*	Functionality (Fitness for Purpose)	>85%	86%		n/a This asset performance measure was introduced on 1 July 2019
1.7	**Seismic compliance of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is >67% NBS. *This is to assess the current state of leased buildings and indicate where further work is required or alternative accommodation options should be considered (where possible). Actions are in progress with landlords to bring buildings up to >67%.*	Functionality (Fitness for Purpose)	>70%	61%		n/a This asset performance measure was introduced on 1 July 2019
1.8	**Car parking compliance** Mobility car park spaces as a percentage of total car park spaces to be greater than New Zealand Guideline 4121 *Percentage of mobility spaces at Waitakere and North Shore Hospitals as percentage of total spaces. The target is based on the New Zealand Standards 4121 and was approved by the Waitematā DHB Disability Advisory Committee as part of delivering the New Zealand Disability Strategy.*	Functionality (Fitness for Purpose)	100%	166% (more mobility spaces than required in standards)	100%	171% (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.

Measure		Indicator	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 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%	109%
2.4	**MRI Utilisation** Annual MRI screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	123%	≥100%	127%
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*	Functionality (Fitness for Purpose)	100%	100%	100%	99%

Measure		Indicator	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 Actual
	having high consequences associated with failure.					
2.6	**Clinical Equipment Condition (Age Based)** Critical clinical equipment less than 3 years past End-of-Life *Percentage of critical clinical equipment that has not reached the end of its useful life, or is up to 3 years past the end of its useful life, where useful life is an assumed typical working life for each type of equipment. This is a new measure introduced on 1 July 2018. The target reflects current performance and is being actively increased over time.*	Condition	>80%	81%	>70%	81%
2.7	**Clinical Equipment Condition** Critical clinical equipment in above average or average condition *Percentage of critical clinical equipment in above average or average condition based on the methodology for measuring asset condition against AS/New Zealand 3551 as developed by the Clinical Engineering New Zealand Managers Forum (March 2017).*	Condition	>75%	82%		n/a This asset performance measure was introduced on 1 July 2019
2.8	**Clinical Equipment Maintenance** Number of non-scheduled maintenance visits/total number of maintenance visits (critical clinical equipment) *Based on the number of assets that are subject to non-scheduled corrective maintenance, or risk/incident management as a percentage of total maintenance visits (annual preventative maintenance plus non-scheduled maintenance). This is a new measure introduced on 1 July 2018.*	Functionality (Fitness for Purpose)	<30%	32%	<30%	36%

ICT Asset Portfolio

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

Measure		Indicator	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 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 and tablet) that comply with the asset age specified in the DHB replacement policy.*	Condition	>75%	88%	>75%	78%
3.4	**End User Devices - Security** Percentage of devices compliant with security update policy *Measures the date of the last security patch of end user devices (excl. mobile and tablet), then determines how many devices expressed as a percentage comply with the DHB security update policy.*	Condition	>80%	58%	>80%	100%
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%	63%	>55%	58%
3.6	**Software (Applications) – Service Interruptions** % of applications not experiencing Service Level Agreement	Functionality (Fitness for	>80%	94%	>80%	100%

	Measure	Indicator	2019/20 Target	2019/20 Actual	2018/19 Target	2018/19 Actual
	(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.*	Purpose)				
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%	56%	>30%	27%
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%	67%	>31%	42%
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%	73%	>75%	100%
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	6.05	<20	4
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%	50%	>35%	41%

Statement of Responsibility

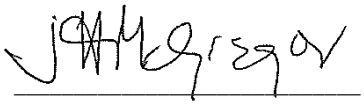
We are responsible for the preparation of the Waitematā District Health Board and group's financial statements and the statement of performance, and for the judgements made in them.

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 2020.

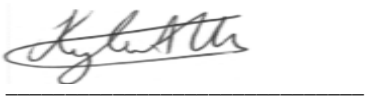
Signed on behalf of the Board:



Professor Judy McGregor, CNZM

Chair

Dated: 30 November 2020



Kylie Clegg

Deputy Chair

Dated: 30 November 2020

Statement of comprehensive revenue and expense for the year ended 30 June 2020

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Revenue						
Patient care revenue	2	1,903,540	1,804,618	1,903,540	1,889,893	1,804,618
Interest revenue		1,817	2,408	1,439	2,119	2,016
Other revenue	3	32,148	32,527	31,528	40,595	30,559
Total revenue	31	1,937,505	1,839,553	1,936,507	1,932,607	1,837,193
Expenditure						
Personnel costs	4	789,361	801,803	789,361	711,554	801,803
Depreciation and amortisation expense	13,14	28,926	30,229	28,926	30,000	30,229
Outsourced services		92,460	85,346	92,460	85,217	85,346
Clinical supplies		125,428	118,879	125,428	125,091	118,879
Infrastructure and non-clinical expenses		45,900	49,452	45,900	24,156	49,452
Other district health boards		326,880	309,105	326,880	329,777	309,105
Non-health board provider expenses		553,646	522,731	553,646	575,036	522,731
Capital charge	5	29,315	36,415	29,315	36,386	36,415
Other expenses	6	13,787	11,882	13,787	15,390	11,828
Total expenditure	31	2,005,703	1,965,842	2,005,703	1,932,607	1,965,788
Surplus/(deficit)		**(68,198)**	**(126,289)**	**(69,196)**	**0**	**(128,595)**
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations	19	0	0	0	0	0
Total other comprehensive revenue and expense		0	0	0	0	0
Total comprehensive revenue and expense		**(68,198)**	**(126,289)**	**(69,196)**	**0**	**(128,595)**

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 2020

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Budget 2020 $000	Actual 2019 $000
Balance at 1 July		502,297	626,849	486,268	621,849	613,126
Equity injections		26,050	2,200	26,050	22,460	2,200
		528,347	629,049	512,318	644,309	615,326
Comprehensive Income						
Surplus/(Deficit)		(68,198)	(126,289)	(69,196)	0	(128,595)
Prior year adjustments		0	(463)	0	0	(463)
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations		0	0	0	0	0
Total comprehensive revenue and expense for the year		**(68,198)**	**(126,752)**	**(69,196)**	**0**	**(129,058)**
Balance at 30 June	19	**460,149**	**502,297**	**443,122**	**644,309**	**486,268**

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 2020

	Notes	Group Actual 2020 $000	Group Actual 2019 $000	Parent Actual 2020 $000	Group and Parent Budget 2020 $000	Parent Actual 2019 $000
Assets						
Current assets						
Cash and cash equivalents	7	56,565	41,053	52,373	67,421	36,685
Receivables	8	55,583	56,357	54,913	57,800	55,685
Investments	9	3,042	750	0	1,500	0
Inventories	10	9,021	8,256	9,021	9,000	8,256
Prepayments		1,128	931	1,128	2,500	931
Assets held for sale	11	21,600	21,600	21,600	0	21,600
Total current assets		146,939	128,947	139,035	138,221	123,157
Non-current assets						
Investments	9	11,023	10,713	0	10,700	0
Investments in associates and joint ventures	12	47,236	40,091	47,236	42,068	40,091
Property, plant and equipment	13	741,649	713,965	741,649	740,273	713,965
Intangible assets	14	12,256	15,064	12,556	3,496	15,064
Total non-current assets		812,164	779,833	801,141	796,537	769,120
Total assets		**959,103**	**908,780**	**940,176**	**934,758**	**892,277**
Liabilities						
Current liabilities						
Payables	15	139,998	113,522	138,098	116,485	113,048
Borrowings	16	0	60	0	0	60
Employee entitlements	17	142,963	122,059	142,963	131,875	122,059
Provisions	18	4,270	4,776	4,270	2,500	4,776
Total current liabilities		287,231	240,417	285,331	250,860	239,943
Non-current liabilities						
Employee entitlements	17	211,723	166,066	211,723	39,589	166,066
Total non-current liabilities		211,723	166,066	211,723	39,589	166,066
Total liabilities		**498,954**	**406,483**	**497,054**	**290,449**	**406,009**
Net assets		**460,149**	**502,297**	**443,122**	**644,309**	**486,268**
Equity						
Contributed Capital	19	407,971	381,921	407,971	402,181	381,921
Accumulated surpluses/(deficits)	19	(254,299)	(185,103)	(254,299)	(63,046)	(185,103)
Property Revaluation Reserves	19	289,450	289,450	289,450	289,451	289,450
Trust funds	19	17,027	16,029	0	15,723	0
Total equity		**460,149**	**502,297**	**443,122**	**644,309**	**486,268**

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 2020

	Notes	Group Actual 2020 $000	Group Actual 2019 $000	Parent Actual 2020 $000	Group and Parent Budget 2020 $000	Parent Actual 2019 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,886,916	1,772,663	1,886,916	1,892,012	1,772,663
Other		42,649	61,865	42,825	37,793	60,954
Interest received		1,596	2,267	1,596	2,802	2,267
Payments to suppliers		(1,136,436)	(1,088,796)	(1,136,436)	(1,153,817)	(1,088,796)
Payments to employees		(722,580)	(677,605)	(722,580)	(711,554)	(677,605)
Payments for capital charge		(28,834)	(36,415)	(28,834)	(37,236)	(36,415)
GST (net)		417	(159)	417	0	(159)
Net cash flow from operating activities	20	43,728	33,820	43,904	30,000	32,909
Cash flows from investing activities						
Sale of fixed assets		0	0	0	30,000	0
Purchase of property, plant and equipment		(47,122)	(26,215)	(47,122)	(54,039)	(26,215)
Acquisition of investments		(7,144)	(1,286)	(7,144)	0	(1,286)
Net cash flow from investing activities		(54,266)	(27,501)	(54,266)	(24,039)	(27,501)
Cash flows from financing activities						
Capital contributions from the Crown		26,050	2,200	26,050	22,460	2,200
Net cash flow from financing activities		26,050	2,200	26,050	22,460	2,200
Net (decrease)/increase in cash and cash equivalents		**15,512**	**8,519**	**15,688**	**28,421**	**7,608**
Cash and cash equivalents at the start of the year		41,053	32,534	36,685	39,000	29,077
Cash and cash equivalents at the end of the year	7	**56,565**	**41,053**	**52,373**	**67,421**	**36,685**

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 2020

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 2020 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 subsidiaries, associates and joint arrangements are incorporated and domiciled in New Zealand.

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

The financial statements for the DHB and the Group are for the year ended 30 June 2020, and were approved for issue by the Board on 30 November 2020.

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 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, PBE IPSAS 38 Disclosure of Interests in Other Entities and PBE IPSAS 39 Employee Benefits for the first time. The nature and effect of the changes as a result of adoption of the new accounting standards are described below. Aside from the standards described above, the Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

PBE IPSAS 34-38

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.The DHB and Group have not applied these standards retrospectively.

The main changes under PBE IPSAS 34-38 that are relevant to The DHB and Group are:

a) Control: The new standards introduce an amended definition of control including extensive guidance on this definition.
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.
c) Disclosures on interests in other entities: The standards disclosure of information about their interests in other entities, including some additional disclosures that were not required under PBE IPSAS 6, 7 and 8.

1 Statement of accounting policies for the year ended 30 June 2020 (continued)

The effects of the implementation of PBE IPSAS 34-38 are as follows:

a) Control: The DHB has assessed the new definition of control and made no changes to the current treatment of controlled entities.

b) Joint arrangements: The DHB has reassessed existing Joint arrangements and have classified an arrangement with Awhina Waitakere Health Campus as Joint Operations. Joint operators recognise their assets, liabilities, revenue and expenses in relation to their interest in the joint operation. Refer to Note 12 for further details.

c) Additional disclosures on interests in other entities are summarised as follows:
   - Significant judgements, assumptions and the methodology used to determine that the reporting entity has control of another entity, that the reporting entity has joint control of an arrangement or significant influence over another entity; and the type of joint arrangement;
   - Additional financial information for joint ventures;
   - The nature and extent of significant restrictions on its ability to access or use assets, and settle liabilities.

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 periods.

The main changes under PBE IPSAS 39 that are relevant to the DHB and Group are:

- The new standard removes the option to defer the recognition of certain actuarial gains and losses arising from defined benefit plans (the "corridor approach");
- It eliminates some of the presentation options for actuarial gains and losses arising from defined benefit plans;
- It 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 effects of the implementation of PBE IPSAS 39 are as follows:

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 under PBE IPSAS 39. Refer to Note 1 Statement of Accounting Policies Superannuation Schemes.

Standards issued and not yet effective, and not early adopted

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Waitematā DHB has not yet determined how the application of PBE FRS 48 will affect its statement of performance.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Waitematā DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

1 Statement of accounting policies for the year ended 30 June 2020 (continued)

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

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

Joint Venture
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint control is the agreed sharing of control of an arrangement by way of a binding arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. Where the joint venture's results are material, the DHB includes the interest in the joint venture in the consolidated financial statements, using the equity method, from the date that joint control commences until the date that joint control ceases. The investments in joint ventures are accounted for in the parent entity financial statements at cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

De-recognition

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

Investments

Bank term deposits

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

Inventories

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

Property, plant, and equipment

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

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

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

Revaluations

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

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

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

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

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

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

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

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end. Work in progress is recognised at cost, less impairment, and is not amortised.

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website 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 an initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver benefits to the DHBs involved. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitematā DHB holds an asset at cost of capital invested by the DHB in FPIM. This investment represents the right to access the FPIM assets and is considered to have an indefinite life. DHBs have the ability and intention to renew the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets' standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

Cash generating assets

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

Non-cash generating assets

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

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the asset and availability of the information. If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education, and sick leave. A actuarial liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences. A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past event that has created a contractual obligation and a reliable estimate of the obligation can be made.

Long-term entitlements

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

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

Presentation of employee entitlements

Sick Leave, continuing medical education, annual leave, vested long service and sabbatical leave that is 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 each lease. Assumptions were made around the term of the period of the lease based on the contractual term and expectations around exercising rights of renewal, which is subject to uncertainty. Further assumptions are made around the expected cost of meeting these lease obligations and estimating the present value of the provision, which also come with inherent uncertainty.

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

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

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

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

Contributions from/(repayment to) the Crown
Contributions from the Crown for DHB Crown approved projects.

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

Trust/special funds
Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds. All trust funds are held in bank accounts that are separate from the DHB's normal banking facilities. Refer to Note 29 for details.

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

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

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

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

1 Statement of accounting policies for the year ended 30 June 2020 (continued)

Cost allocation

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

Critical accounting estimates and assumptions

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

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

Land and building revaluations

Note 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.

1 Statement of accounting policies for the year ended 30 June 2020 (continued)

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.

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.

Wilson Home Trust
The DHB does not control the Wilson Home Trust and the Trust is therefore not consolidated into the DHB's Annual Report. Careful consideration has been made to determine if the DHB has control of the Wilson Home Trust when adopting PBE IPSAS 34-38. As detailed in The Wilson Home Trust's Audited Performance Report for the year ended 30 June 2019, the Trust has net assets of $14.7m and a surplus of $1.8m. The Trust, under their accounting policies, account for land and buildings at cost. As the DHB accounts for land at fair value and buildings at fair value less accumulated depreciation there would be a variation in net assets that would be disclosed in the DHB's Annual Report if the DHB controlled the Wilson Home Trust. As a full fair value assessment of the Wilson Home Trust's land and buildings are not available, the DHB is unable to fully assess the impact that this would have on the net assets of the DHB. However, the DHB estimates that the value of the net assets of the Wilson Home Trust would be material to the DHB if the Trust was controlled.

2 Patient care revenue

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Health and disability services (MOH contracted revenue)	1,779,469	1,677,063	1,779,469	1,677,063
ACC contract revenue	11,512	11,700	11,512	11,700
Inter district patient inflows	85,439	84,384	85,439	84,384
Revenue from other district health boards	8,436	7,393	8,436	7,393
Other patient sourced revenue	18,684	24,078	18,684	24,078
Total patient care revenue	**1,903,540**	**1,804,618**	**1,903,540**	**1,804,618**

3 Other revenue

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Clinical Training Agency	9,750	9,868	9,750	9,868
Donations and bequests received	5,767	604	5,767	604
Rental revenue	855	941	855	941
Professional, training and research	5,255	5,167	5,255	4,537
Dividend income	167	0	167	0
Other revenue	10,354	15,947	9,734	14,609
Total other revenue	**32,148**	**32,527**	**31,528**	**30,559**

4 Personnel costs

	Notes	Group Actual 2020 $000	Group Actual 2019 $000	Parent Actual 2020 $000	Parent Actual 2019 $000
Salaries and wages		700,289	656,165	700,289	656,165
Contributions to defined contribution schemes		22,511	21,172	22,511	21,172
Increase/(decrease) in liability for employee entitlements		66,561	124,466	66,561	124,466
Total personnel costs		**789,361**	**801,803**	**789,361**	**801,803**

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 2020 was 6% (2019: 6%).

6 Other expenses

	Notes	Group Actual 2020 $000	Group Actual 2019 $000	Parent Actual 2020 $000	Parent Actual 2019 $000
Audit fees for Waitematā DHB financial statement audit		249	232	249	232
Audit fees (for subsidiary financial statements)		0	0	0	0
Operating lease expense		9,823	8,891	9,823	8,891
Impairment of debtors	8	1,938	2,310	1,938	2,310
Board members fees	24	390	359	390	359
Other expenses		1,387	90	1,387	36
Total other expenses		**13,787**	**11,882**	**13,787**	**11,828**

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 $4.192m (2019: $4.368m) generated for specific purposes such as research. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

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

	Group Actual 2020 $000	Group Actual 2019 $000	Parent Actual 2020 $000	Parent Actual 2019 $000
Cash at bank and on hand	4,194	2,618	2	0
Call deposits	0	1,750	0	0
NZ Health Partnerships Limited	52,371	36,685	52,371	36,685
Total cash and cash equivalents for the purposes of the statement of cash flows	**56,565**	**41,053**	**52,373**	**36,685**

8 Receivables

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Ministry of Health	27,142	23,823	27,142	23,823
Other receivables	10,502	10,875	9,851	10,203
Other accrued revenue	21,131	24,899	21,112	24,899
Less: Provision for impairment	(3,192)	(3,240)	(3,192)	(3,240)
Total receivables	**55,583**	**56,357**	**54,913**	**55,685**

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 2020			Group 2019		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	51,815	(22)	51,793	51,094	(3)	51,091
Past due 1-30 days	1,067	(239)	828	3,159	(266)	2,893
Past due 31-60 days	1,361	(202)	1,159	1,329	(227)	1,102
Past due 61-90 days	362	(173)	189	290	(192)	98
Past due >90 days	4,170	(2,556)	1,614	3,725	(2,552)	1,173
Total	**58,775**	**(3,192)**	**55,583**	**59,597**	**(3,240)**	**56,357**

	Parent 2020			Parent 2019		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	51,145	(22)	51,123	50,425	(3)	50,422
Past due 1-30 days	1,067	(239)	828	3,159	(266)	2,893
Past due 31-60 days	1,361	(202)	1,159	1,326	(227)	1,099
Past due 61-90 days	362	(173)	189	290	(192)	98
Past due >90 days	4,170	(2,556)	1,614	3,725	(2,552)	1,173
Total	**58,105**	**(3,192)**	**54,913**	**58,925**	**(3,240)**	**55,685**

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

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	
	2020 $000	2019 $000	2020 $000	2019 $000
Balance at 1 July	3,240	2,273	3,240	2,273
Additional provisions made	1,938	2,310	1,938	2,310
Receivables written off	(1,986)	(1,343)	(1,986)	(1,343)
Balance at 30 June	**3,192**	**3,240**	**3,192**	**3,240**

9 Investments

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

	Group		Parent	
	2020 $000	2019 $000	2020 $000	2019 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	3,042	750	0	0
Total current portion	3,042	750	0	0
Non-current portion				
Portfolio investments	11,023	10,713	0	0
Total non-current portion	11,023	10,713	0	0
Total investments	**14,065**	**11,463**	**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 $11.023m (2019: $10.713m). 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 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Pharmaceuticals	787	787	787	787
Surgical and medical supplies	8,234	7,469	8,234	7,469
Total inventories	**9,021**	**8,256**	**9,021**	**8,256**

The write-down of inventories held for distribution amounted to $nil (2019: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2019: $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 2019	12,212	9,388	21,600
Transfer from Property, plant and equipment	0	0	0
Total assets held for sale	**12,212**	**9,388**	**21,600**

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

The sale of this property has not been recognised in 2019/20 financial year as the planned sale was delayed due to COVID-19. The sale of the property is expected to occur in the 2020/21 financial year.

12 Investments in associates and joint ventures

	Principal activity	Interest held 30 Jun 2020	Balance date
Investments in joint ventures			
healthAlliance N.Z. Limited – Class A shares	Provider of shared services	25%	30 Jun
Healthsource New Zealand Limited	Provider of shared services	25%	30 Jun
Investments in associates			
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	Provision of health support services	33.3%	30 Jun

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

Investments in joint ventures

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

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

Joint operations

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

Value of investments in associates, joint ventures and partnerships

	Group		Parent	
	2020 $000	2019 $000	2020 $000	2019 $000
healthAlliance N.Z. Limited	46,842	39,779	46,842	39,779
HealthSource New Zealand Limited	170	0	170	0
South Kaipara Medical Centre	0	88	0	88
McCrae Research	224	224	224	224
Total investments	**47,236**	**40,091**	**47,236**	**40,091**

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.

Waitematā DHB sold 20% interest in South Kaipara Medical Centre in October 2019. The transfer of ownership was effective 1st December 2019 with the first instalment made on 12 February 2020. The second instalment is subject to any adjustments required under the Sale and Purchase Agreement and is to be paid on the completion of 12 months following 1 December 2019. No gain on sale is expected upon the second instalment.

There were no impairment losses in the value of associates and joint ventures assessed for 2020 (2019: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $46.842m (2019: $39.779m).

Summary of financial information of associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2020					
Northern Regional Alliance Ltd	23,770	20,211	3,559	18,223	1,101
Total	**23,770**	**20,211**	**3,559**	**18,223**	**1,101**
2019					
Northern Regional Alliance Ltd	22,347	19,891	2,456	14,897	913
South Kaipara Medical Centre	512	221	291	2,299	68
Total	**22,859**	**20,112**	**2,747**	**17,196**	**981**

12 Investments in associates and joint ventures (continued)

As of 30 June 2020 healthAlliance N.Z. Limited has transferred ownership of HealthSource New Zealand Limited directly to the Northern Region DHB's. HealthSource New Zealand Limited was the only subsidiary of healthAlliance N.Z. Limited prior to 30 June 2020. Actual figures for healthAlliance N.Z. Limited for the year ended 30 June 2020 exclude HealthSource New Zealand Limited figures. HealthSource New Zealand Limited figures are reported separately as they also have a joint venture status with Waitematā DHB at the balance date.

healthAlliance N.Z. Limited	2020 $000	2019 $000
Current assets	25,192	27,737
Non-current assets	199,102	185,145
Current Liabilities	22,851	24,485
Non-current liabilities	11,436	6,827
Included in the above amounts are:		
Cash and cash equivalents	15,653	14,012
Current financial liabilities (excluding trade payables)	10,082	8,365
Non-current financial liabilities (excluding trade payables)	11,436	6,827
Net assets (100%)	**190,007**	**181,570**
Revenue	137,819	155,895
Other comprehensive income	0	0
Total comprehensive income (100%)	(2,087)	291
Included in the above amounts are:		
Depreciation and amortisation	42,658	46,406
Interest income	0	126
Interest expense	0	8

HealthSource New Zealand Limited	2020 $000	2019 $000
Current assets	7,977	0
Non-current assets	217	0
Current Liabilities	5,865	0
Non-current liabilities	1,693	0
Included in the above amounts are:		
Cash and cash equivalents	6,458	0
Current financial liabilities (excluding trade payables)	4,191	0
Non-current financial liabilities (excluding trade payables)	1,693	0
Net assets (100%)	**636**	**0**
Revenue	34,131	0
Other comprehensive income	0	0
Total comprehensive income (100%)	(41)	0
Included in the above amounts are:		
Depreciation and amortisation	55	0
Interest income	56	0
Interest expense	0	0

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

	2020 $000	2019 $000
Share of surplus/(deficit) before tax:	(165)	390
Less: Tax expense	0	0
Share of surplus/(deficit)	**(165)**	**390**

The accounting treatment of New Zealand Health Partnerships Limited interest has changed since prior year and 2019 comparative Share of surplus/(deficit) before tax has been restated to exclude New Zealand Health Partnerships Limited portion.

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 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
Balance at 1 July 2019	249,915	419,926	137,415	36,459	4,881	23,387	871,983
Additions from WIP	16,923	4,961	6,696	1,451	1,226	(31,258)	0
Revaluation increase/(decrease)	0	0	0	0	0	0	0
Additions to WIP	0	0	0	0	0	56,635	56,635
Disposals	0	0	0	(89)	0	(1,539)	(1,628)
Transfer to intangible assets	0	0	0	0	0	0	0
Transfer to assets held for sale	0	0	0	0	0	0	0
Balance at 30 June 2020	266,838	424,887	144,111	37,821	6,107	47,225	926,989
Accumulated depreciation and impairment losses							
Balance at 1 July 2018	0	6,290	95,822	25,919	4,121	0	132,152
Depreciation expense	0	17,015	7,435	2,220	233	0	26,903
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	55	(94)	(999)	0	0	(1,038)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2019	0	23,360	103,163	27,140	4,354	0	158,017
Balance at 1 July 2019	0	23,360	103,163	27,140	4,354	0	158,017
Depreciation expense	0	17,398	7,331	2,070	612	0	27,411
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	(88)	0	0	(88)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2020	0	40,758	110,494	29,121	4,966	0	185,340
Carrying amounts							
At 1 July 2018	262,127	412,626	32,449	7,694	304	39,950	755,150
At 30 June and 1 July 2019	249,915	396,566	34,252	9,319	527	23,387	713,965
At 30 June 2020	266,838	384,129	33,617	8,699	1,141	47,225	741,649

The net carrying amount of assets held under finance leases is nil (2019: $60k) for clinical equipment. There are no IT assets in Work In Progress that need to be transferred to healthAlliance N.Z. Limited (2019: $360k).

COVID-19 Impact on Fair Valuations

The economic climate from March 2020 has been changing rapidly due to uncertainty presented by COVID-19. There has been reduced sales data since COVID-19 pandemic took effect due to the hesitation in purchase decisions. The on-going impact from COVID-19 will likely prolong market uncertainty resulting in the increased uncertainty around the fair value of land and building.

Land

Waitematā DHB has acquired 2.84ha of land adjacent to the Mason Clinic for $16.4m. The settlement took place on 2 December 2019.

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 a high level desktop assessment and is not reflected in the numbers. This desktop revaluation assessment confirmed the carrying value of land and buildings carried forward at 30 June 2020 still approximates fair value at this time.

13 Property, plant and equipment (continued)

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

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

	2020 $000	2019 $000
Buildings	38,427	19,474
Clinical equipment	6,411	1,943
Other equipment	1,824	1,610
IT equipment	562	360
Total work in progress	**47,225**	**23,387**

Impairment
No impairment loss has been identified in property, plant and equipment in 2020 (2019 : 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 Tāmaki Makaurau pursuant to the provisions of a Deed of Settlement with the Crown in relation to Treaty of Waitangi claims. Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims has been estimated in the value of the land.

14 Intangible assets

Finance, Procurement and Information Management System (FPIM); previously known as the National Oracle Solution (NOS)
The FPIM rights were tested for impairment at 30 June 2020 by comparing the carrying amount of the intangible asset to its recoverable service amount. For the year ended 30 June 2020, no new impairment indicators were identified.

There has been no further impairment of the FPIM carrying amount required for the year ended 30 June 2020 (2019: $1.624m). In 2019, the FPIM Governance Board resolved to transfer the overall responsibility for FPIM from NZHP to Ministry of Health (MoH). However, at this stage NZHP remains responsible for delivery of the FPIM programme and service under MoH-led governance and until a decision is made on the longer-term operating model for FPIM.

14 Intangible assets (continued)

Movements for each class of intangible assets are as follows.

Parent and Group	FPIM Rights $000	Acquired Software $000	Work in Progress $000	Total $000
Cost				
Balance at 30 June 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**
Additions to WIP*	0	0	5,036	5,036
Additions from WIP	0	3,416	(3,416)	0
Transferred to healthAlliance N.Z. Limited	0	(7,042)	(803)	(7,845)
Disposals	0	(100)	(23)	(123)
Impairment	0	0	0	0
Balance at 30 June 2020	2,849	10,312	5,886	19,047
Accumulated amortisation and impairment losses				
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**
Amortisation expense	0	2,091	0	2,091
Transferred to healthAlliance N.Z. Limited	0	(2,214)	0	(2,214)
Balance at 30 June 2020	0	6,791	0	6,791
Carrying amounts				
At 1 July 2018	3,496	234	0	3,730
At 30 June 2019	**2,849**	**7,123**	**5,092**	**15,064**
At 30 June 2020	**2,849**	**3,520**	**5,886**	**12,256**

*This includes transfer from PPE WIP

15 Payables

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Creditors and accrued expenses	123,329	99,432	121,429	98,958
Revenue in advance	7,011	5,338	7,011	5,338
GST payable	9,177	8,752	9,177	8,752
Capital charge payable	481	0	481	0
Total payables	**139,998**	**113,522**	**138,098**	**113,048**

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 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Current portion				
Finance leases	0	60	0	60
Non-current portion				
Finance leases	0	0	0	0
Total borrowings	**0**	**60**	**0**	**60**
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 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Minimum lease payments payable				
No later than one year	0	60	0	60
Later than one year and not later than five years	0	0	0	0
Later than five years	0	0	0	0
Total minimum lease payments	0	60	0	60
Future finance charges	0	0	0	0
Present value of minimum lease payments	**0**	**60**	**0**	**60**
Present value of minimum lease payments				
No later than one year	0	60	0	60
Later than one year and not later than five years	0	0	0	0
Later than five years	0	0	0	0
Total present value of minimum lease payments	**0**	**60**	**0**	**60**

Finance lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default.

Description of finance leasing arrangements
There are no current finance leases held by the DHB.

17 Employee entitlements

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Current portion				
Accrued salaries and wages	12,224	6,942	12,224	6,942
Annual leave	95,329	81,636	95,329	81,636
Sick leave	1,311	1,119	1,311	1,119
Sabbatical leave	232	150	232	150
Continuing medical education	7,014	6,162	7,014	6,162
Work-related entitlements	(2)	(136)	(2)	(136)
Unpaid payroll	7,264	6,972	7,264	6,972
Other employee entitlements	8,538	6,593	8,538	6,593
Unsettled CEAs	1,230	3,959	1,230	3,959
Long service leave	3,605	2,886	3,605	2,886
Retirement gratuities	6,218	5,776	6,218	5,776
Total current portion	142,963	122,059	142,963	122,059
Non-current portion				
Holiday pay provision	166,600	124,800	166,600	124,800
Continuing medical education	8,927	7,843	8,927	7,843
Long service leave	8,102	8,172	8,102	8,172
Sabbatical leave	2,929	2,823	2,929	2,823
Retirement gratuities	22,432	19,766	22,432	19,766
Sick leave	2,733	2,662	2,733	2,662
Total non-current portion	211,723	166,066	211,723	166,066
Total employee entitlements	**354,686**	**288,125**	**354,686**	**288,125**

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.

Holidays Act provision

The DHB is liable for leave entitlements under the Holidays Act 2003 ('the Act').

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").

Work has been on-going 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

17 Employee entitlements (continued)

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 the 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 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. Waitematā DHB has made progress in its review and it now believes it can determine a reliable estimate of its obligation to address historic non-compliance under the MoU.

The amount provided as at 30 June 2020 is $166.6m (2019: $124.8m), which includes:

- reassessed position as at 30 June 2019 after the review of the methodology as $143.6m. This includes an estimate for administrative and software update costs to complete this process,
- in year provision of an additional $20.6m plus an uplift of the total provision for inflation.

The liability has been estimated by:

- selecting a sample of current and former employees excluding any outliers,
- calculating the underpayment for these employees over the full period of liability (using Hours paid method),
- extrapolating the result across all current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year.

18 Provisions

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Current portion				
ACC Partnership Programme	1,800	1,834	1,800	1,834
Make good provision	2,470	2,942	2,470	2,942
Total current portion	**4,270**	**4,776**	**4,270**	**4,776**

Movements for each class of provision	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Balance at 1 July	4,776	4,653	4,776	4,653
Movement in provisions	(506)	123	(506)	123
Amounts used	0	0	0	0
Balance at 30 June	**4,270**	**4,776**	**4,270**	**4,776**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2020. 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.

18 Provisions (continued)

Risk margin

A risk margin of 8.2% (2019: 8.1%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. The risk margin has been determined after consideration of past claims history, costs, and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

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

- an average assumed rate of inflation of 1.7% (2019: 1.52%)
- a weighted average discount factor of 1.08% (2019: 1.83%) 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 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Crown equity				
Balance at 1 July	381,921	379,721	381,921	379,721
Capital contributions from the Crown	26,050	2,200	26,050	2,200
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	407,971	381,921	407,971	381,921
Accumulated surpluses/(deficits)				
Balance at 1 July	(185,103)	(56,045)	(185,103)	(56,045)
Prior year adjustments	0	(463)	0	(463)
	(185,103)	(56,508)	(185,103)	(56,508)
Surplus/(deficit) for the year	(68,198)	(126,289)	(69,196)	(128,595)
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(998)	(2,306)	0	0
Balance at 30 June	(254,299)	(185,103)	(254,299)	(185,103)
Revaluation reserves				
Balance at 1 July	289,450	289,450	289,450	289,450
Impairment loss	0	0	0	0
Revaluations	0	0	0	0
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	16,029	13,723	0	0
Movement	998	2,306	0	0
Balance at 30 June	17,027	16,029	0	0
Total equity	**460,149**	**502,297**	**443,122**	**486,268**

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

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Net surplus/(deficit)	**(68,198)**	**(126,289)**	**(69,196)**	**(128,595)**
Add/(less) non-cash items				
Depreciation and amortisation expense	28,926	30,229	28,926	30,229
Total non-cash items	28,926	30,229	28,926	30,229
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/loss investments	0	1,624	0	1,624
(Gains)/losses on disposal of property, plant and equipment	1,658	(26)	1,658	(26)
	1,658	1,598	1,658	1598
Add/(less) movements in statement of financial position items				
Debtors and other receivables	1,447	(399)	1,447	(1,310)
Inventories	(765)	(323)	(765)	(323)
Creditors and other payables	14,389	4,683	15,563	6,989
Provisions	(506)	123	(506)	123
Employee entitlements	66,777	124,198	66,777	124,198
Net movements in working capital items	81,342	128,282	82,516	129,677
Net cash flow from operating activities	**43,728**	**33,820**	**43,904**	**32,909**

21 Capital commitments and operating leases

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Capital commitments				
Property	43,038	1,301	43,038	1,301
Equipment	2,022	210	2,022	2,107
Total capital commitments	**45,060**	**1,511**	**45,060**	**3,408**

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 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Not later than one year	6,956	6,441	6,956	6,441
Later than one year and not later than five years	14,524	16,949	14,524	16,949
Later than five years	4,142	5,581	4,142	5,581
Total non-cancellable operating leases as lessee	**25,622**	**28,971**	**25,622**	**28,971**

22 Contingencies

Contingent liabilities

Lawsuits against the DHB

Waitematā DHB and its associates were notified of potential legal claims at 30th June 2020 which creates a contingent liability totalling approximately $285k (2019: approximately $180k) which related to various disputed claims against the DHB.

At balance date, Unitec Institute of Technology have granted $87k (2019: $174k) towards the refurbishment of Awhina Health Campus which was completed on 2 November 2011. If certain conditions in the joint operation agreement are not fulfilled, Waitematā DHB would need to repay some, or all, of this amount.

22 Contingencies (continued)

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

- A potential underpayment of $24.6m for the underpayment of annual leave to Registered Medical Officers (RMO)
    - Under the Multiple Employer Collective Agreement (MECA) with the Resident Doctors Association (RDA) when RMO leave one DHB and join another one in the region, any annual leave liability is transferred to the receiving DHB and the leave balance is paid to that DHB.
    - The Labour Inspectorate has ruled that this is a breach and that each DHB should have paid out the annual leave to the RMO when they left the DHB. Given the specific circumstances that protects the employees entitlement to take leave when transferring between DHBs and the written agreements that are in place the Labour Inspectorate does not intend to take further enforcement action in relation to the historical practice of crediting annual leave entitlements. This does not prevent an affected employee bringing the claim against the employer and does not prevent the Labour Inspectorate from taking action in the future.
    - The extent of any liability is contingent upon a future action being made by the Labour Inspectorate or an affected employee. In addition, this is not an area that has yet been contested in the courts and there is an indication of significant uncertainty to the probability and reliability of any estimation.
- A potential underpayment of holiday pay of $30.8m for the exclusion of allowances from gross earnings when calculating annual leave entitlements
    - These allowances (like higher duties and Clinical Leadership) are paid irrespective of whether or not an employee is on annual leave . Because of this, the DHB exclude these payments from gross earnings when calculating the rate at which annual leave should be paid.
    - The Labour Inspectorate's view is that leave is underpaid because these payments should be included in gross earnings when calculating the rate of annual leave payments. They also advised that the specific allowances should not be paid when staff are on leave.
    - An estimate of the underpayment has been included in the Holiday Pay Provision of $166.6m. This is based on the assumption that a line by line method of remediation will be undertaken and that the difference between what was paid for holiday pay (Gross earnings plus the allowance) and what should have been paid using the correct Average Weekly Earnings.
    - The $30.8m represents an estimate of the potential underpayment if the gross earnings are adjusted to include the allowances and no consideration is taken to include the allowance in the comparison of what has been paid to what was paid. The DHB is working through how this issue can be remediated and for the extent and value of any liability is contingent upon the result of this remediation or any future action being made by the Labour Inspectorate or an affected employee.

23 Related party transactions

All related party transactions have been entered into on an arm's length basis. The DHB is a wholly-owned entity of the Crown. Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2019: $nil).

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $1.791b (2019: $1.689b) to provide health services in the Waitematā area for the year ended 30 June 2020.

23 Related party transactions (continued)

Transactions with key management personnel

Key management personnel compensation	Actual 2020 $000	Actual 2019 $000
Board members:		
Remuneration	362	346
Full-time equivalent members	11	11
Salaries and other employee benefits of Executive Leadership Team	3,895	3,267
Full-time equivalent members	10	10
Total key management personnel remuneration	**4,257**	**3,613**
Total full-time equivalent personnel	**21**	**21**

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board members. Key management personnel include the Chief Executive Officer and the other nine members of the management team (2019: nine members).

24 Board member remuneration

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

	Actual 2020 $000	Actual 2019 $000
Prof Judith McGregor (Chair)	60	60
Prof Max Abbott	32	27
Edward Benson-Cooper	32	28
Sandra Coney	31	27
Kylie Clegg	40	36
Warren Flaunty	34	30
James Le Fevre	13	29
Morris Pita	12	28
Allison Roe	30	27
Matire Harwood	11	26
Brian Neeson	14	28
Christopher Carter	18	0
Renata Watene	18	0
Arena Williams	17	0
Total board member remuneration	**362**	**346**

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $28k (2019: $12k) – Norman Wong (Audit and Finance Committee).

The DHB provided a deed of indemnity to Board members for certain activities undertaken in the performance of DHB functions. The DHB affected Directors' and Officers' liability and professional indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees. No Board members received compensation or other benefits in relation to cessation (2019: $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 2020	Actual 2019		Actual 2020	Actual 2019
$100,000 – 109,999	478	382	$360,000 – 369,999	11	9
$110,000 – 119,999	264	224	$370,000 – 379,999	9	11
$120,000 – 129,999	186	164	$380,000 – 389,999	6	5
$130,000 – 139,999	109	72	$390,000 – 399,999	3	8
$140,000 – 149,999	74	51	$400,000 – 409,999	10	10
$150,000 – 159,999	52	33	$410,000 – 419,999	8	6
$160,000 – 169,999	31	37	$420,000 – 429,999	10	12
$170,000 – 179,999	16	24	$430,000 – 439,999	6	5
$180,000 – 189,999	34	22	$440,000 – 449,999	5	6
$190,000 – 199,999	27	20	$450,000 – 459,999	4	4
$200,000 – 209,999	20	24	$460,000 – 469,999	4	6
$210,000 – 219,999	16	18	$470,000 – 479,999	7	5
$220,000 – 229,999	25	21	$480,000 – 489,999	7	2
$230,000 – 239,999	23	16	$490,000 – 499,999	2	0
$240,000 – 249,999	21	23	$500,000 – 509,999	0	1
$250,000 – 259,999	25	20	$510,000 – 519,999	1	1
$260,000 – 269,999	20	22	$520,000 – 529,999	1	0
$270,000 – 279,999	24	20	$530,000 – 539,999	1	2
$280,000 – 289,999	12	15	$540,000 – 549,999	1	0
$290,000 – 299,999	13	22	$570,000 – 579,999	1	0
$300,000 – 309,999	22	14	$580,000 – 589,999	0	1
$310,000 – 319,999	14	16	$600,000 – 609,999	0	1
$320,000 – 329,999	18	14	$630,000 – 639,999	1	1
$330,000 – 339,999	13	13	$650,000 – 659,999	1	0
$340,000 – 349,999	16	13	$670,000 – 679,999	0	1
$350,000 – 359,999	16	14	$730,000 – 739,999	1	0
			Grand Total	**1,669**	**1,411**

During the year ended 30 June 2020 there were 100 (2019: 100) employees who received compensation and other benefits in relation to cessation totalling $2.259m (2019: $1.657m).

26 Events after the balance date

There were no significant events after the balance date.

27 Financial instruments

27a Financial instrument categories

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

	Group		Parent	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Financial assets measured at amortised cost	$000	$000	$000	$000
Cash and cash equivalents	56,565	41,053	52,373	36,685
Debtors and other receivables	55,583	56,357	54,913	55,685
Term investments	3,042	750	0	0
Portfolio investments	11,023	10,713	0	0
Total financial assets	**126,213**	**108,873**	**107,286**	**92,370**
Financial liabilities measured at amortised cost				
Creditors and other payables (excluding revenue in advance and GST)	123,810	99,432	121,910	98,958
Finance leases	0	60	0	60
Total financial liabilities measured at amortised cost	**123,810**	**99,492**	**121,910**	**99,018**

27 Financial instruments (continued)

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 (2019: nil).

Sensitivity analysis

As at 30 June 2020, 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.

27 Financial instruments (continued)

Credit quality of financial assets

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

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	0	0	0	0
AA -	57,245	5,252	52,373	0
A	465	852	0	0
A+	0	0	0	0
A	361	411	0	0
A-	450	504	0	0
BBB+	509	0	0	0
BB+	0	0	0	0
Total counterparties with credit ratings	59,030	7,019	52,373	0
Total counterparties without credit ratings				
Cash, cash equivalents	0	36,685	0	36,685
Investments	11,600	8,812	0	0
Total counterparties without credit ratings	11,600	45,497	0	36,685
Total cash, cash equivalents and investments	**70,630**	**52,516**	**52,373**	**36,685**
Debtors and other receivables				
Existing counterparty with no defaults in the past	55,583	56,357	54,913	55,685
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**55,583**	**56,357**	**54,913**	**55,685**

Liquidity risk

Management of liquidity risk

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

27 Financial instruments (continued)

Contractual maturity analysis of financial assets

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
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**
2020						
Cash on hand	56,565	56,565	56,565	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	55,583	55,583	55,583	0	0	0
Investments	14,065	14,065	3,041	9,281	1,688	55
Total	**126,213**	**126,213**	**115,189**	**9,281**	**1,688**	**55**
Parent						
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**
2020						
Cash on hand	52,373	52,373	52,373	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	54,913	54,913	54,913	0	0	0
Total	**107,286**	**107,286**	**107,286**	**0**	**0**	**0**

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

Contractual maturity analysis of financial liabilities

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
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**
2020						
Creditors and other payables	123,810	123,810	123,810	0	0	0
Finance leases	0	0	0	0	0	0
Total	**123,810**	**123,810**	**123,810**	**0**	**0**	**0**
Parent						
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**
2020						
Creditors and other payables	121,910	121,910	121,910	0	0	0
Finance leases	0	0	0	0	0	0
Total	**121,910**	**121,910**	**121,910**	**0**	**0**	**0**

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

28 Capital management

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

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

29 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary – Three Harbours Health Foundation (THHF). The DHB does not hold an equity investment in its wholly owned subsidiary (2019: $nil).

Summary of financial information of Three Harbours Health Foundation

	Assets	Liabilities	Revenue	Surplus/ (Deficit)
	$000	$000	$000	$000
2020	18,926	1,900	1,062	998
2019	16,508	480	2,360	2,306

30 Patient trust monies and restricted funds

Patient trust monies

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

	Actual 2020 $000	Actual 2019 $000
Balance at 1 July 2019	114	98
Monies received	1,096	790
Payments made	(1,048)	(774)
Balance at 30 June 2020	**162**	**114**

Trust/special fund assets (restricted)

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

	Group		Parent	
	Actual 2020 $000	Actual 2019 $000	Actual 2020 $000	Actual 2019 $000
Current assets				
Cash and cash equivalents	4,192	4,368	0	0
Receivables	670	672	0	0
Investments	3,042	750		
	7,904	**5,790**	**0**	**0**
Non-current assets				
Investments	11,023	10,713	0	0
Total trust/special fund	**18,927**	**16,503**	**0**	**0**

31 Explanation of major variances against budget

COVID-19 Impact

Total financial impact of COVID-19 in 2019/20 was $26.8m unfavourable and the summary is outlined further in this note below.

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

- Total revenue for the year was below budget by $2.1m due to under delivery of electives programme resulting in lower revenue from the MOH.
- Expenditure for the year was $39.3m higher than budget, which is mostly due to:
  - Personnel costs being higher due to the Holiday Pay provision being increased by $41.8m as explained in note 17.
  - Personnel costs being $24.7m higher due to variations in expected MECA costs and unbudgeted FTE increases.
  - Outsourced services costs $6.8m higher due to additional Radiology outsourcing due to industrial action and to help fill unexpected vacancies.
  - $4.8m savings in clinical supplies occurred notably due to under delivery of electives programme.
  - Infrastructure and non-clinical costs together with depreciation, capital charge and other expenses were higher than budget by $11.3m, mainly due to budgeted saving initiatives not being met that were partially offset by $7m reduction in capital charge due to prior year loss.
  - NGO expenses and DHB IDF off-sets were $40.4m favourable to budget that occurred mainly due to favourable variance in Funder NGO contracts and accrual reassessments.

COVID-19 impacts were $26.8m unfavourable and are broken down as follows:

- Net additional revenue associated with COVID-19 was $7m, which is due to:
  - Additional funding received from the Crown in response to COVID-19 of $13.7m
  - $5.7m of personal protective equipment that were distributed by the Ministry of Health
  - $10.1m unrecognised surplus of the sale of a commercial premise, as the planned sale is delayed until 2020/21 financial year
  - $2.3m revenue lost attributed to COVID-19.
- Total expenditure attributed to COVID-19 was $33.8m, which is mostly due to:
  - Additional personnel costs of $11.3m.
  - Additional outsourced services costs of $0.5m.
  - $5.2m additional cost in clinical supplies made up from $8.2m COVID-19 test costs and staff personal protective equipment that were partially offset by $3m savings in clinical supplies occurring mainly due to reduced service treatment consumables attributed to COVID-19.
  - Infrastructure and non-clinical additional costs were $0.7m, which included Community-based assessment centres (CBAC) related costs, IT costs, cleaning supplies, installation of Triage Screening tents etc.
  - Payments to external NGO providers in response to COVID-19 were $16.1m.

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

- $21m deferral of the sale of a commercial premise included in assets held for sale.
- Employee entitlements provisions in total were $181.8m higher than budgeted. The main driver of this was the $114.3m Holiday Pay provision late adjustment in 2018/19 that was not included in the 2019/20 budget and additional $41.8m Holiday Pay provision reassessment which is explained in note 17. The remainder of the variance is driven by annual leave provision and continuing medical entitlements (CME) increases due to COVID-19 and other long-term employee entitlements provisions.

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

- Increased operating cash flow of $13.7m was due to $17.4m lower payments to suppliers, which are mainly driven by variances in expenditure discussed above, and $8.4m reduction in payments for capital charge that were partially offset with $11m higher payments to employees.
- Lower investing cash inflow of $30.2m was mainly due to $30m deferral of the sale of a commercial premise. The remainder is attributed to changes to initial phasing assumptions of capital expenditure.

32 Compliance with Crown Entities Act 2004

Extension to the date DHBs are required to finalise and publish 2020/21 Statements of Intent
Legislation passed on 30 April 2020 allowed Ministers to extend the time for meeting planning requirements that apply under the Crown Entities Act 2004 by up to three months due to the impacts of COVID-19. The relevant extension will be repealed on 1 October 2020.

The Minister of Health agreed to extend the timeline for finalising and publishing the 2020/21 statement of performance expectation (SPE) to 15 August 2020. The extension also applies to the statement of intent (SOI) if the DHB choses to produce one (noting the Minster of Health did not ask DHBs to produce updated SOIs for 2020/21).

The reason the extension has been granted is to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

Accordingly, the DHB published its 2020/21 statement of performance expectation (SPE) and statement of intent (SOI) on 15 August 2020.

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 2019/20 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.

Holidays Act non-compliance
As at 30 June 2020, the DHB maintains a liability for Holidays Act non-compliance of $166.6m. This represents management's current best estimate at that date. Work is still on-going between District Health Boards, the Council of Trade Unions (CTU) health sector unions and the Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate to rectify and remediate any Holidays Act non-compliance by DHBs. This estimated liability indicates a significant obligation for the DHB to settle. Based on current and projected cash balances, the DHB would not be able to pay this amount without additional support from the Government.

Cost of COVID-19
The financial year 2019/20 has brought to light the impact that unexpected events can have on a DHB's financial planning. COVID-19 had a significant impact on the Waitematā DHB's performance during the financial year and continues to have on-going implications for the DHB. Subsequent to balance sheet date new cases of community transmission continue to be identified in the Auckland Region, therefore the Waitematā DHB must remain vigilant to further outbreaks and the impact that this may have on its financial position and going concern assumption. In the event of an outbreak escalating, the DHB may not be able to cover the additional related costs without additional support from the Government.

Declining projected cash flows
As detailed in our Statement of Performance Expectations for the 2020/21 financial year, the DHB is projecting negative net cash flows for both the 2020/21 financial year and the proceeding three years. This assumes the DHB successfully implements its financial sustainability programme, therefore, based on the current funding assumptions, the DHB may not be in a position to cover their on-going obligations without support from the Government.

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 Waitematā District Health Board and Group's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of Waitematā 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 appropriations, of the Health Board and Group on his behalf.

Opinion

We have audited:

- the financial statements of the Health Board and Group on pages 30 to 64, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flow 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 4 to 19 and page 24.

In our opinion:

- the financial statements of the Health Board and Group on pages 30 to 64:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2020; 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 4 to 19 and page 24:
  - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2020, including:
    - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 November 2020. This is the date at which our opinion is expressed.

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

Emphasis of matters

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

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

Note 17 on page 52 and 53, outlines that the Health Board and Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board and Group has made progress during the 30 June 2020 year, and estimated a provision of $166.6 million, as at 30 June 2020 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

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

The Going Concern note on page 64 summarises the Health Board and Group's use of the going concern assumption in preparing the financial statements. The Health Board and Group has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board and Group will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Health Board and Group's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board and Group over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

The Covid-19 impact on services note on page 10 and the Covid-19 impact on financial statements on page 63 outline the impact of Covid-19 on the Health Board and Group.

Basis for our opinion

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

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

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

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board and Group for assessing the Health Board and Group 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 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 3 and 20 to 29, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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