WAITEMATA DHB
ANNUAL REPORT 2014/2015

Waitemata
District Health Board

Best Care for Everyone

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CHAIRMAN/CEO STATEMENT

Dr Lester Levy, CNZM
Chair

This year has been one of significant growth and achievement for Waitemata District Health Board. We are the largest and fastest-growing DHB in New Zealand with our population of 580,000 expected to rise by more than 100,000 in the next 10 years.

During the 2014/15 year, considerable work has begun to meet the future demand for our services. Our organisational promise 'best care for everyone' and our 2014/15 board priorities to 'achieve better outcomes' and 'relief of suffering' through enhanced patient experience have placed our patients at the heart of this growth and development.

A reflection on 2014/15

Our efforts over the year are strongly reflected in the health outcomes of our population. The latest findings from the New Zealand Health Survey show that overall, the Waitemata population continue to enjoy the best health status of any DHB in the country, and were ranked first in a number of key health indicators. Our mortality rates from cardiovascular disease and cancer continue to decline and our survival rates from cancer are among the highest in New Zealand. Smoking rates within our population are reducing and we are well positioned to be smoke-free by 2025. The health status of our population is most strongly reflected by the life expectancy of our population. In 2014, our population's life expectancy was 83.7 years, more than one-and-a-half years higher than the national figure. While there are improvements to be made, life expectancy among our Māori and Pacific population continues to be among the highest in New Zealand at 77.7 years for Māori and 79.6 years for Pacific.

To provide the very best care for all our patients, and ensure this leads to better health outcomes, we have an organisation-wide focus on quality and clinical safety. The latest Hospital Standardised Mortality Ratios (HSMR), which are a way of comparing how many patients died within 30 days of admission to hospital to the expected number of deaths, show that our hospitals have the lowest hospital death rate in New Zealand. Our highly safe and effective care is also evidenced by our performance against other quality indicators. We have improved our performance across all the Health, Quality and Safety Commission markers in 2014/15. We are now achieving the target for good hand hygiene practice and this has seen our healthcare associated infection rate remain well below the national average. All older patients were assessed for the risk of falling and the number of serious patient falls has decreased to less than 1 per 10,000 bed-days.

Waitemata DHB is delivering the national bowel screening pilot, offering our residents a unique opportunity to participate in screening. Detecting bowel cancer at an early stage significantly improves the chance of survival. During 2014, round two of the Waitemata Bowel Screening Pilot was completed and, as of 1 April 2015, cancer had been detected in 255 people, through colonoscopy carried out as part of the pilot.

The DHB continues to increase the number of positive interventions to relieve suffering and support our patients to lead active, productive and independent lives. A clear demonstration of this is the 18,185 elective discharges delivered in the 2014/15 year – the largest increase in elective discharges in the country over the last five years.

Waitemata DHB has been nationally recognised for its work using patient feedback to drive improvements in care, and enhance patient experience. Our patient experience reporting programme takes the experiences of patients and their families and links feedback to the DHB's values of everyone matters; with compassion; connected and better, best, brilliant to help us live up to these standards and drive improvements in care. Other initiatives to improve both the care and experience of people using our services include the introduction of protected meal times for patients, the refurbishment of eight family rooms at North Shore Hospital and the roll-out of free wi-fi across North Shore and Waitakere hospitals.

Alongside our excellent results in improving health outcomes, we are on a sustainable financial path, having lived within our means for the past five years and generating a small surplus in 2014/15. This has been achieved against the backdrop of an increasingly challenging financial landscape of reduced funding growth by containing costs to affordable levels and providing services in a more efficient way.

Dr Dale Bramley
Chief Executive Officer

A focus on the future

This year saw the launch of Waitemata 2025 – our vision of the health services and facilities we will need to establish in the next 10 years to meet the future needs of our district's population. A number of exciting developments are already underway and planning is taking place for major longer term projects that will ensure our DHB is future proofed to manage the impending demand on our services. New major developments already approved include a significantly expanded Emergency Department at Waitakere Hospital and the opening of the first ever women's ward at North Shore Hospital.

One of the significant projects completed in 2014/15 was the opening of our purpose-built adult mental health inpatient facility He Puna Wāiora – A pool of wellness. The $25 million development with capacity for 46-beds, adjacent to North Shore Hospital, signals a new era in the provision of mental health services for our population.

We would like to take this opportunity to thank our community-based healthcare partners and organisations. We would also like to acknowledge our official fundraising body, the Well Foundation, which raises additional funds to enhance healthcare at our hospitals and in our communities.

As we embark on a year of new challenges, we most significantly thank our nearly 7000 staff who work determinedly to provide high-quality health services for our growing and diversifying population. Thank you for your support in making 2014/15 a milestone year for our DHB and the people it serves.

Dr Lester Levy, CNZM
Chair

Dr Dale Bramley
Chief Executive Officer

MĀORI TE TIRITI - PARTNERSHIP STATEMENT

R Naida Glavish ONZM
Chief Advisor Tikanga

Tū Tonu ngā Manaakitanga!

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

It is helpful to bear this whakatauākī in mind as we reflect on the achievements of the past year presented in this Annual Report. I am extremely pleased to note that an increased number of tamariki were fully immunised at 8 months of age, and 95% of tamariki started school having completed their B4 School checks. The health and development of the most vulnerable members of our whānau is crucial for the future of our communities.

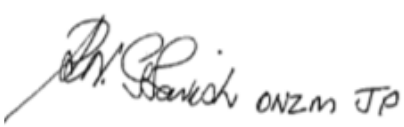
As we acknowledge all of those who have contributed to a milestone year for Māori health, we also need to challenge ourselves to do more. Many indictors in this report show that Māori often suffer disproportionately from health conditions compared to other groups in our communities. One only needs to view life expectancy data to get a sense of how immense the challenge to eliminate health inequities between Māori and non-Māori really is.

When I look back over the past year, and all of its achievements, the theme that emerges is partnership. The combined efforts of hospital based services, primary care providers and community organisations have contributed to a dramatic drop in the number of our whānau smoking. In order to eliminate smoking from our communities completely, every part of the health sector must be mobilised behind our vision for a smokefree Aotearoa.

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

Te Rūnanga o Ngāti Whātua remains steadfast to our commitment to working in partnership with Waitemata DHB. This annual report highlights the importance of our partnership, but, more importantly, it provides the basis for our partnership as we look forward to the years ahead.

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



Rangimarie Naida Glavish ONZM
Co-Chair, Te Rūnanga o Ngāti Whātua

THE WAITEMATA DISTRICT

Our population

Largest and fastest growing DHB population in New Zealand with 580,000 residents and expecting population growth of 18% by 2025 (100,000+ new residents)

We are ethnically diverse with 10% Māori, 7% Pacific, 19% Asian and the remainder European/Other

In 2014 7,675 babies were born to Waitemata mothers

Our life expectancy is the highest in New Zealand at 83.7 years, 1.6 years higher than the national figure

Our Organisation

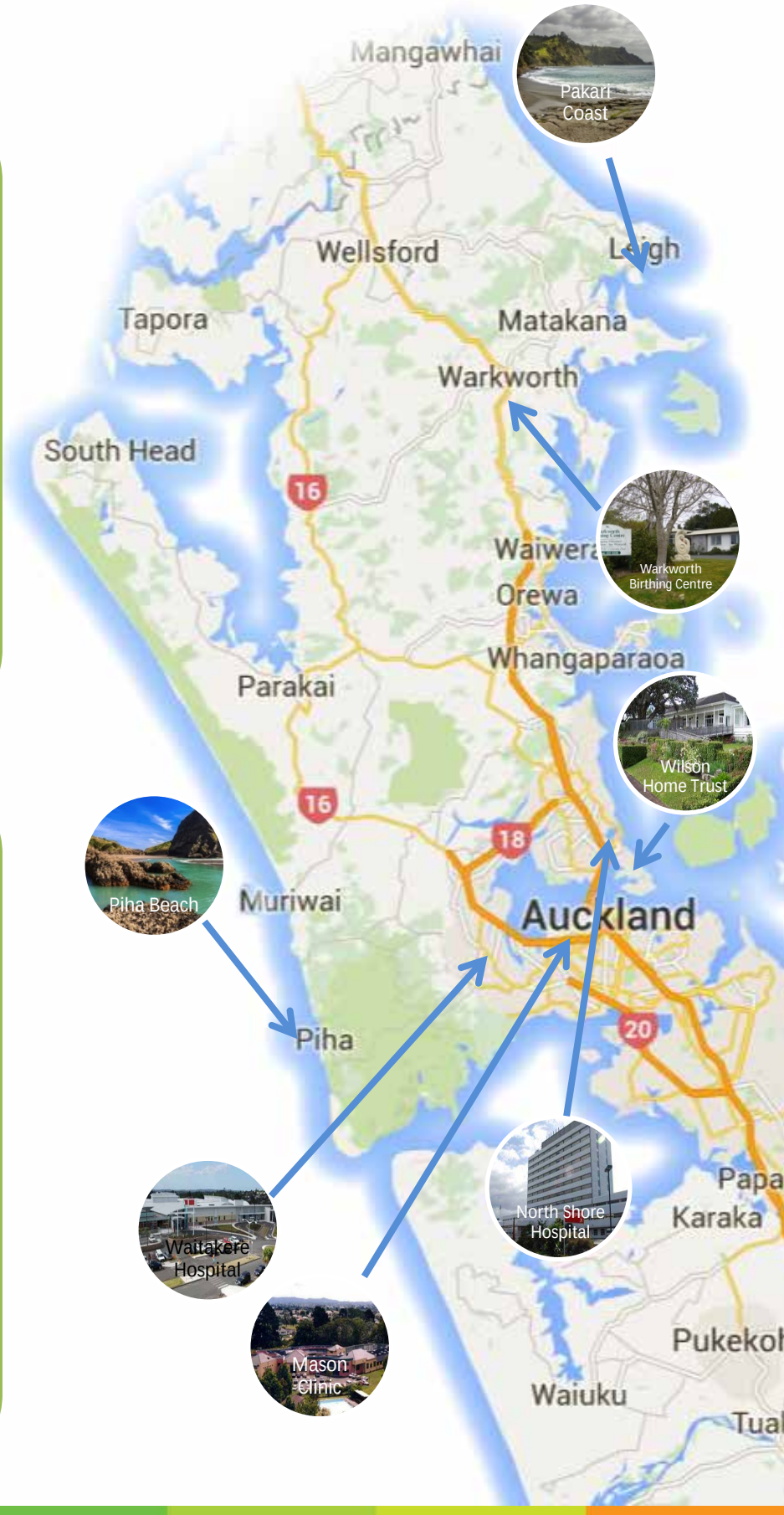
We employ over 6,800 staff

Our budget in 2014/15 was $1.5 billion

Our major facilities are North Shore and Waitakere Hospitals, Mason Clinic and the Wilson Centre

We are the regional provider of child disability, forensic psychiatric, alcohol and drug and school dental services

We are the national provider of hyperbaric oxygen therapy services and the national bowel screening pilot



KEY 2014/15 HIGHLIGHTS

We are the healthiest population in New Zealand

Life expectancy in Waitemata is 83.7 years, over one and a half years higher than the national figure and continues to increase. Our mortality rates from cardiovascular disease and cancer, the two biggest causes of death, along with our smoking rates, continue to decline and are among the lowest in the country. Our five year survival rate for those diagnosed with cancer is the highest in the country. This is a strong testament to our excellent performance in the area of cancer detection and treatment.

Our children get the healthiest start to life

Our infant mortality rate is the lowest in the country (2.3 per 1,000 live births versus the national rate of 4.8 per 1,000 live births). Our immunisation rates are very high, with nearly 95% of our 8 month- and 2 year-old children fully immunised. Coverage rates for Before School checks remain above the national target.

We are tackling health inequalities in our population

Life expectancy among our Māori and Pacific population is among the highest in New Zealand at 77.7 years for Māori and 79.6 years for Pacific. Immunisation coverage among our Māori and Pacific children continues to increase. During the 2014/15 year we fully immunised 88% of Māori children and 95% of Pacific children by 8 months of age. Cervical and breast screening rates continue to improve with Pacific breast screening rates above the overall rate for the DHB.

Our hospitals are performing exceedingly well

We delivered 18,185 elective procedures in 2014/15 and achieved the largest increase in elective discharges in the country over the last 5 years. MRI volumes have increased by 41% (5,570 in 2013/14 to 7,833 in 2014/15) and CT volumes increased by 5% (30,024 in 2013/14 to 31,545 2014/15). Our hospitals are performing exceedingly well with excellent compliance across the Health Quality and Safety markers and the lowest rate of complaints to the Health and Disability Commissioner of any of the 20 DHBs.

Our population has rapid access to services

Our emergency departments see and treat more people faster than ever before, with over 95% of patients discharged, admitted or transferred within six hours, a major improvement from 61% five years ago. Waiting times for elective surgery have reduced with nearly 100% of patients waiting no longer than four months for their first assessment, or for their first treatment.

We are investing in new and upgrading existing facilities

We are making significant investments in state-of-the-art, modern facilities and services including a new emergency department. He Puna Waiora - the new mental health facility at North Shore Hospital - opened in April 2015. At the same time, refurbishment of our existing facilities is well underway with significant plans in place to continue developing our facilities until 2025 .

We are living within our means

We have lived within our means for the past five years and generated a surplus in 2014/15. We have continued to invest in growing our frontline staffing numbers to keep up with demand. Doctor, nurse and allied health staff FTE has grown over the period with the number of doctors at Waitemata growing 34% since 2009/10, while efficiencies in back office functions have seen administration staff increase by only 4%.

WHAT ARE WE TRYING TO ACHIEVE?

Best care for everyone

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

Our **promise** is that we deliver the **'best care for everyone'**. This is our promise to the community and the standard for how we will work together. For us that means we strive to provide the best care possible to every single person and their family engaged with our services. This requires us to develop an organisation-wide culture that puts patients first and is relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.

Our **purpose** defines what we strive to do and achieve, and focuses us on delivering the 'Best Care for Everyone'. Our **purpose** is to:

- Promote wellness
- Prevent, cure and ameliorate ill health, and
- Relieve suffering of those entrusted into our care.

The Waitemata DHB Board has two **priorities**:

- **Better outcomes** (for patients, whānau, clinicians, our staff, and our population)
- **Relief of suffering***

Our values and behaviours reflect our purpose and describe the internal culture we strive for. They have shaped:

- The way our staff plan and make decisions
- The way our staff behave and interact with patients, service users, whānau and with each other
- How the DHB has recruited, inducted, appraised and developed staff
- How the DHB measured and continued to improve everyone's experience

* This priority was changed to 'Enhance patient experience' in 2015/16.

WHAT DIFFERENCE HAVE WE MADE FOR THE HEALTH OF OUR POPULATION?

Waitemata DHB residents have the highest life expectancy in the country

We are tracking well to be smoke-free by 2025

Our outcomes framework (over page) forms an essential part of the way we are held to account for making a difference to the health of our population. The framework focuses on the two high-level outcomes we want to achieve across the health system and beyond.

These outcomes are to:

- Increase life expectancy and improve quality of life
- Reduce the difference in life expectancy between population groups.

While we will be able to provide information on the performance against both these high-level outcomes, the nature of population health is such that the improvements in these outcomes will take years – sometimes even decades – to see marked change. To measure our performance over a shorter time period we report on a set of supporting health indicators that help focus our understanding of how well we are doing year by year and ensure we provide 'the best care for everyone'. These indicators cover the full spectrum of what we, and our population, understand health to be. Our long-term outcomes are focused on developing and maintaining positive trends over time (five to ten years) rather than achieving fixed annual targets. Sitting underneath the long-term outcome indicators, we have a second set of impact measures which measure our direct impact over a shorter time period (one to five years).

Our outputs framework, detailed in the Statement of Performance, presents a snapshot of the services provided for our population and helps evaluate the DHB's performance over time. Where measures are contained in both our outcome and output frameworks we have only reported on them in one section of the report.

Overall the progress against our indicators suggests we are delivering on our vision and we remain a high performing DHB that is truly making a difference to the health of our population. Our smoking rates continue to decline, along with our mortality rates from cardiovascular disease and cancer, which remain below the national average and among the lowest in the country.

The children in our district continue to experience a healthy start to life with the lowest rate of infant mortality in the country, high rates of immunisation, and excellent performance across other child health indicators.

Our population has access to high quality health services when they need them, with nearly 100% of patients waiting no longer than four months for their first assessment or treatment, and our emergency departments operating well within the 6 hour waiting target. We have exceeded our elective surgery target for the sixth straight year, delivering 18,185 elective surgical procedures in 2014/15.

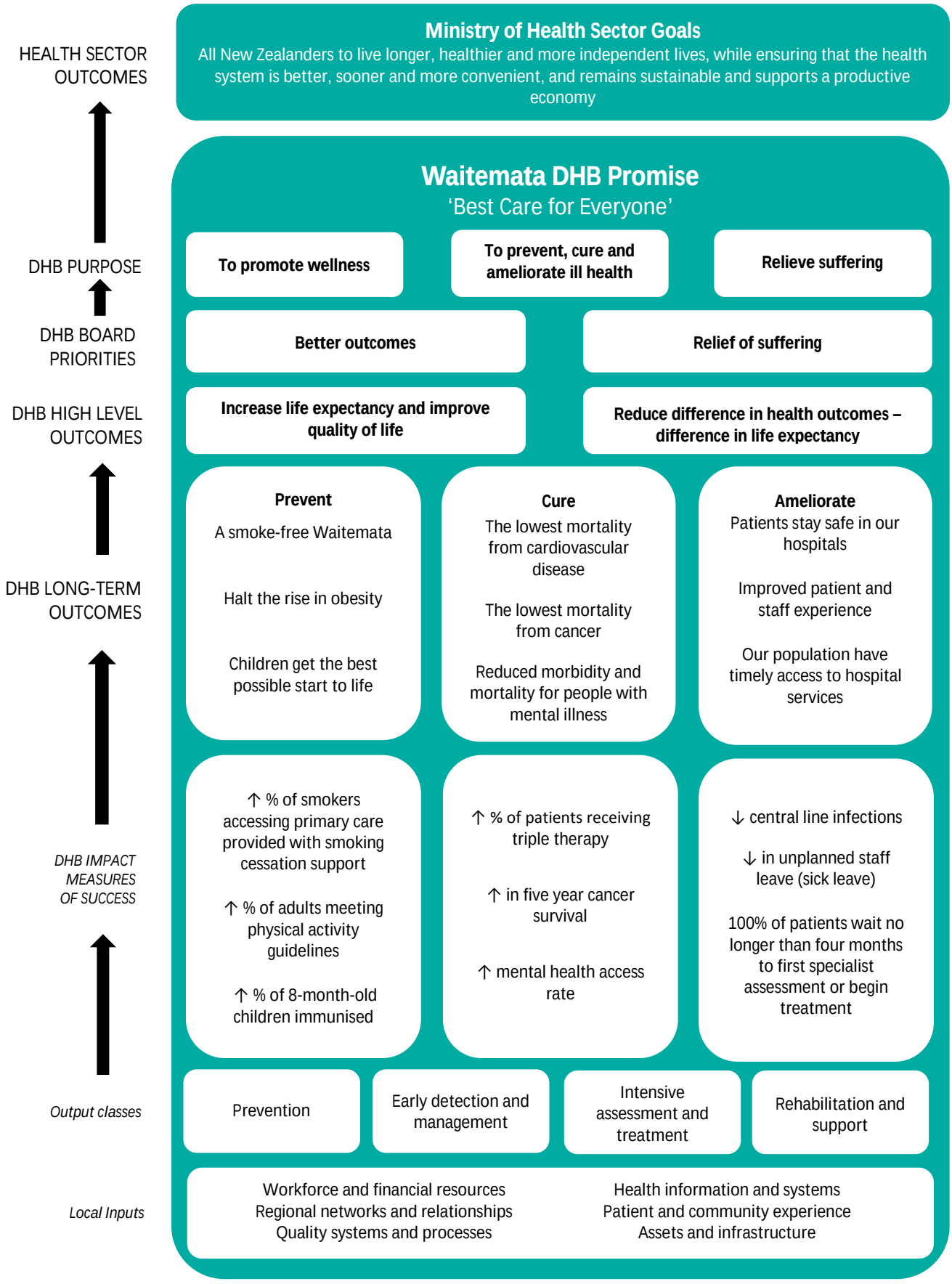
"Everything was right on time."

Jan – Assessment, Treatment and Rehabilitation, Muriwai Ward

Our mortality rate from cardiovascular disease is the lowest in the country

We have exceeded our elective surgery target for the sixth straight year

PERFORMANCE FRAMEWORK



HIGH LEVEL OUTCOMES

The high level outcomes that we aim to achieve for our population are to increase their life expectancy and quality of life and to reduce the ethnic inequalities that are present within our population. Although an increase in life expectancy does not directly translate to improvements in quality of life, many of our outcome and impact indicators are likely to contribute to this.

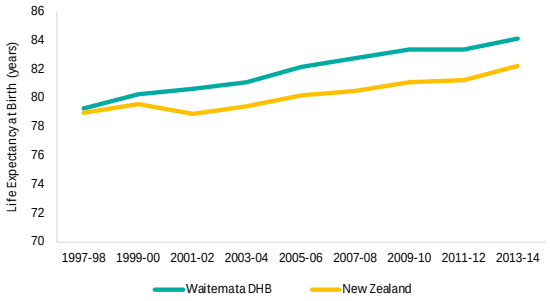
*People live on average **1.6 years** longer in Waitemata than New Zealand as a whole*

An increase in life expectancy

Our population continues to have the highest life expectancy* in the country at 83.7 years, which in 2014 was 1.6 years higher than New Zealand as a whole. In Waitemata, life expectancy has increased by 2.5 years over the past 10 years.

83.7 Years 2014

81.2 years 2004



*Overall life expectancy has increased **2.5 years** over the past decade*

A reduction in the ethnic gap in life expectancy

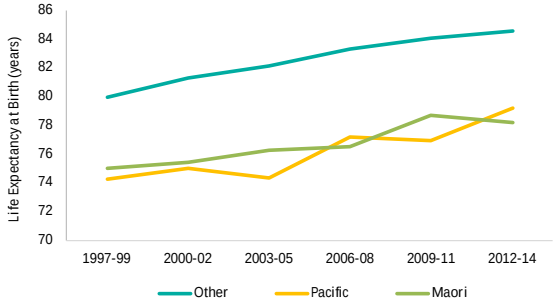
Life expectancy among our Māori and Pacific populations is among the highest in New Zealand. However, these groups continue to have a lower life expectancy compared with other ethnicities, with a gap of 6.3 years for Māori and 5.3 years for Pacific. Although life expectancy is increasing in our Māori population, it is doing so at a slower rate compared with our other population groups, having only increased by 1.9 years over the previous decade. Within our Pacific population, life expectancy has increased faster than any other population group, increasing by 4.8 years over the past decade.

5.3 years Pacific 2012-14

7.8 years 2003-05

6.3 years Māori 2012-14

5.9 years 2003-05



*Life expectancy of our Pacific population has increased **4.8 years** over the past decade*

*Note: The most recent life expectancy data available is for the 2014 calendar year. Two-year combined estimates have been presented to reduce the effect of year to year variations in death rates.

PREVENTING ILL HEALTH

'Support people to be healthier and take more responsibility for their health'

Impact Measure:* 31% *or* 53,947 *identified smokers received cessation support in 2014/15, either with a referral to 'quit smoking' services, pharmacological smoking cessation aids or behavioural support in primary care, an increase from 14% in Q1 2013/14

98% or 13,389 smokers hospitalised in Waitemata facilities received smoking cessation advice (full year)

Prevention is critical to keeping people healthy and out of hospital. Supporting good health and wellbeing at all stages of a person's life can lead to increased life expectancy with extra years being lived in good health. Our focus is on the two largest causes of preventable ill health, namely smoking and obesity, as well as ensuring our children have the healthiest start to life.

A smoke-free Waitemata

Despite New Zealand having comprehensive tobacco control policies and programmes, smoking remains the leading modifiable risk factor for many diseases. We estimate smoking directly results in the deaths of over 350 of our residents every year. Targeting smoking provides us with an opportunity to significantly reduce health inequalities and drive improvements in the overall health of our population.

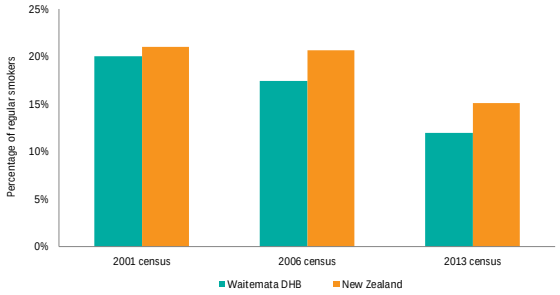
Long-term outcome

A reduction in the prevalence of smoking

Adult smoking rates in Waitemata continue to decline, having reduced from 20% in 2001 to 12% in 2013, and remain lower than those observed nationally. Despite a reduction in the ethnic specific prevalence, smoking among our Māori and Pacific populations remains nearly twice that of other ethnicities.

12%
2013*

17%
2006



Our success in driving down the overall smoking prevalence suggests our efforts to help smokers quit, such as the ABC initiative in hospitals and primary care, are proving effective. In 2014/15 we provided brief smoking cessation advice to 98% of identified smokers attending our hospitals, and nearly 100% in primary care. One in three identified smokers accessing primary care are now provided with cessation support, either through a referral to 'quit smoking' services or provided with pharmacological smoking cessation aids. This rate of support has more than doubled since 2013/14 and remains higher than the national figure of one in four.

Throughout 2014/15 we have had a strong focus on ensuring we provide pregnant mothers with information and support to quit smoking during their pregnancy. Working with Midwives, Specialist Smoke-free Services and Māori Health we have collaboratively developed information and resources to be given to women at confirmation of pregnancy to encourage and assist with their quit smoking attempt.

*Note: The New Zealand Census (undertaken every five years) provides the most robust estimate of smoking prevalence. Due to the 2011 Census being delayed, some timelines may be inconsistent.

Halt the rise in obesity

Impact measure: ***42%*** *of our adult population are meeting recommended physical activity guidelines (2011-14 NZ Health Survey), a decrease from 48% in 2006/07*

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Not only does obesity impact on quality of life, but it is a significant risk factor for many chronic diseases, including cardiovascular disease and some cancers. Many of the drivers of obesity sit outside the direct control of health, however not outside of our influence. We have continued to support the creation of health promoting environments that encourage and make it easier for people to adopt healthier lifestyle choices as well as provide medical intervention where appropriate.

Long-term outcome

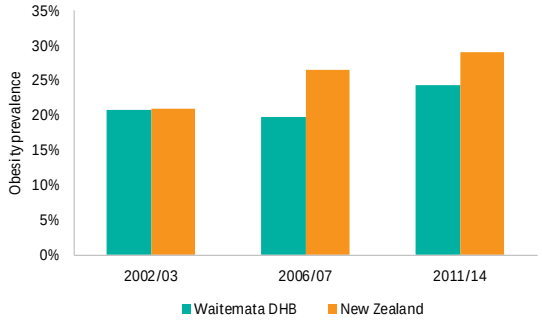
6,511 *Green Prescription referrals were made (full year), an increase of 15% from the previous year*

A reduction in the prevalence of adult obesity

Although the prevalence of obesity is lower in Waitemata compared with New Zealand, it is increasing. Nearly one in four of our adult population are now considered to be obese. When compared across ethnicities, 43% of our Māori and 65% of our Pacific adults are now considered obese.

24% 2011/14

20% 2006/07



82% *of mothers are breastfeeding at discharge following birth (full year)*

Reversing the rising rates of obesity is complex and requires a multifaceted approach. The need to encourage individuals to participate in physical activity has never been greater and is our impact measure in the area of obesity. Despite the health benefits of physical activity, our adult population are exercising less. In 2011-14, only 42% of our adult population were meeting daily physical activity guidelines, compared with 48% in 2006/07.

About ***1000*** *individuals participated in Enua Ola (full year)*

We have invested in a number of programmes and initiatives to tackle the rise of obesity in our district and its related health issues. These include lifestyle interventions such as green prescription - a doctor's written advice to a patient to increase their levels of physical activity, and Enua Ola - a church and community group based health and exercise programme targeted at our Pacific population, as well as working to improving access to bariatric surgery. We have continued to support healthy public policies that address the major causes of obesity, such as improving the built and food environments in which people live and work. One initiative is 'Healthy Auckland Together' which is an intersectoral, regional obesity prevention initiative and is focused on four initial key priorities; healthy food environments, children and young persons' settings, supporting Healthy Families NZ, and increasing physical activity through environmental change. The DHB has updated and amended its organisational healthy food policies.

We performed ***76*** *bariatric surgical procedures (full year)*

*Note: The New Zealand Health Survey has recently become a continuous survey, however pooling of multiple years of survey data is required to provide estimates at a DHB level.

Children get the healthiest start to life

The creation of healthy generations of children, who can enjoy their lives to the fullest and reach their potential, is critical to the region's future. The most effective time to intervene in terms of reducing inequalities and improving long term health and wellbeing outcomes is before birth and in early childhood.

Impact measure: ***92%*** *of Waitemata children were fully immunised by eight months of age (full year), an increase from 87% in Sept 2012*

7,675 *babies were born to Waitemata mothers in 2014*

Children visited our school dental services ***111,270*** *times in 2014/15*

93% *of children received a comprehensive Before School Check (full year)*

Long-term outcome

A reduction in infant mortality

The infant mortality rate* (death of a live-born baby within the first year of life) within Waitemata was the lowest in the country in 2012 at 2.3 per 1,000 live births versus the national rate of 4.8 per 1,000 live births. This rate has consistently remained lower than the national rate and continues to decline.

2.3
2012*

3.0
2006

We have made substantial gains in ensuring our children experience the healthiest start to life. Our impact measure in child health is increasing our immunisation rates at eight months of age. During 2014/15 we fully immunised 92% of children by eight months of age compared to 87% in the 12 months to September 2012. With our strong focus and ongoing work in this area, we are in a good position to reach the national 95% target over the coming year. The equity gap is also closing with the eight month immunisation rate in Māori children increasing from 83% in Q1 2012/13 to 88% in Q4 2014/15.

The Before School Check service is another important opportunity to support children's health and wellbeing. It is a universal, comprehensive screening and health education opportunity for four year old children. We have continued our strong performance this year with coverage rates of 95% in Māori, 92% in Pacific and 93% overall, well exceeding the 90% national target.

Through our Rheumatic Fever prevention programme we are making gains in reducing Rheumatic Fever in our population (see following page). Our rate of rheumatic fever is the lowest among the Northern region DHBs and one of the lowest in the North Island.

Hospital admission rates for injuries arising from assault, neglect or maltreatment of children increased from 11 per 100,000 children aged 0-14 in 2013/14 to 17 per 100,000 children in 2014/15. This comes following four years of consistent year on year decline.

"The days following the birth were really great"

Toni – Maternity Services

*Note: Mortality rate calculations require complete coded deaths data. An official 'cause of death' becomes available approximately two years following a death. 2012 is the most recent complete year available.

Tackling rheumatic fever in our population

'Sore throat – Rheumatic Fever – Heart Damage'

***6,996** children were swabbed as part of our school based rheumatic fever programme in five schools (full year)*

*We have established **22** sore throat clinics in GP practices and pharmacies throughout the Waitemata DHB region*

Rheumatic fever is a serious illness that can develop after a 'strep throat' – a throat infection caused by a Group A Streptococcus bacteria. Most strep throats heal well and don't lead to rheumatic fever. However, in a small number of people an untreated strep throat leads to rheumatic fever one to five weeks after a sore throat. This can cause the heart, joints, brain and skin to become inflamed and swollen.

The rate of rheumatic fever hospital admissions has been declining within the Waitemata DHB region since 2009, with the single year rate in 2014/15 being 1.6 admissions per 100,000 population (9 cases). Our three year combined rate* over the previous six years continues to trend downwards. The rate decreased from 2.4 per 100,000 population in 2009-11, to 2.0 per 100,000 population in 2012-14.

Waitemata DHB places great importance on reducing rheumatic fever in our population. As part of our efforts we have maintained our focus on improving access to timely identification and treatment and raising awareness through our rheumatic fever prevention programme. The programme includes provision of sore throat clinics in identified schools and 22 GP clinics and pharmacies throughout the district. These services make it easier for children and young people to get their sore throats checked, and treated if necessary, by providing family-friendly access to sore throat services. The programme also identifies eligible families for referral to the Auckland Healthy Homes Initiative. The school-based programme also has an emphasis on improving health literacy and families'/whānau awareness of key rheumatic fever prevention messages.

We have continued our strong support of the Auckland Healthy Homes Initiative, the joint venture between the National Hauora Coalition and Alliance Health Plus. The initiative identifies families with children living in crowded households and at risk of rheumatic fever. The initiative facilitates access to a range of interventions to reduce crowding and the risk of rheumatic fever. Families identified through our rapid response and school based clinics as well as in hospital are referred to the initiative.

*Note: A combined year rate accounts for year to year variation which can occur when calculating rates with a small number of cases

CURING ILL HEALTH

'Support people to stay well with early detection and effective management'

***Impact measure:* 58%** *of patients who have had an ischaemic event are receiving and adhering to their triple therapy medication, an increase from 57% in March 2014*

132,297 *people have completed a CVD risk assessment in the last 5 years, or* ***90%*** *of target population, as at June 2015*

Our population received ***968*** *coronary revascularisations (full year) adding a total of 1,517 quality adjusted life years to our population*

"The nurses in ICU were absolutely amazing, they were angels. I felt completely safe in their hands"

Anita – Thrombosis Service

We have continued to make strong gains in improving the management of ill health. This is reflected in the reduction in the rates of mortality from cardiovascular disease and cancer. Our focus is on improving the detection and management of these diseases, as well as providing rapid assessment and treatment for patients when they are ill.

The lowest mortality from cardiovascular disease

Cardiovascular disease is a leading cause of mortality in Waitemata and it contributes significantly to premature deaths. The burden of cardiovascular disease can be reduced with lifestyle change, early intervention and effective management. Significant gains have been made over the past decade in the treatment of cardiovascular disease and improvements in lifestyle. However, to ensure a continuous reduction in the rate of mortality from cardiovascular disease, we need to continue our focus on both prevention and treatment.

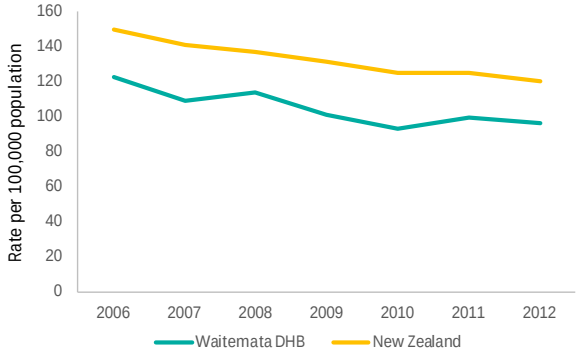
Long-term outcome

A reduction in mortality from cardiovascular disease

Mortality due to cardiovascular disease has declined steadily over the years and continues to trend downwards. The rate in Waitemata (96.6 per 100,000 population) is consistently lower than the national rate (120.3 per 100,000 population) and remains the lowest in the country.

96.6
2012

122.6
2006



We made strong gains in 2014/15 in ensuring our population at risk of developing cardiovascular diseases are detected early and those developing disease are well managed. Ninety percent of our eligible population are now having their cardiovascular disease risk assessed, an increase from 80% at the end of the previous year. Of our population that have experienced blood clots that have resulted in a heart attack or stroke, 58% are currently receiving and adhering to their triple therapy medication, this is our main impact measure and is gradually increasing.

For those in our population that required surgical intervention for their CVD, 968 people received coronary revascularisations. This resulted in 1,517 quality adjusted life years (QALYs) for our population. This was an increase of 130 QALYs from 2010/11.

***Impact measure:* 69%** *of people diagnosed with cancer survive five years after their diagnosis, the highest survival rate in New Zealand. This has increased from 66% in 2006/07*

77% *of patients received their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer (Jan-Jun 2015)*

In the past three years ***114,600*** *Waitemata women aged 25-69 have been screened for cervical cancer*

68% *of 50 to 69 year old women were screened for breast cancer (as at June 2015)*

"The surgeon and the radiographer worked together so well, they managed me perfectly"

Alan – Otorhinolaryngology Service

The lowest mortality from cancer

Cancer is the second leading cause of mortality in Waitemata DHB and contributes significantly to a high proportion of all premature deaths. To ensure that there continues to be a reduction in mortality from cancer, there needs to be concerted action in prevention, early detection and treatment.

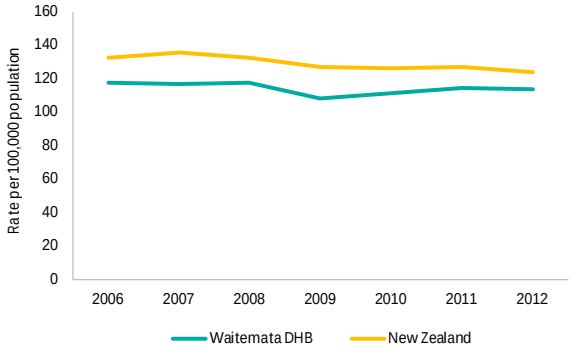
Long-term outcome

A reduction in mortality from cancer

Mortality due to cancer has declined steadily in recent years and continues to trend downwards. The rate in Waitemata (114 per 100,000 population) is consistently lower than the national rate (124 per 100,000 population), and remains one of the lowest in the country.

114.0
2012

117.3
2006



We have made strong gains in cancer screening coverage and reducing the time patients with a high suspicion of cancer wait before receiving their first specialist assessment and their first cancer treatment. This is reflected in our five-year survival rates from cancer - our main impact measure in lowering our mortality rate from cancer. For individuals diagnosed with cancer in 2008-2009, the five year survival rate was 69%, the highest of any DHB, increasing from 63% in 1998-1999.

Cervical screening three-year-coverage rates have remained stable at 76%. However, we are making gains in reducing the ethnic inequalities. Between December 2012 and June 2015 Māori coverage increased from 54% to 56% and Pacific from 66% to 72%. Asian coverage has remained stable at 63%. Breast screening coverage has increased to 68% from 66% two years prior. Coverage within our Pacific population (77%) remains above the national target of 70%, however breast screening rates in Māori remain lower at only 59%. We have made significant progress towards achieving the new cancer health target. In Q4 2014/15 81% of patients received their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer compared with 66% in Q2 2014/15.

During 2014 the second round of the bowel screening pilot took place. For all those who received an invite in round two, the average participation was 50% and 81% of those screened in the first round returned for a second screening. As of the beginning of April 2015, 255 people had had a cancer detected through a colonoscopy delivered as part of the Bowel Screening Pilot (public or privately funded).

Bowel Screening Pilot

'A winning move'

The bowel screening pilot underway within the Waitemata DHB region has been extended until December 2017. The programme is currently screening selected people aged between 50–74 years, who reside in the Waitemata DHB area. The programme is the first of its kind in New Zealand and will be used to assess the feasibility of a national screening programme.

International evidence shows that a bowel screening programme can save lives through early diagnosis and intervention. People who are diagnosed with bowel cancer, and receive treatment when it is at an early stage, have a greater than 90 percent chance of surviving five years. After five years they have the same survival rate as someone who has never had bowel cancer.

41,044 *people have returned a bowel screening test kit so far during round two of the bowel screening pilot (March 2015)*

In addition to finding cancers, the pilot is also detecting many non-cancerous polyps called adenomas, which grow on the wall of the bowel. Although a small proportion of adenomas become cancerous, a high proportion of colorectal cancers develop from adenomas. These polyps are removed at colonoscopy but despite this, some participants with adenomas will still be at increased risk of developing bowel cancer.

Over 41,000 people have returned bowel screening test kits during round two of the pilot. Although uptake was initially slow within some population groups, a number of initiatives have been put in place that have improved coverage rates. These initiatives included providing more comprehensive and multi-lingual information on the screening and colonoscopy process, and telephone pre-assessments to encourage people to attend their colonoscopy appointments and to better prepare them. As of 1 April 2015 the programme has detected cancers in 255 participants.

The pilot has detected cancers in over ***250*** *participants*

Early detection of bowel cancer as a result of the pilot may have saved the life of Devonport resident Nicki Sumicz. Her roller-coaster ride started in 2013 when her screening kit unexpectedly arrived in the mail. A week after sending off her kit Nicki received a phone call from her doctor confirming a positive trace of cancer. Nicki didn't think twice about going for her colonoscopy. Although Nicki was shocked at receiving a diagnosis of bowel cancer, "this test quite possibly saved my life as my bowel cancer was found before it had the chance to spread," she says.

69% *of people diagnosed with bowel-cancer within our district survive at least five years after their diagnosis, the highest survival rate for this type of cancer in New Zealand; survival rates are even higher when diagnosed at an early stage*

Impact measure: ***3.0%*** *of our 0-19 year olds and* ***3.5%*** *of 20-64 year olds accessed mental health services (full year as at March 2015)*

88% *of adult mental health clients and* ***96%*** *of addictions clients were seen within three weeks of referral (full year as at March 2015)*

We undertook ***10,841*** *mental health home visits (full year)*

75% *of children and youth were discharged from community based mental health services with a transition (discharge) plan (Q4 2014/15)*

Reduced morbidity and mortality for people with mental illness

Mental illness is one of the leading causes of disability and overall health loss in our population. Many common mental health problems, such as depression, anxiety and substance abuse, emerge early in life and have life-long consequences. Ensuring early access to appropriate services will have a positive impact on health and social outcomes for our population.

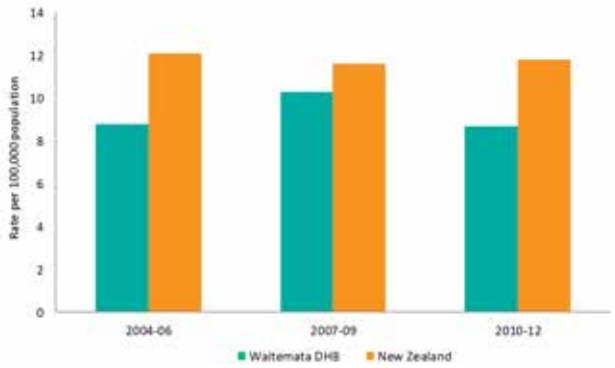
Long-term outcome

A reduction in suicide rates

Our three-year suicide rate (8.7 per 100,000 population) is the third lowest in the country and has declined since 2007-2009. Our rate remains below the national rate (11.8 per 100,000 population). Despite our rate declining, between 2010 and 2012 the number of suicides has increased yearly with 43 in 2010, 51 in 2011 and 58 in 2012.

8.7
2010/12

10.3
2007/09



Access rates to mental health services, our main impact measure, have increased in 0-19 year olds from 2.5% in 2009/10 to 3.0% and have remained stable at 3.5% in our 20-64 year olds. We have exceeded waiting time targets for adult mental health, with 88% seen within three weeks and 95% seen within eight weeks. Access rates to specialist alcohol and drug services are improving, with 96% accessing services within three weeks and 99% within eight weeks of referral.

In June we finalised the joint Auckland and Waitemata DHB Suicide Prevention and Postvention Action Plan for 2015 - 2017. The plan focuses on developing a Suicide Prevention and Postvention Inter-agency Working Group, developing a centralised suicide and self-harm data collection process and workforce development including primary care focusing on at-risk clients and postvention support.

A significant achievement in Maternal Mental Health was the opening of He Kakano Ora, the new Auckland and Waitemata DHB Crisis Respite and Support Hours Service. The Service, provided by WALSH Trust, began providing support to women in their own homes and residential respite services in June.

The Ranui Social Sector Trial is continuing to progress well with funding extended until 30 June 2016. A major achievement of the trial has been a significant reduction in stand down and expulsion rates in a number of participating schools. Rates have reduced from nearly twice the national average in 2013 to now be at the national average.

He Puna Waiora

'A pool of wellness'

On April 15 we opened our modern, $25 million, purpose built and contemporary facility to house mental health services. The new facility located adjacent to North Shore Hospital will not only help the DHB meet the needs of our rapidly expanding population, it also provides a purpose built facility that will enable the DHB to deliver mental health services more effectively.

He Puna Wāiora replaces Taharoto, which was part of the North Shore Hospital maternity ward complex built in the mid-1950s. Almost 30 years ago, in 1988, it closed as a maternity service facility and then, three years later, opened as a mental health facility with very little alteration. The first mental health patients moved into Taharoto in 1991, just prior to the closure of Carrington Hospital. In more recent times, Taharoto has been a non-purpose built, aging facility at the end of its service life and no longer appropriate for modern health service delivery.

Waitemata DHB provides one of the largest mental health services in the country

He Puna Wāiora has increased the bed capacity for what is the largest mental health service in the country. The new unit has also been future-proofed for population growth and will ultimately be able to cater for up to 46 patients. It will serve the population of the North Shore and Rodney and complements our other adult acute inpatient unit at Waitakere Hospital. He Puna Wāiora will serve as a strong foundation to support our comprehensive community-based services across specialist services, NGOs and primary care. It is a product of a genuine consultation process that has taken into account the needs of the local community to deliver a facility everyone is happy with.

He Puna Wāiora replaces a 60 year old building that has housed mental health services for 25 years

While He Puna Wāiora is in a separate facility to the main North Shore Hospital, a corridor link has been built to connect the building with the main hospital. This ensures ready access to diagnostics and other medical specialists, which is crucial when caring for those with other associated health conditions. The opening of He Puna Wāiora is a further demonstration of Waitemata DHB's commitment to meeting the needs of our population.

He Puna Wāiora has been future-proofed for population growth and will cater for up to 46 patients

AMELIORATING ILL HEALTH

'People receive timely, high quality, supportive and safe services'

Health services play a major role in providing intensive assessment and treatment when people are ill, and supporting people to regain functionality after illness and to remain healthy and independent. Patients want assurance that when they access our services they are receiving the best and safest care possible. Our focus in this area has been on ensuring patients have timely access to services, stay safe in our hospitals, and have an excellent experience when they access our services.

Patients stay safe in our hospitals

To provide the very best care for all our patients, we need to ensure that the care we provide is safe and clinically effective. We have continued improving quality and safety through our First, Do No Harm programme, being open and transparent about our performance and monitoring the Health Quality and Safety Commission's quality and safety markers (HQSMs). We have aimed to improve in all areas of harm identified in the national patient safety campaign: Open for better care.

Impact measure: *Central line infections have remained below* ***1 per 1,000*** *line days (full year)*

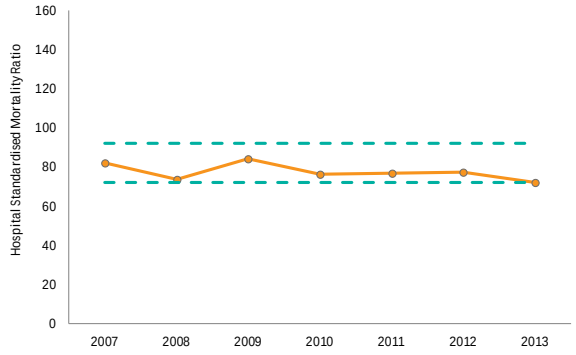
Long-term outcome

A reduction in the Hospital Standardised Mortality* Ratio

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality and safety that measures whether the death rate at a hospital is higher or lower than would be expected. Our HSMR has consistently been lower than the national figure and is the lowest in the country.

72
2013

84
2009



100% *of older patients had their risk of falling assessed (Q4 2014/15)*

Compliance with the five moments for hand hygiene was over ***80%*** *(Q4 2014/15)*

During 2014/15 we improved our compliance across the HQSM markers. Compliance with good hand hygiene practice has increased from 72% (Sept-13) to 80% (June-15), and the associated impact measure, Staph. aureus infection, was 0.06 per 1000 bed days in 2014/15, and has remained below the national average of 0.12 since 2012. The number of patient falls resulting in major harm has decreased from 2 per 10,000 bed days to less than 1. The rate of central line infections in our intensive care unit is less than 1 per 1,000 line days, having remained below 1 since December 2013. Our extremely strong results in these areas have been driven by our clinicians working in partnership with patients, their whanau and the community, along with the work of our quality improvement team and an organisational culture that puts patients first.

* HSMR is adjusted for a variety of factors such as population size, age profile, patient complexity, range of treatments and operations provided etc. The average of all national hospitals is an HSMR of 100 thus an HSMR under 100 indicates a hospital has lower hospital mortality than the national average

Impact measure: *unplanned staff leave has increased from* ***8.3%*** *in 2013/14 to* ***8.6%*** *(2014/15 full year)*

We had the lowest number of complaints to the Health and Disability Commissioner of any DHB in the country (January-June 2015)

8,242 *patients and family members completed our local patient survey (2014/15 full year)*

"I met the anaesthetist, the intensivist and the surgeon all in one session. So I had one appointment and that idea I think is brilliant"

Kathleen – Oncology Services

Improved patient experience

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. Our focus is on individualised care, tailoring services to meet patient and whānau needs, and engaging them as partners in their care. An enhanced patient experience leads to better emotional health, symptom resolution, less reported pain and more effective self-management. We also know that an engaged and satisfied workforce is linked with better patient experience and improved health outcomes. Therefore enhancing staff experience and ensuring their wellbeing supports us achieving our purpose.

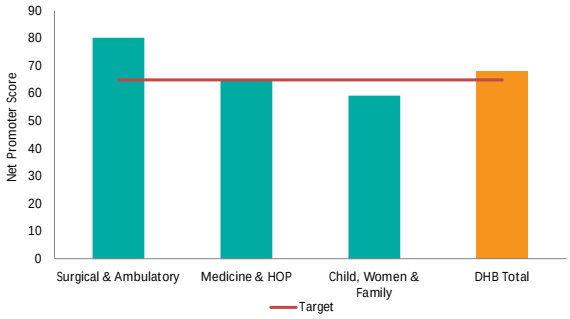
Long-term outcomes

An increase in net promoter scores across all divisions

Used in our hospitals for two years, the Friends and Family Test* is an important tool in measuring overall patient experience as well as providing valuable feedback at a divisional level in the form of free text comments. We have seen a steady rise in the net promotor score (NPS) within the DHB. We are now achieving an NPS of 68 at a DHB level, an increase from 64 in 2013/14.

68
2014/15

64
2013/14



Staff engagement and wellbeing is central to the delivery of high quality and safe services. Ensuring we are a 'Healthy Workplace' is a focus for Waitemata DHB. In 2014/15, 8.6% of all staff hours were taken as unplanned leave (sick leave), a slight increase on the previous year. The development of a staff experience survey has been delayed.

During the past year the Health Quality and Safety Commission designed a new 20 item adult inpatient survey that began in August 2014. This survey runs quarterly in all DHBs and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. The results for Waitemata DHB show significant improvement over that time. Our average scores are above 8 out of 10 for all four domains.

Our strong focus on enhancing patient experience has been reflected in Waitemata having the lowest number of complaints to the Health and Disability Commissioner (HDC). Between January and June 2015 the HDC received 46 complaints per 100,000 discharges from Waitemata patients, versus a national rate of 85 complaints per 100,000 discharges. A more detailed discussion of our patient experience work can be found over the page.

*The survey uses the Net Promoter Score which is the percentage of service 'promoters' (people who answered extremely likely) minus the percentage of detractors (those who answered, extremely unlikely, unlikely, or neither likely nor unlikely). For 2014/15 73% of respondents were promoters and 4% were detractors, giving a Net Promoter Score of 68.

Enhancing the Experience of Patients and Whānau

'Good communication and ensuring a positive patient experience is the right thing to do for our patients and is critical to the delivery of safe, high quality health care'

"I was very delighted when the Korean interpreter was there – communication is the most important thing"

Mrs Ko – Asian Health Support Service

"The staff at the Special Care Baby Unit are fantastic, a really relaxed environment"

Amy – Special Care Baby Unit

Patient experience refers to everything that happens to a patient. This can begin with a phone call to the hospital or their doctor's office. It includes the whole time a patient is at hospital and any follow-up contact that happens after. Listening to patients' perspectives can help us better understand how the care we deliver can be improved. Effective communication impacts patient safety, quality and patient experience and has a positive impact on patient outcomes. In February we produced the first suite of values-based reports drawing on content from our in-house patient experience survey. The reports take qualitative (free text) feedback from patients and maps this against the organisational values and behavioural standards. By doing this we gain an understanding of our performance in working to our values. The reports have been received positively by staff, partly due to the values and behavioural standards being co-designed. The first reports clearly showed that of our 16 behavioural standards, being 'welcoming and friendly' was the most significant driver of a positive patient experience.

In response to what our patients were telling us, we implemented a 'welcoming' campaign that included a raft of communication and educational activities. We also brought together a group of around 100 experience leads to take this work forward within their services and teams. We completed the second round of values reports in June 2015, which showed an improvement across almost all standards, including being welcoming and friendly. Our work to use patient and whānau feedback to measure performance against organisational values was recognised by a national public sector excellence award in July 2015. Our next campaign focuses on the standards, 'feedback' and 'speak up'. This campaign will reinforce the importance of appreciating one another, and the excellent work that is carried out every day, as well as giving constructive feedback when we see things that could be improved.

In addition to our values reporting we have developed a library of patient stories on film. Twenty-one patient videos have been completed from a wide range of hospital services. The stories can be used for staff training, public awareness (where consent allows) and to complement other patient experience data sources. The stories are available on the newly developed Waitemata DHB website, which was redeveloped after consultation with the community. The website is a key source of patient information and we have worked to make sure it is user-friendly and provides fast, easy access to the information the community has told us they most want. The website was developed using responsive design so that viewing is automatically optimised to people's preferred devices.

Over the last year we have also worked to implement our six ward priorities:

1. Welcoming and Friendly
2. Partners in Care
3. Friends and Family Test
4. Bedside Handover
5. Protected Mealtimes
6. Discharge Calls

The majority of our six ward priorities have been implemented and we continue to monitor the quality of those activities through patient and whānau feedback and regular reporting to senior management. Performance is also made publicly available on our Quality Boards.

Our population has timely access to hospital services

Impact measure: ***99%*** *of patients were waiting no longer than four months for their first specialist assessment or to begin treatment, as at the end of June 2015*

Ensuring timely access is an important element of health care. Patients waiting for specialty health and hospital services face undue stress in addition to their underlying health conditions. We have made working to reduce waiting times a priority. A core element of reducing waiting times has been our investment in medical specialists and infrastructure required for treatment as well as improving and refining our clinical pathways.

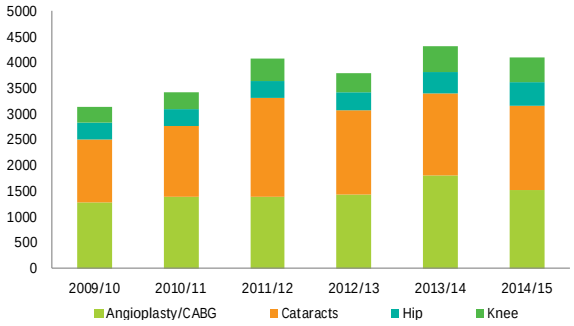
Long-term outcome

An increase in Quality Adjusted Life Years gained from selected procedures

Surgery significantly contributes to quality of life by remedying or improving disabling conditions. Using the measure of quality adjusted life years (QALY) it is possible to estimate the number of quality years of life gained by our population through five selected procedures for which QALYs have been calculated. In 2014/15 our population gained a total of 4,106 QALYs from selected procedures, a slight decrease of 210 QALYs on 2013/14.

4,106
2014/15

4,316
2013/14



We discharged, admitted or transferred ***96%*** *of patients attending ED within 6 hours (Q4 2014/15)*

18,185 *elective surgeries were performed (full year), a* ***6%*** *increase on the previous year and exceeding our target for the sixth straight year*

In 2014/15 we delivered 18,185 elective procedures, an increase of 1,109 (6%) on the previous year and 640 discharges more than the target. Waiting times for elective surgery, our main impact measure in timely access to hospital services, have reduced with nearly 100% of patients waiting no longer than four months for their first assessment or their first treatment. In its first full financial year of operation, the Elective Surgical Centre which opened in 2013 has been a major contributor to our elective performance in 2014/15.

Diagnostic imaging is a critical element in reducing the overall waiting time of a patient and in the last year MRI volumes at Waitemata DHB increased by 41% and CT volumes by 5%. We anticipate that in the coming years we will see additional gains in this area with our new MRI suite now in operation.

Our emergency departments are performing extremely well with over 95% of patients waiting no longer than six hours to be admitted, transferred or discharged. We are currently in the process of upgrading and expanding our emergency departments at North Shore and Waitakere hospitals. The $9.8 million expansion at Waitakere will provide a fit-for-purpose emergency department that will ensure we can continue to provide high-quality 24 hour care to our population.

WHAT DIFFERENCE HAVE WE MADE FOR THE HEALTH OF OUR MĀORI POPULATION?

As a DHB we are committed to achieving the very best health outcomes for Māori and reducing inequalities. We want to see our Māori population living longer and enjoying a better quality of life. We want to see a system that is responsive to the health needs of our Māori population and is integrated, well resourced, and sustainable so that gains we make today can be built upon by future generations.

Life expectancy of our Māori population is among the highest in the country at ***77.7*** *years (2014)*

86% *of eligible Māori received a heart and diabetes check (Q4 2014/15)*

2,560 *Māori smokers received behavioural support to quit either with a referral to 'quit smoking' services or pharmacological smoking cessation aids (full year)*

An increase in Māori life expectancy

We have seen a steady gain in life expectancy among our Māori population with a gain of 1.9 years over the previous ten years. Māori living within our district experience the fourth highest life expectancy among Māori across all DHBs. However, despite this positive trend, the ethnic gap in life expectancy between Māori and other ethnicities is increasing, having increased from 5.9 years in 2003/05 to 6.3 years in 2012-14. Higher mortality rates at a younger age from cancer and cardiovascular disease contribute over three years to this gap.

78.2
2012-14

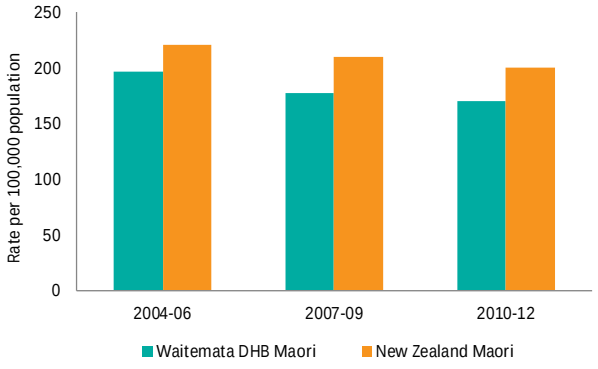
76.3
2003-05

A reduction in mortality from cancer among Māori

The mortality rate from cancer among our Māori population has steadily declined and is consistently lower than the national Māori rate. However, the mortality rate from cancer remains over 50% higher than non-Māori within our district and remains the leading cause of death within our Māori population.

170.4
2010-12

196.2
2004-06



We have made strong improvements in Māori health over the past few years, with some significant achievements in 2014/15. Immunisation rates in eight month old Māori children increased from 83% in Q1 2012/13 to 88% in Q4 2014/15. B4 School checks in Māori children are well above the national target of 90%, with 95% receiving their B4 School check in 2014/15. Cervical screening uptake in Māori women has improved from 47% to 56% over the previous four years. Māori receiving a heart and diabetes check has increased from 68% in 2012/13 to 86% in 2014/15. We are now supporting our Māori population better than ever to quit smoking with 95% of Māori smokers accessing primary care and 98% accessing our hospitals receiving brief advice to quit (Q4 2014/15).

*There were **1,281** Māori tamariki born in Waitemata in 2014*

***88%** of Māori tamariki were fully immunised on-time by 8 months of age (full year)*

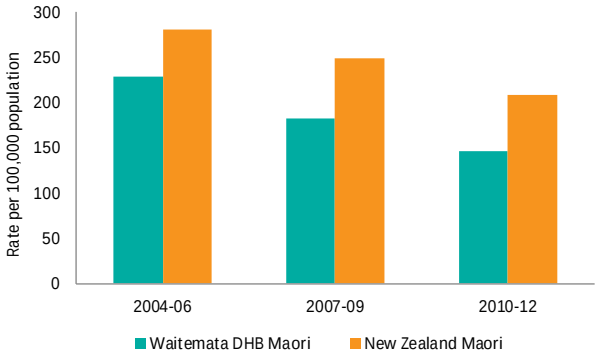
***74%** of Māori diabetics received their annual review (full year)*

Mortality from cardiovascular disease among Māori

Mortality rates from cardiovascular disease among our Māori population have significantly declined and are consistently lower than the national rate for Māori. However, the rate remains nearly 50% higher than non-Māori within our district and is the second leading cause of death within our Māori population.

147.2
2010-12

208.0
2004-06



Waitemata DHB continued to take the Northern Region lead in the roll out of the Primary Care Ethnicity Data Audit Tool. We have exceeded the target of 95% of general practitioner practices implementing the audit tool by 30 June 2015 with implementation currently at 98%. This represents 234 practices across Waitemata and Auckland DHBs. Auditing of ethnicity data allows identification of errors. Being able to accurately identify those practices with high volumes of enrolled Māori patients helps us to focus services more appropriately.

Waitemata DHB in conjunction with Te Whānau o Waipareira and East Tamaki Healthcare launched a new diabetes service at Whānau House in West Auckland late in 2014. The service is targeted at high needs Māori patients who need additional support with their diabetes management. The initiative has significantly reduced the number of Māori that did not attend (DNA) their hospital appointments over a 6 month period. For example, the retinal screening clinic which had routinely reported 45% - 57% of Māori not attending, has halved its DNA rate.

In June we finalised our new Māori Health Outcomes Framework. The framework (Ngā Painga Hauora) was developed in collaboration with Sir Mason Durie and Māori health providers throughout Auckland and Waitemata DHBs. The primary purpose of the framework is to measure the contribution the health sector is making towards improved health outcomes for Māori. In the first instance the framework will be used to measure the contribution Māori providers are making to Māori health outcomes as part of the integrated contracting process. Following this, the framework will be used to support measuring and reporting the broader health sector's contribution to Māori health outcomes.

BEING A GOOD EMPLOYER

We are committed to being an Equal Employment Opportunities (EEO) employer through our organisation-wide EEO good employer practices relating to the recruitment and selection, development, management and retention of all staff. As an employer member of the Equal Employment Trust for the last 5 years, Waitemata DHB remains committed and continues to strive to be a good employer across our diverse workforce and at every stage in our employees' careers.

We have available a wide variety of programmes to fulfil our good employer commitment, and demonstrate our strength as an equal opportunity employer. The strategic aims of our Good Employer policy are to provide:

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

*We have around **6,800** employees at Waitemata DHB (5,700 FTE)*

Of our employees:
***57.2%** are NZ/European*
***5.8%** are Māori*
***4.6%** are Pacific*
***23.0%** are Asian*
***9.4%** are of other ethnicities*

Our Good and Equal Employment Programmes

The following innovative programmes show our commitment to being a good employer and employing a diverse workforce to care for our district and regional populations.

Recruitment, Selection and Development

Professional Development Fund: The DHB has a Professional Development Fund to support individual professional development for workforces that do not normally have access to specific professional development funding.

Nursing and Medical New Graduates: The DHB has long been an employer supportive of training and supporting new graduates. In 2014 the DHB supported 133 new nursing graduates in primary care, mental health and hospital services. Over 30 new graduate resident doctors were recruited in December 2014 and are half way through their first year of practise.

Nursing and Health Care Assistant Assessment Programme: The DHB runs assessment programmes allowing nurses and health care assistants from overseas or returning to practice to showcase their skills, knowledge and experience. The DHB has actively recruited from this programme.

***24.2%** of our employees are male and **75.8%** female*

"The Group Assessment Interview Day which the Waitemata DHB conducted was very good and the best ever that I have attended in any job interview..... I felt welcomed already and part of this great team.....
The Vision of the DHB had been effectively demonstrated and acknowledged by the Recruitment Team and Senior Nursing staff. I would like to salute everyone who had made it possible for me to become a new employee of Waitemata DHB."

Kelera Batiwale, Registered Nurse

The average age of a Waitemata employee is ***44.7*** *years with* ***39.3%*** *of our employees aged 50 or over*

42.4% *of our employees work part time, a total of 1,940 FTE*

0.3% *of our employees have declared a disability*

Leadership development

The DHB provides a comprehensive leadership development programme including modules and sessions designed to develop new leaders, Foundations of Management, and grow new skills in giving feedback, coaching, cultural competency, how to manage bullying and harassment, supervision, and leading our values.

Care re-design – Clinical Leadership: Waitemata DHB's dedicated clinical leadership programme, *Enhanced Care Management and Clinical Leadership*, is led by Richard Bohmer, a Professor of Management Practice at Harvard Business School. The programme is being delivered to cohorts of senior clinical and managerial leaders in the organisation. The intention of the programme is for participants to work together in clinically led teams to (re)design systems of care for key population subgroups, and that the care redesign methodology applied by the programme will become the standard operating model for Waitemata DHB. The programme involves a series of modules covering strategy, operations design, culture and change, improvement and innovation and systems review.

Pacific leaders' development: The DHB ran its first Pacific leaders' coach development programme in June. Eight leaders in the Pacific workforce are participating. The programme made a great start with participants commenting that it was the 'most meaningful' leader development they had attended.

Growing our Māori and Pacific Health workforce

The DHB has a strong focus on growing and building the capacity of our Māori and Pacific Health workforces with several programmes including:

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

The Rangatahi Programme: The Rangatahi Programme has been developed for Māori and Pacific senior secondary school students to facilitate Māori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce.

Health Care Assistant Recruitment: The DHB supported the employment of ten trainee Māori and Pacific Health Care Assistants in 2015. The trainee roles are aimed at those who haven't had any experience or qualifications in health, and who otherwise wouldn't have an entry point into the Health Care Assistance workforce. The pilot in 2014 resulted in eight people employed in Health Care Assistant roles, and they are all still in their roles a year later. Some will be studying NZQA Level 3 care assistant training through Waitemata DHB and Careerforce, our Health Industry Training Organisation.

"I believe I've gone through a lot this year, I've learnt so much but there's still a lot I need to learn. I'm studying Health care Level 3, and hopefully after that I'll do nursing"

Health Care Assistant, Ward 2

Our employees undertake ***one of 80*** *health, support, technical, specialist and management related professions*

Organisational culture and values

The DHB has recently been recognised at the Institute of Public Administration New Zealand (IPANZ) awards for Excellence in Integrity and Trust for our extensive work linking patient experience to our organisation's values. The values work is about hearing from patients and their families and linking feedback to the DHB's values to drive improvements in care. The values programme is based around the four organisational values and is now well resourced with values, standards and behaviours material as well as guidance on the kind of behaviours and actions that translate our values from words to our way of working.

Remuneration and recognition

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

34.6% *of our employees are in nursing related professions, making it the largest proportion of our employed workforce*

The DHB runs the following staff recognition programmes:

Chief Executive awards - an award provided to staff who are recognised for a specified activity or action which demonstrates a DHB goal, priority or value
Health Hero - a monthly award to a staff member who demonstrates outstanding achievement of the organisations values, standards and behaviours
Long service awards - recognition of staff who have 10 years plus service with the DHB

In Partnership with Unions

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

Workplace flexibility and design

The DHB is entering into a large building programme across all our sites which means consideration of facility design so that it is fit for purpose for our staff, patients, family and whānau. Staff are involved in planning discussions about construction and design needs to enable appropriate and long lasting spaces that staff can work in and which aid the delivery of the best patient experiences and outcomes we can provide.

The DHB also offers flexible hours, as noted by our large part time workforce, and supports this flexibility by trying to provide rosters that meet organisational and personal needs.

Policies

The DHB has been reviewing people based policies including changes to improve the recruitment, conflict of interest, bullying and harassment, code of conduct and, protected disclosures (whistle-blowers), recruitment and retention of staff with disabilities and leave management policies. All policies are sent to union partners for their feedback.

Health and Safety

'Safe and happy staff translates to happy patients and better care all around'

Waitemata DHB attaches great importance to the health and safety of its staff. It continues to be a top priority for the Board, with a significant amount of work currently underway in this area. The DHB has established a Health and Safety Charter to ensure a standard for health and safety across the organisation. In addition, regular reporting on health and safety risks and indicators has allowed early identification of issues that arise. Finally, regular reviews are undertaken of our health and safety reporting and risk management systems in preparation for the Health and Safety Reform Bill, with several 'deep dive' reviews in community worker safety and contractor health and safety planned in 2015/16.

***3,642** employees received an annual flu vaccination*

Our work around the management of hazardous substances has enabled us to gain an Enviro-Mark accreditation at Gold level. This is something not many other organisations have attained and our work has been instrumental in the management of all of our 400+ chemicals being purchased, used and disposed of in the DHB. We have also maintained the highest level of achievement for the nine years we have been in the ACC partnership programme which is an employer co-ordinated staff injury management programme.

As well as physical health and safety risks, future planning is also strongly focused on the organisational culture, security and wellbeing of staff and includes the current development of a healthy workplaces strategy over the next 3 years. The strategy will use the World Health Organisation's (WHO) healthy workplaces framework as a basis for looking at staff engagement with, attitudes and behaviours about health and safety, workplace environment, design, and psychosocial factors, and workforce diversity.

Well @ Work

'Keeping our staff healthy and well'

Health, work and wellbeing are strongly linked. Waitemata DHB recognises these critical links and is moving forward to ensure we are a 'Healthy Workplace'. In March 2015 the DHB held Well@Work, a health and wellbeing Expo for our 6,800+ staff across our main sites. The Expo consisted of a wide range of health and wellbeing activities, including: cardiovascular and diabetes health checks; free massage; hula hoop competitions; advice on being smoke-free; melanoma checks, and more. Complementing the expo, an online survey on health and wellbeing was the most successful survey in Waitemata DHB history. The findings from the survey are being used to guide future work in supporting staff health and wellbeing.

*Over **1,100** staff participated in the healthy workplace team challenge*

The Healthy Workplaces Team Challenge over an eight week period saw 1,167 staff taking a total of 597,753,097 steps, the equivalent of walking around the world approximately ten times. Overall 59% of participants increased their daily physical activity to over 10,000 steps per day. Many staff noted the challenge was a fun interactive programme, and also improved teamwork, morale, sleep and generally feeling healthier. Along with annual exercise challenges, the establishment of an on-site staff gym at North Shore hospital has been a huge success and is further contributing to the health and fitness goals of our staff.

LIVING WITHIN OUR MEANS

We have lived within our means for the past five years

In 2014/15 we generated a financial year surplus of
$3.0 million

We must ensure we are on a sustainable financial path into the future. This is extremely challenging in the current fiscally constrained environment that is also characterised by increasing demand for services (reflecting our rapidly changing population demographics) and operating costs and capital related costs growing at a pace faster than the funding growth.

Staying within Budget

In 2014/15 we have once again 'lived within our means' and exceeded our forecasted budget expectations by delivering a final year surplus of $3.0M. This has been achieved in the face of reduced funding growth and managing to contain costs to affordable levels by providing services in a more efficient and cost effective way. Furthermore, business transformation and performance improvement initiatives identified and implemented by our staff, and savings realised from national and regional initiatives will ensure we are well placed to deliver positive financial results over the coming years.

$3.0M
Actual surplus

$1.0M
Budgeted surplus

Financial year surplus ($,000)			
11/12	12/13	13/14	14/15
$6,299	$9,899	$7,286	**$3,018**

Our positive 2014/15 financial result has been driven by our commitment to 'living with our means'.

Clinical supply costs form a large proportion of our budget. National and regional supplier contracts have been negotiated by our procurement service provider healthAlliance. Working with the healthAlliance supply chain teams has allowed us to realise the benefits from being a high volume buyer. Contracts have been negotiated in closer alignment with the national catalogue pricing and standardisation of product lists. These processes have allowed us to purchase the right product at the right price, without compromising patient care as well as minimising waste and supply chain shortages.

We have continued reviews of our rostering processes throughout the DHB. We have worked to ensure we have the right clinical capacity at the right times – flexible staffing levels have assisted in managing low and high peak periods. Management of staff vacancies as well as monitoring of annual and sick-leave has allowed us to manage personnel costs more effectively.

Budget holders have been better supported to manage their business. We have ensured that relevant and clear financial information is available to them and capital and IT projects have clearly defined projected benefits.

STATEMENT OF PERFORMANCE

Overview

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

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures in each section reflect the performance of the broader health and disability services provided to Waitemata residents, not just those provided by the DHB. We have a particular focus on improving health outcomes and reducing health inequalities for Māori. Therefore, a range of measures throughout the SP monitor our progress in improving the health and wellbeing of our Māori population, as identified in the Waitemata DHB Māori Health Plan 2014/15.

Measuring our outputs helps us to understand how we are progressing towards our impacts, and high level outcome measures of an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Auckland DHB population is now 82.5 years, an increase of 2.6 years since 2004. The life expectancy gap is 5.2 years for Māori and 6.5 years for Pacific.

National health targets

2014/15 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. Results below show the full year's performance as well as the fourth quarter's result where relevant.

Health Targets		Target	Q4 2014/15	Full Year
Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours	95%	96%	96%
Improved Access to Elective Surgery	An increase in the volume of elective surgery by an average of 4,000 discharges per year (across all DHBs)	17,545	n/a	18,185
Shorter waits for Cancer Treatment	All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (Q1 only)*	100%	n/a	100%*
Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment.*	85%	77%	73%
Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time.	95%	93%	92%
Better Help for Smokers to Quit	95% of hospitalised smokers and	95%	98%	98%
	90% seen in primary care provided with advice to help quit	90%	94%	97%
More Heart and Diabetes Checks	90% of the eligible population have had their cardiovascular risk assessed over the last five years	90%	n/a	90%

*From October 2014, the Shorter Waits for Cancer Treatment target was changed to Faster Cancer Treatment – 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management), to be achieved by July 2016. Therefore the full year result shown for the Shorter Waits for Cancer Treatment health target is actually just for quarter one.

Output class measures

During 2014/15 we reviewed the criteria against which we measure our output performance for the year. As a result of this review we have developed a new grading system - below - and this has been applied to assess performance against each indicator in the Output Measures section. While this differs to that presented in the 2014/15 Annual Plan, it should give a clearer picture of our performance for the year and better identify those areas which require continued focus to ensure achievement. A rating has not been applied to to demand driven indicators.

Criteria		Rating	
On target or better		Achieved	
95-99.9%	0.1% - 5% away from target	Substantially Achieved	
90-94.9%	5.1% - 10% away from target*	Not achieved, but progress made	
<90%	>10% away from target**	Not Achieved	

*and improvement on previous year

** or 5.1-10% away from target and no improvement on previous year

The following tables include our output measures from the 2014/15 Statement of Performance by Output Class. Outputs are goods or services provided by the DHB and other entities. Outputs are a variety of types, including policy advice, administration of contracts and the provision of specific services, for example B4 School Checks or elective surgeries. Output measures are intended to reflect our performance over the year.

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target or grade the result
$	A decreased number indicates improved performance
#	An increased number indicates improved performance
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage
N/A	Not Available

Output Class 1: Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. These services are designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases and population health protection services such as immunisation and screening services.

HEALTH PROMOTION

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	C	97.7%	97% (Q4)	95%	98%	●
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit	C	55.2%	101%[1] (Q4)	90%	97%	●
Number of people accessing Green Prescriptions	V	5,330 est.[2]	5,675	6,523	6,511	●
Enforcement of the Smokefree Environments Act 1990						
Number of retailer compliance checks conducted	V	457	302	300	284[3]	●
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted	V	498	227	300	284	●
Enforcement of alcohol legislation						
Number of license applications risk assessed	V	1,235	1,226	1,200 est.	4,354	●
Number of premises visited where joint Controlled Purchase Operations (CPOs) were conducted (alcohol)	V	325	180	400	284[3]	●
Legislation advocacy and advice						
Number of submissions made (demand driven)	V	26	45	25 est.	55	●

HEALTH PROTECTION

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Communicable disease surveillance and control activities						
Total number of communicable disease notifications per reporting period	V	5,597	6,115	5,500 est.	5,617	●
Number of notifications investigated and found to be a confirmed or probable case	V	4,706	4,941	4,500 est.	4,564	●

[1] The denominator for this target is adjusted to represent only smokers who have been seen by a health practitioner. In addition to offering advice in primary care settings, WDHB contacted patients who had not recently attended their general practice to offer them brief advice and support to quit smoking, therefore the numerator counted patients not included in the denominator.
[2] Baseline data in 2014/15 Annual Plan was incorrect, correct data included here
[3] Lower than target as ARPHS had a CPO officer position vacant, all positions have been filled as of August 2015.

HEALTH PROTECTION (continued)						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Tuberculosis						
Number of TB contacts followed up	V	795	1,080	750 est.	821	
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	81%	83.6	≥85%	99.9%	
Percentage (and number) of eligible infants vaccinated with a BCG	C	98.4% (4,811)	98.3% (4,613)	≥99% (4,800)	97% (6,226)	
Refugee health screening service						
Number of quota refugees screened[4]	C	848	778	750	771	
Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule	C	98%	New Measure	98%	100%	
Drinking water quality						
Percentage of the population that received drinking water from fully compliant supplies	Q	97%	New Measure	≥95%	97%	

Note the services described in the above tables are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support all above measures is for all three metro Auckland DHBs.

POPULATION BASED SCREENING						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Breast Screening						
Coverage rates among eligible groups	C	68%	68%	70%	68%	
Proportion of women screened who report that their privacy was respected	Q	99.70%	100%	95%	n/a[5]	
Proportion of women screened who receive their results within 10 working days	T	97.80%	99%	95%	99%	
Bowel Cancer Screening Programme Pilot						
Percentage of people invited to participate who returned a correctly completed test kit	C	55%	56.8%[6]	60%	51.4%[7]	
Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations.	Q	94%	99%	95%	n/a[8]	
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 11 weeks[9]	T	98%	83%	95%	99.3%	
Gateway Assessment Service						
Number of referred children waiting over the contracted for a Gateway Assessment.[10]	T	4	8	0	40	

[4] The NZ Government, in agreement with the UN, has a refugee quota programme which offers 750 places per year (+/- 10%).
[5] We are no longer collecting surveys to report on this indicator.
[6] Round 1 participation (January 2012 – December 2013)
[7] Round 2 participation (January 2104-March 2015, data extracted 1/8/2015). Round 2 is still underway so this number may increase.
[8] This question is no longer asked in the patient satisfaction survey. However for 2014/15, 88% of people found the accompanying booklet easy to understand
[9] Immunochemical faecal occult blood test
[10] Health and education assessment for children in, or at high risk of needing, CYF care. Priority referrals to be assessed within 20 days, all other referrals within 40 days of referral. In 2014/15 waiting time counted from date referral received, but majority of referrals received are incomplete (so assessment cannot be carried out). In 2015/16 waiting time to be counted from time referral completed to give more accurate measure of how service performing.

Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, pharmacist services, and child and adolescent oral health and dental services. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Ensuring good access to early detection and management services for all population groups, including prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions, contributes to preventing, ameliorating and curing ill health. Early detection and management services also enable patients to maintain their functional independence and prevent relapse of illness.

PRIMARY HEALTH CARE

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Primary care enrolment rates[11]	C	94%	95%	95%	95%	●
Immunisation health target achievement - 95% of eight month olds fully immunised by December 2014	C	92%	92%	95%	92%	●
Cervical screening coverage	C	76%	77%	80%	76%	●
Percentage of B4 School Checks completed	C	68%	92%	90%	93%	●
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C	75%	89%	90%	90%	●
GMS claims from after-hours providers per 10,000 of population	T	446 per 10,000	443 per 10,000	Ω	487 per 10,000	
Proportion of practices with cornerstone accreditation	Q	51%	42%	↑	53%	●

Note: The diabetes good management indicator has been removed due to inadequate data reporting systems. Reporting to be rectified in 2015/16.

COMMUNITY REFERRED TESTING & DIAGNOSTICS

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Number of community laboratory tests by provider - Diagnostic Medab (DML)[12] - Labtests Auckland (LTA)	V	373,809 3,214,963	128,768 3,515,875	Ω	5,704 3,723,540	
Number of community laboratory complaints [13]	Q	LTA=60	28	↓	31	●
Number radiological procedures referred by GPs to hospital	V	52,888	52,974	Ω	62,139	
Average waiting time at LTA collection centres, 7am - 11am	T	8.9 mins	10.2 mins	<30 mins	8.7 mins	●
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 90%	80%	90%	98%	●
		MRI 32%	49%	80%	90%	●

[11] Numerator 2015-Q2 enrolments, denominator 2014/15 population projections (2014 update)
[12] DML's laboratory contracts transferred to LTA from October 2013 and APS from October 2014.
[13] This result is for all 3 metro Auckland DHBs. LTA results only reported. DML no longer provides lab services.

ORAL HEALTH						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Enrolment rates in children under five by ethnicity: • Māori • Pacific • Other • Total population	C	 64% 64% 97% 82%	 67% 66% 90% 83%	 84%	 61.7%[14] 67.7% 85.4% 79.3%	
Utilisation rates for adolescents	C	64%	73%	85%	66.9% [15]	
Number of visits of preschool and school children to oral health services (including adolescents)	V	114,096	119,823	Ω	111,270[16]	
Number of complaints in the financial year	Q	13	8	↓	38[17]	
Arrears rates by ethnicity: • Māori • Pacific • Other • Total population	T	 8.6% 8.3% 8.6% 8.6%	 6.3% 7.1% 6.9% 6.8%	 Overall 7% 	 10.8%[16] 9.4% 8.8% 9.2%	

PHARMACY						
Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total value of subsidy provided	V	$110,095k	$110,656k	Ω	$114,702k	
Number of prescription items subsidised	V	6,430,920	6,468,038	Ω	6,784,126	
Number of Medicine Use Reviews conducted by community pharmacy	Q	192	90	↑	86[18]	

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services are generally complex and provided by health care professionals that work closely together. They include:

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

On a continuum of care these services are at the complex end of treatment services and focused on individuals. Effective and prompt resolution of medical and surgical emergencies and acute conditions prevents, ameliorates and cures ill health and relieves suffering. It also reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life in older adults, thereby improving population health.

[14] Duplicate enrolments slightly inflated historic enrolment figures, this has now been corrected. Closer linkages with Well Child providers are being developed to increase enrolment numbers in the 0-2 age range. Enrolment in maternity wards continues.
[15] A significant number of adolescents living in WDHB are enrolled with contracting dentists in ADHB area – combined Auckland & Waitemata utilisation 70%. A strategy to improve adolescent coverage has been developed and is currently being consulted on.
[16] Staff shortages, booking processes and DNAs have contributed to increased arrears. Recruitment in early 2015 has increased staff numbers and has already resulted in improvement in arrears (monitored weekly). Further recruitment is planned from the next graduating cohort from both AUT and Otago.
[17] Improved reporting practices have seen the number of recorded complaints in oral health increase.
[18] There has been a lack of engagement in the MUR service. The DHB plans to re-engage with our providers to increase uptake.

ACUTE SERVICES						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
Number of ED attendances	V	110,449	113,108	Ω	117,292	
Acute WIES total (DHB Provider)	V	54,260	58,649	55,132	56,230	
Readmission rates – acute readmissions within 28 days	Q	8.0%	9.9%	7.8%	8.2% [19]	
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	T	96%	96%	95%	96%	
Shorter waits for cancer treatment - all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (no longer a health target as of October 2014)	T	Chemo 100% Radiation 100%	100%	100%	100%	
Percentage of stroke patients thrombolysed	T	6.3%	4.8%	6.0%	4.7% [20]	

MATERNITY						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
Number of births	V	6,730	6,714	Ω	6,950	
Number of first obstetric consultations	V	3,904	3,999	Ω	4,119	
Number of subsequent obstetric consults	V	3,899	3,758	Ω	3,402	
Proportion of all births delivered by caesarean section	Q	29.0%	29.3%	↓	29.5%	
Established exclusive breastfeeding at discharge excluding NICU admissions	Q	81%	78%	75%	77%	
Third/fourth degree tears for all primiparous vaginal births	Q	3.80%	3.45%	↓	4.40% [21]	
Admission of term babies to NICU	Q	3.0%	2.2%	↓	1.7%	
Number of women booking with LMC before end of 1st trimester [22]	T	30%	67%	↑	68%	

ELECTIVE (INPATIENT/OUTPATIENT)						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
Delivery of health target for elective surgical discharges	V	15,965	17,076	17,545	18,185	
Surgical intervention rates: (standardised rate per 10,000 pop)	C					
· Joints		19.91	22.39	21	26.42 [23]	
· Cataracts		32.28	30.94	27	30.49	
· Cardiac		7.24	6.68	6.5	6.12 [24]	
· PCR		15.04	14.76	12.5	14.22	
· Angiography		43.60	42.52	34.7	41.53	

[19] Readmissions April-14 to March-15
[20] April-14 to March-15. 6% is a regional target. A pathway is being developed to increase the number of patients who are eligible for thrombolysis.
[21] Perineal trauma is more common in Asian women, and this population is increasing. Service members have attended the Health Roundtable meeting on perineal trauma and are promoting a new preventive treatment which will be audited in 15/16.
[22] Ist trimester taken to be <=12 weeks, as per MAT reporting. Maternity data supplied by MOH (community and DHB midwives) – CY2013 and 2014 results reported.
[23] Data April 2014 – March 2015
[24] Graded 'not significantly different from target' by MOH

ELECTIVE (INPATIENT/OUTPATIENT)						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
Number of first specialist assessment (FSA) outpatient consultations	V	38,655	42,798	Ω	42,199	
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Q	0.06	0.05	↓	0.06	
Post-operative sepsis and DVT/PE rates - HQSC	Q	DVT 8.4 PE 7.8	7.6 6.1	↓	7.6[25] 4.7	
Patients waiting longer than four months for their first specialist assessment (FSA)	T	8.19%	5.9%	0%	0.8%	
Patients given a commitment to treatment but not treated within four months	T	8.18%	4.9%	0%	0.7%	
Central Line Associated Bacteraemia (CLAB)	Q	0.95	0.80	<1 / 1,000 line days	0.65/1,000	

ASSESSMENT TREATMENT AND REHABILITATION (INPATIENT)						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
AT&R bed days	V	37,808	38,871	Ω	40,262	
No. of AT&R inpatient events	V	2,000	1,962	Ω	1,937	
In-hospital fractured neck of femur (FNOF) (total) – HQSC	Q	11	13	↓	10[25]	
Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	T	50%	47%	90%	47% [26]	

MENTAL HEALTH						
Output Measures	**Notes**	**Baseline**	**2013/14 Results**	**2014/15 Target**	**2014/15 Results**	**Achievement**
Accessing mental health services:						
· Age 0-19, Māori	C	3.60%	3.62%	3.6%	4.17%[27]	
· Age 0-19, Total		2.60%	2.64%	3.0%	3.04%	
· Age 20-64, Māori		7.90%	7.96%	8.0%	7.76%	
· Age 20-64, Total		3.50%	3.56%	3.5%	3.46%	
· Age 65+ Total		2.10%	2.12%	3.0%	2.11%[28]	
Child and Youth with a Transition (discharge) plan	Q	New measure	New measure	95%	66%[29]	
% of clients seen within 3 weeks	T			80%		
· Mental Health		81%	87%		79%[27]	
· Addictions		96%	97%		96%	
% of clients seen within 8 weeks				95%		
· Mental Health		94%	97%		92%	
· Addictions		99%	99%		99%	

[25] Preliminary HQSC data, as at Sept 2015
[26] Specialist nurse is being trialled to manage wait list, and business case being developed for an early supported discharge team.
[27] Data April 2014 – March 2015
[28] MHSOA has now increased focus on increasing access rates, and managing an increasing older population. 94% of 65+ are seen within 3 weeks, so waiting times are not a contributing factor.
[29] New requirement in 2014/15. Compliance has increased from 21% in Q2 to 75% in Q4 and is expected to reach target in 2015/16.

Output Class 4: Rehabilitation and Support Services

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

We aim to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities, people with mental health problems and people who have age-related disabilities. Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups.

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

HOME BASED SUPPORT

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Average hours per month of home based support services for: • Personal care • Household management	V	 61,741 20,624	 64,183 19,001	 Ω Ω	 65,098 16,915	
Proportion of people aged 65+ receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Q	42%	51%	65%	77%	●
Percentage of NASC clients assessed within 6 weeks	T	90%	77%	↑	75%[30]	●

PALLIATIVE CARE

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Number of contacts	V	20,563	20,914	Ω	19,647	
Proportion of cancer patients admitted to hospice against proportion of cancer deaths, by ethnicity[31]. - Māori - Pacific	C	Admits: Deaths 8%:5% 5%:3%	 6%:5% 4%:4%	1:1	 6%:4% 5%:4%	●
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	13.6%	8%	↓	7.8%	●

RESIDENTIAL CARE

Output Measures	Notes	Baseline	2013/14 Results	2014/15 Target	2014/15 Results	Achievement
Total number of subsidised aged residential care bed days	V	821,953	836,766	Ω	843,822	
Proportion of aged care providers with 4 year audit certification[32]	Q	13%	13%	↑	16%	●

[30] Growing > 65 year old population is causing increased demand, with no additional resources pending review of the model for HBSS.

[31] Cancer deaths are used as a proxy for establishing hospice need between population groups. Ethnicity specific hospice admission rates should not be lower than cancer death rates if hospice service is providing equal access to all population groups.

[32] 4 year certification is infrequently awarded and considered 'gold standard'. Facilities must first demonstrate several years of continuous improvement. >80% of providers are achieving 3 year certification.

Cost of Service Statement – for year ending 30 June 2015

	Prevention Services		Early Detection & Management		Intensive Assessment & Treatment		Rehabilitation and Support		Total	
	$000		$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**28,108**	**26,720**	**397,537**	**394,800**	**927,150**	**880,615**	**187,984**	**224,961**	**1,540,778**	**1,527,096**
Expenditure										
Personnel	8,755	8,040	62,680	55,498	468,495	442,683	28,168	33,933	568,098	540,154
Outsourced Services	1,271	823	11,013	5,682	56,449	45,326	5,547	9,629	74,280	61,461
Clinical Supplies	1,602	1,532	11,058	10,572	88,205	84,328	4,841	4,628	105,706	101,059
Infrastructure & Non-Clinical Supplies	1,565	1,553	9,404	10,717	94,574	85,487	3,664	327	109,207	97,430
Payments to Providers	14,616	14,722	296,680	311,330	228,567	222,792	141,536	177,098	681,400	725,992
Total Expenditure	**27,809**	**26,720**	**390,835**	**393,800**	**936,290**	**880,615**	**183,756**	**224,961**	**1,538,691**	**1,526,096**
Net Surplus / (Deficit)	**298**	**0**	**6,702**	**1,000**	**(9,140)**	**0**	**4,228**	**0**	**2,087**	**1,000**

Non-Departmental Appropriations

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs.

Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

ABOUT OUR ORGANISATION

Waitemata DHB Attendance at Board and Committee Meetings: July 2014 – June 2015

Board Member		Board *(8 meetings)*	HAC *(8 meetings)*	Audit and Finance *(8 meetings)*	CPHAC *(8 meetings)*	DiSAC *(3 meetings)*	MHGAC *(4 meetings)*
	Lester Levy	8	5*	8	4*	2*	2*
	Anthony Norman	8	8	8	x	x	x
	Max Abbot	6	8	4	6	2	x
	Warren Flaunty	7	6	8	8	x	x
	Gwen Tepania-Palmer	8	7	x	8	x	4
	Sandra Coney	8	7	x	7	3	x
	Morris Pita	6	7	7	x	x	4
	James Le Fevre	7	7	x	x	x	2
	Allison Roe	8	8	x	8	x	4
	Christine Rankin	6	7	5	4	x	x
	Pat Booth	6^	6^	x	5^	1^	x

x *not a member of the committee*
* *ex-officio member*
^ *leave of absence*

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.
For the 2014/15 year there were no permissions, waivers or modifications given under the clauses of this legislation.

Trusts

Waitemata DHB controls the Three Harbours Health Foundation. The newly formed Well Foundation replaces the two sub-trusts – the North Shore Hospital Foundation and the West Auckland Health Services Foundation.

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

Waitemata DHB also holds a 20% shareholding in South Kaipara Medical Centre Limited Partnership. This is a joint venture with the Helensville District Health Trust and two local GPs to ensure sustainability of a rural general practice.

Ministerial Directions

Directions issued by a Minister during the 2014/15 financial year, or that remain current are as follows:

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

FINANCIAL PERFORMANCE

Statement of Responsibility

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

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waitemata District Health Board for the year ended 30 June 2015.

Signed on behalf of the Board:

Dr Lester Levy
Chair
Dated: 30 October 2015

Anthony Norman
Deputy Chair
Dated: 30 October 2015

Statement of comprehensive revenue and expense for the year ended 30 June 2015

	Notes	Group Actual 2015 $000	Group Actual 2014 (restated) $000	Parent Actual 2015 $000	Group and Parent Budget 2015 $000	Parent Actual 2014 (restated) $000
Revenue						
Patient care revenue	2	1,509,335	1,447,734	1,509,335	1,494,837	1,447,734
Interest revenue		8,199	7,041	7,841	6,010	6,718
Other revenue	3	23,602	22,969	23,602	26,250	22,969
Total revenue	30	1,541,136	1,477,744	1,540,778	1,527,097	1,477,421
Expenditure						
Personnel costs	4	568,097	522,239	568,097	540,154	522,239
Depreciation and amortisation expense	12,13	23,517	23,390	23,517	25,308	23,390
Outsourced services		74,280	61,632	74,280	61,461	61,632
Clinical supplies		98,463	94,243	98,463	93,631	94,243
Infrastructure and non-clinical expenses		46,545	46,635	46,545	38,002	46,635
Other district health boards		258,780	249,000	258,780	332,694	249,000
Non-health board provider expenses		422,621	435,294	422,621	393,298	435,294
Capital charge	5	18,618	15,188	18,618	15,768	15,188
Interest expense		12,492	12,742	12,492	13,861	12,742
Other expenses	6	14,705	10,095	15,278	11,920	11,175
Total expenditure	30	1,538,118	1,470,458	1,538,691	1,526,097	1,471,538
Share of associate and joint venture surplus / (deficit)	11	0	0	0	0	0
Surplus / (deficit)		**3,018**	**7,286**	**2,087**	**1,000**	**5,883**
Other comprehensive revenue and expense						
Gain on property revaluations	18	54,245	38,831	54,245	0	38,831
Total other comprehensive revenue and expense		54,245	38,831	54,245	0	38,831
Total comprehensive revenue and expense		**57,263**	**46,117**	**56,332**	**1,000**	**44,714**

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

Statement of changes in net assets/equity for the year ended 30 June 2015

	Notes	Group Actual 2015 $000	Group Actual 2014 (restated) $000	Parent Actual 2015 $000	Group and Parent Budget 2015 $000	Parent Actual 2014 (restated) $000
Balance at 1 July		256,459	203,602	248,391	197,937	196,937
Change in accounting policy		0	6,740	0	0	6,740
		256,459	**210,342**	**248,391**	**197,937**	**203,677**
Comprehensive Income						
Surplus		3,018	3,534	2,087	1,000	2,131
Change in accounting policy		0	3,752	0	0	3,752
Surplus (restated)		**3,018**	**7,286**	**2,087**	**1,000**	**5,883**
Other comprehensive revenue and expense						
Gain on property revaluations		54,245	38,831	54,245	0	38,831
Total comprehensive revenue and expense for the year (restated)		**57,263**	**46,117**	**56,332**	**1,000**	**44,714**
Balance at 30 June (restated)	18	**313,722**	**256,459**	**304,723**	**198,937**	**248,391**

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

Statement of financial position as at 30 June 2015

	Notes	Group Actual 2015 $000	Group Actual 2014 (restated) $000	Parent Actual 2015 $000	Group and Parent Budget 2015 $000	Parent Actual 2014 (restated) $000
Assets						
Current assets						
Cash and cash equivalents	7	144,900	124,647	143,393	61,299	123,403
Receivables	8	39,593	36,318	39,240	26,100	36,319
Investments	9	1,936	1,633	0	0	0
Inventories	10	6,370	5,458	6,370	5,500	5,458
Prepayments		335	156	335	500	156
Total current assets		193,134	168,212	189,338	93,399	165,336
Non-current assets						
Investments	9	5,170	4,815	0	0	0
Investments in associates and joint ventures	11	25,855	24,279	25,855	27,336	24,279
Property, plant and equipment	12	637,183	563,273	637,183	571,086	563,273
Intangible assets	13	5,113	4,920	5,113	4,738	4,920
Total non-current assets		673,321	597,287	668,151	603,160	592,472
Total assets		**866,455**	**765,499**	**857,489**	**696,559**	**757,808**
Liabilities						
Current liabilities						
Payables	14	126,013	122,819	126,046	116,303	123,196
Borrowings	15	26,049	127,537	26,049	83,893	127,537
Employee entitlements	16	113,798	95,730	113,798	85,755	95,730
Provisions	17	619	736	619	500	736
Total current liabilities		266,479	346,822	266,512	286,451	347,199
Non-current liabilities						
Borrowings	15	251,848	132,928	251,848	188,671	132,928
Employee entitlements	16	34,406	29,290	34,406	22,500	29,290
Total non-current liabilities		286,254	162,218	286,254	211,171	162,218
Total liabilities		**552,733**	**509,040**	**552,766**	**497,622**	**509,417**
Net assets		**313,722**	**256,459**	**304,723**	**198,937**	**248,391**
Equity						
Contributed Capital	18	103,015	103,015	103,015	103,015	103,015
Accumulated surpluses / (deficits)	18	(42,785)	(44,872)	(42,785)	(55,495)	(44,872)
Property Revaluation Reserves	18	244,493	190,248	244,493	151,417	190,248
Trust funds	18	8,999	8,068	0	0	0
Total equity		**313,722**	**256,459**	**304,723**	**198,937**	**248,391**

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

Statement of cash flows for the year ended 30 June 2015

	Notes	Group Actual 2015 $000	Group Actual 2014 (restated) $000	Parent Actual 2015 $000	Group and Parent Budget 2015 $000	Parent Actual 2014 (restated) $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		1,519,457	1,422,420	1,519,457	1,488,858	1,422,420
Other		40,658	40,080	39,554	32,229	38,724
Interest received		7,562	6,295	7,528	6,010	6,281
Payments to suppliers		(941,893)	(876,180)	(941,263)	(927,009)	(875,564)
Payments to employees		(540,677)	(506,469)	(540,677)	(540,152)	(506,469)
Payments for capital charge		(18,919)	(15,623)	(18,919)	(15,768)	(15,623)
Interest paid		(15,605)	(12,441)	(15,605)	(13,860)	(12,441)
GST (net)		(1,190)	(1,378)	(1,190)	(4,000)	(1,378)
Net cash flow from operating activities	19	49,393	56,704	48,885	26,308	55,950
Cash flows from investing activities						
Receipt from sale of property, plant and equipment		0	0	0	0	0
Receipt from sale or maturity of investments		0	0	0	0	0
Purchase of property, plant and equipment		(44,393)	(29,825)	(44,393)	(51,662)	(29,825)
Purchase of intangible assets		(226)	(1,464)	(226)	0	(1,464)
Acquisition of investments		(1,821)	(6,470)	(1,576)	0	(6,100)
Net cash flow from investing activities		(46,440)	(37,759)	(46,195)	(51,662)	(37,389)
Cash flows from financing activities						
Capital contributions from the Crown		0	0	0	0	0
Proceeds from loans		17,300	0	17,300	9,000	0
Repayment of loans		0	(83)	0	(1,000)	(83)
Net cash flow from financing activities		17,300	(83)	17,300	8,000	(83)
Net (decrease) / increase in cash and cash equivalents		**20,253**	**18,862**	**19,990**	**(17,354)**	**18,478**
Cash and cash equivalents at the start of the year		124,647	105,785	123,403	78,653	104,925
Cash and cash equivalents at the end of the year	7	**144,900**	**124,647**	**143,393**	**61,299**	**123,403**

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

NOTES TO THE FINANCIAL STATEMENTS

1 Statement of accounting policies for the year ended 30 June 2015

Reporting entity

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

The Waitemata District Health Board's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes.

The consolidated financial statements of Waitemata DHB for the year ended 30 June 2015 comprise Waitemata DHB and its subsidiaries (together referred to as "Group") and Waitemata DHB's interest in associates and jointly controlled entities. The Waitemata DHB group consists of the controlling entity, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board). Joint ventures are healthAlliance N.Z. Limited (25% Class A shares), New Zealand Health Innovation Hub Limited Partnership (25%) and Awhina Health Campus.

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

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

The financial statements for the DHB are for the year ended 30 June 2015, and were approved by the Board on 30 October 2015.

Basis of preparation

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

Statement of compliance

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

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

These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. The material adjustments arising on transition to the new PBE accounting standards are explained in Note 31.

Presentation currency and rounding

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

Effect of first-time adoption of PBE standards on accounting policies and disclosures

This is the first set of financial statements of the DHB and group that is presented in accordance with PBE standards. The DHB and group have previously reported in accordance with NZ IFRS (PBE).

The accounting policies adopted in these financial statements are consistent with those of the previous financial year, except for instances when the accounting or reporting requirements of a PBE standard are different to requirements under NZ IFRS (PBE) as outlined below.

The changes to accounting policies and disclosures caused by first time application of PBE accounting standards are as follows:

PBE IPSAS 23: Revenue from Non-Exchange Transactions

PBE IPSAS 23 prescribes the financial reporting requirements for revenue arising from non-exchange transactions. There is no equivalent financial reporting standard under NZ IFRS (PBE).

In adoption of the accounting standard for the first time, Management has reassessed the nature of previously unrecognised revenue. The reassessment is to comply with PBE IPSAS 23. This has resulted in a retrospective adjustment whereby previously unrecognised revenue has now been recognised in the financial statements for the year ended 30 June 2014.

Full disclosure is included in Note 31.

Standards issued that are not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on and after 1 July 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting statements was updated to incorporate requirements and guidance for the not-for-profit sector. These updated statements apply to PBEs with reporting periods beginning on or after 1 April 2015. The DHB will apply these updated standards in preparing its 30 June 2016 financial statements. The DHB expects there will be minimal or no change in applying these updated accounting standards.

Summary of significant accounting policies

Subsidiaries

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

The DHB does not consolidate its controlled entity Milford Secure Properties as it is dormant and is not material.

Joint ventures

A joint venture is a contractual arrangement whereby two or more parties undertake an economic activity that is subject to joint control.

Waitemata DHB is party to three joint ventures arrangements. One is a jointly controlled operation; Awhina Waitakere Health Campus. The DHB recognises in its financial statements the assets it controls, the revenue that it earns, the liabilities and expenses that it incurs from this joint operation.

The second joint venture is healthAlliance N.Z. Limited, which is a jointly controlled entity. Any contribution of cash or other resources to the joint venture is recognised in the financial statements as an investment in the joint venture entity. The value of the investment in healthAlliance Joint Venture is reviewed annually for any impairment losses. The investment in healthAlliance Joint Venture is accounted for using the equity method.

The third joint venture is New Zealand Health Innovation Hub Limited Partnership, which is a jointly controlled entity. The interest in this joint venture is not accounted for as it is not material to Waitemata District Health Board.

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

Associate
An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The interests in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) are not accounted for as they are not material to Waitemata District Health Board.

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

MOH revenue
The DHB is primarily funded through revenue received from the Ministry of Health. This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Ministry has been determined to be equivalent to the amounts due in the funding arrangements.

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

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

Donated services
Certain operations of the DHB are reliant on services provided by volunteers. Volunteers' services received are not recognised as revenue or expenditure by the DHB.
Interest revenue
Interest revenue is recognised using the effective interest method.

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

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

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

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

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

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

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

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

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

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

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

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

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

Investments

Bank term deposits

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

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

Derivative financial instruments

Derivative financial instruments are used to manage exposure to foreign exchange risk and interest rate risks arising from the DHB's operational, financing and investment activities. The DHB has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently re-measured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

The full fair value of a derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise the derivatives are classified as non-current.

Bond forward rate agreement (Bond FRA)

Bond Forward Rate Agreement (FRA) is initially recognised at fair value on the date a contract is entered into, and is subsequently re-measured at the fair value at each balance date, with the resulting gain or loss recognised in the surplus or deficit.

Inventories

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

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

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

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

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current 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 non-current assets 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.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

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

- Land
- Buildings (including fit outs and underground infrastructure)
- Clinical 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, buildings and underground infrastructure are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

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

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

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

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

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

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

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

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

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

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

- Buildings (including components) 6 to 80 years (1.67%-16.67%)
- Underground Infrastructure 35 to 43 years (2.33% to 2.86%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%)

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

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

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

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

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

Staff training costs are recognised as an expense when incurred.
Costs associated with maintaining computer software are recognised as an expense when incurred.
Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation

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

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

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

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

FPSC rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

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

Non-cash generating assets

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

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

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

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

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

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

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

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

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

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

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

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

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

Provisions

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

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Accredited Employers Programme

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

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

Equity

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

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- trust funds.

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

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

Cost allocation
The DHB has determined the cost of outputs using the cost allocation system outlined below.
Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output.

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

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

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

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

Land, building, underground infrastructure, fixed dental clinics and pads revaluations
Note 12 provides information about the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads.

Estimating the fair value of land and building revaluations
The significant assumptions applied in determining the fair value and buildings are disclosed in note 12.

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

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

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

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

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

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

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

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

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

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

Some individual DHBs have entered into contracts for services with providers on behalf of themselves (contracting DHB) and other DHBs (recipient DHB) 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.

Comparative Figures
Comparative information has been reclassified as appropriate to achieve consistency in disclosure with the current year.

2 Patient care revenue

	Group		Parent	
	Actual 2015 $000	Actual 2014 (restated) $000	Actual 2015 $000	Actual 2014 (restated) $000
Health and disability services (MOH contracted revenue)	1,413,424	1,356,843	1,413,424	1,356,843
ACC contract revenue	9,586	9,904	9,586	9,904
Inter district patient inflows	76,139	70,554	76,139	70,554
Revenue from other district health boards	5,359	5,580	5,359	5,580
Other patient sourced revenue	4,827	4,853	4,827	4,853
Total patient care revenue	**1,509,335**	**1,447,734**	**1,509,335**	**1,447,734**

3 Other revenue

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Clinical Training Agency	8,615	8,907	8,615	8,907
Donations and bequests received	257	404	213	207
Rental revenue	594	528	594	528
Professional, training and research	2,146	2,831	3,478	3,304
Other revenue	11,990	10,299	10,702	10,023
Total other revenue	**23,602**	**22,969**	**23,602**	**22,969**

4 Personnel costs

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Salaries and wages	534,052	490,619	534,052	490,619
Contributions to defined contribution schemes	17,696	14,633	17,696	14,633
Increase/(decrease) in liability for employee entitlements	16,349	16,987	16,349	16,987
Total personnel costs	**568,097**	**522,239**	**568,097**	**522,239**

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 2015 was 8% (2014: 8%).

6 Other expenses

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Audit fees for Waitemata DHB financial statement audit	204	212	204	212
Audit fees (for subsidiary financial statements)	15	10	15	10
Operating lease expense	10,040	8,626	10,040	8,626
Impairment of debtors	1,386	1,272	1,386	1,272
Board members fees Note 23	372	367	372	367
Loss on bond forward rate agreements	3,291	(204)	3,291	(204)
Koha	0	17	0	17
Other expenses	(603)	(205)	(30)	875
Total other expenses	**14,705**	**10,095**	**15,278**	**11,175**

7 Cash and cash equivalents

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Cash at bank and on hand	17	16	0	0
Call deposits	1,490	1,228	0	0
Health Benefits Limited	143,393	123,403	143,393	123,403
Total cash and cash equivalents for the purposes of the statement of cash flows	**144,900**	**124,647**	**143,393**	**123,403**

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

Cash and cash equivalents include funds of $1,507k (2014: $1,244k) donated or bequeathed for a specific purpose. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

Waitemata DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (NZ Health Partnerships Limited from 1 July 2015) and the participating DHBs. This Agreement enables Health Benefits Limited (NZ Health Partnerships Limited from 1 July 2015) 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 Health Benefits Limited (NZ Health Partnerships Limited from 1 July 2015), which will incur interest at on-call interest rate received by Health Benefits Limited (NZ Health Partnerships Limited from 1 July 2015) plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST; for Waitemata DHB that equates to $46.709m (2014: $44.615m).

8 Receivables

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Ministry of Health	19,970	19,363	19,970	19,363
Other receivables	8,765	6,957	8,765	6,957
Other accrued revenue	13,962	13,092	13,609	13,093
Less: Provision for impairment	(3,104)	(3,094)	(3,104)	(3,094)
Total receivables	**39,593**	**36,318**	**39,240**	**36,319**

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 2015			Group 2014		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	36,178	(281)	35,897	34,422	(46)	34,376
Past due 1-30 days	1,246	(263)	983	883	(256)	627
Past due 31-60 days	1,823	(196)	1,627	971	(321)	650
Past due 61-90 days	615	(522)	93	342	(193)	149
Past due > 90 days	2,835	(1,842)	993	2,794	(2,278)	516
Total	**42,697**	**(3,104)**	**39,593**	**39,412**	**(3,094)**	**36,318**

	Parent 2015			Parent 2014		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	35,825	(281)	35,544	34,423	(46)	34,377
Past due 1-30 days	1,246	(263)	983	883	(256)	627
Past due 31-60 days	1,823	(196)	1,627	971	(321)	650
Past due 61-90 days	615	(522)	93	342	(193)	149
Past due > 90 days	2,835	(1,842)	993	2,794	(2,278)	516
Total	**42,344**	**(3,104)**	**39,240**	**39,413**	**(3,094)**	**36,319**

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

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

8 Receivables (continued)

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

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Balance at 1 July	3,094	2,016	3,094	2,016
Additional provisions made	1,386	1,860	1,386	1,860
Receivables written off	(1,376)	(782)	(1,376)	(782)
Balance at 30 June	**3,104**	**3,094**	**3,104**	**3,094**

9 Investments

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,936	1,633	0	0
Total current portion	1,936	1,633	0	0
Non-current portion				
Term deposits with maturities greater than 3 months and remaining duration greater than 12 months	5,170	4,815	0	0
Total non-current portion	5,170	4,815	0	0
Total investments	**7,106**	**6,448**	**0**	**0**

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

The fair value of term deposits with a remaining duration greater than 12 months is $ 5.170m (2014: $4.815m). The fair value has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs.

There is no impairment provision for investments.

10 Inventories

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Pharmaceuticals	598	702	598	702
Surgical and medical supplies	5,772	4,756	5,772	4,756
Total inventories	**6,370**	**5,458**	**6,370**	**5,458**

The write-down of inventories held for distribution amounted to $0 (2014: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2014: $nil). However, some inventories are subject to retention of title clauses.

11 Investments in associates, joint ventures and partnerships

	Interest held 30-Jun-15	Balance date
Investments in joint ventures		
healthAlliance N.Z. Limited – Class A shares	25%	30-Jun
New Zealand Health Innovation Hub Limited Partnership	25%	30-Jun
Investments in associates		
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	33.30%	30-Jun
South Kaipara Medical Centre	20%	30-Jun

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

Value of investments in associates, joint ventures and partnerships

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
healthAlliance N.Z. Limited	25,767	24,191	25,767	24,191
New Zealand Health Innovation Hub Limited Partnership	0	0	0	0
South Kaipara Medical Centre	88	88	88	88
Total investments	**25,855**	**24,279**	**25,855**	**24,279**

There were no impairment losses in the value of associates and joint ventures assessed for 2015 (2014: $nil). The fair value of investment in healthAlliance N.Z. Limited is the same as the book value $25.767m (2014: $24.191m).

11 Investments in associates, joint ventures and partnerships (continued)

Summary of financial information of joint ventures and associates

	Assets $000	Liabilities $000	Equity $000	Revenues $000	Surplus $000
2015					
healthAlliance N.Z. Limited	125,389	23,492	101,897	123,276	(37)
New Zealand Health Innovation Hub Limited Partnership	1,157	185	972	699	(389)
Northern Regional Alliance Ltd (formerly Norther DHB Support Agency)	11,627	10,117	1,510	14,969	124
South Kaipara Medical Centre	509	221	288	2,099	(47)
Total	**138,682**	**34,015**	**104,667**	**141,043**	**(349)**
2014					
healthAlliance N.Z. Limited	114,572	19,158	95,414	109,648	169
New Zealand Health Innovation Hub Limited Partnership	1,614	1,053	561	937	(740)
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	10,424	9,038	1,386	14,233	607
South Kaipara Medical Centre	484	189	295	1,346	(145)
Total	**127,094**	**29,438**	**97,656**	**126,164**	**(109)**

Share of surplus / (deficit) of associate entities.

	Actual 2015 $000	Actual 2014 $000
Share of surplus / (deficit) before tax:	(75)	31
Less: Tax expense	0	0
Share of surplus / (deficit)	**(75)**	**31**

The Group's share of the surplus / (deficit) in associated entities above has not been accounted for on the grounds of immateriality.

12 Property, plant, and equipment

Parent and Group	Land $000	Buildings $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Cost or valuation							
Balance at 1 July 2013	123,232	331,471	98,811	28,860	4,052	39,347	625,773
Additions from WIP	0	38,477	10,446	1,543	0	(50,466)	0
Revaluation increase/(decrease)	38,831	0	0	0	0	0	38,831
Additions to WIP	0	0	0	0	0	34,060	34,060
Disposals	0	(1,424)	(8,444)	(3,435)	(71)	(2,410)	(15,784)
Balance at 30 June 2014	**162,063**	**368,524**	**100,813**	**26,968**	**3,981**	**20,531**	**682,880**
Balance at 1 July 2014	162,063	368,524	100,813	26,968	3,981	20,531	682,880
Additions from WIP	0	29,512	11,260	2,802	87	(43,661)	0
Revaluation increase/(decrease)	23,497	(7,874)	0	0	0	0	15,623
Additions to WIP	0	0	0	0	0	43,470	43,470
Disposals	0	0	0	(451)	0	(442)	(893)
Balance at 30 June 2015	**185,560**	**390,162**	**112,073**	**29,319**	**4,068**	**19,898**	**741,080**

Parent and Group	Land $000	Buildings $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Accumulated depreciation and impairment losses							
Balance at 1 July 2013	0	16,390	67,805	20,794	3,983	0	108,972
Depreciation expense	0	14,328	6,963	1,886	25	0	23,202
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	(1,298)	(7,960)	(3,252)	(57)	0	(12,567)
Elimination on revaluation	0	0	0	0	0	0	0
Balance at 30 June 2014	**0**	**29,420**	**66,808**	**19,428**	**3,951**	**0**	**119,607**
Balance at 1 July 2014	0	29,420	66,808	19,428	3,951	0	119,607
Depreciation expense	0	14,290	7,243	1,815	22	0	23,370
Impairment losses	0	0	0	0	0	0	0
Elimination on disposal/transfer	0	0	0	(458)	0	0	(458)
Elimination on revaluation	0	(38,622)	0	0	0	0	(38,622)
Balance at 30 June 2015	**0**	**5,088**	**74,051**	**20,785**	**3,973**	**0**	**103,897**
Carrying amounts							
At 1 July 2013	123,232	315,081	31,006	8,066	69	39,347	516,801
At 30 June and 1 July 2014	**162,063**	**339,104**	**34,005**	**7,540**	**30**	**20,531**	**563,273**
At 30 June 2015	**185,560**	**385,074**	**38,022**	**8,534**	**95**	**19,898**	**637,183**

12 Property, plant, and equipment (continued)

The net carrying amount of assets held under finance leases is $1.191m (2014: $1.059m) for clinical equipment.

IT assets in Work In Progress $3.682m (2014: $715k) will be transferred to healthAlliance N.Z. Limited once completed.

Valuation

The total fair value of land and buildings valued by M E Gamby of Telfer Young as at 30 June 2015 amounted to $566.2m.

Land

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

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

The most recent valuation of land was performed by a registered independent valuer, E Gamby of Telfer Young and the valuation is effective as at 30 June 2015 and the land and building values were adjusted accordingly.

Buildings

Specialised hospital buildings and underground infrastructure are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

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

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

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

Work in progress

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

Parent and Group	**2015 $000**	**2014 $000**
Buildings	17,934	17,491
Equipment and vehicles	1,964	3,040
Total work in progress	**19,898**	**20,531**

12 Property, plant, and equipment (continued)

Impairment

The review and revaluation of buildings resulted in an impairment loss of Nil (2014: Nil). Total combined impairment losses to date of $8.988m consist of:

- $6.605m for a leaky building and $13k seismic upgrade cost at the Mason Clinic;
- $503k seismic upgrade cost at North Shore Hospital;
- $1.867m seismic upgrade cost at Waitakere Hospital.

Condition assessments and remediation plans have been prepared for all buildings. Work has been completed for urgent temporary and minor repairs. Unspent capital and operational funds have been reprioritised to cover repair costs, with the full programme of work expected to take two to three years. Litigation advice has been taken and legal action is underway. Decanting space options for housing patients are also being worked through.

Restrictions on title

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

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims cannot be quantified and is therefore not reflected in the value of the land.

13 Intangible assets

Movements for each class of intangible assets are as follows:

Parent and Group	FPSC Rights $000	Acquired Software $000	Total $000
Cost			
Balance at 30 June 2013	3,129	3,023	6,152
Additions from WIP	0	441	441
Additions to WIP	1,464	0	1,464
Transfer from/(to) assets held for sale	0	(217)	(217)
Balance at 30 June 2014	4,593	3,247	7,840
Additions from WIP	0	0	0
Additions to WIP	226	114	340
Transfer from/(to) assets held for sale	0	0	0
Balance at 30 June 2015	4,819	3,361	8,180
Accumulated amortisation and impairment losses			
Balance at 30 June 2013	0	2,922	2,922
Amortisation expense	0	188	188
Transfer to assets held for sale	0	(190)	(190)
Balance at 30 June 2014	0	2,920	2,920
Amortisation expense	0	147	147
Transfer to assets held for sale	0	0	0
Balance at 30 June 2015	0	3,067	3,067
Carrying amounts			
At 1 July 2013	3,129	101	3,230
At 30 June 2014	**4,593**	**327**	**4,920**
At 30 June 2015	**4,819**	**294**	**5,113**

At 30 June 2015, the DHB had made payments totalling $4.819m (2014: $4.593m) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC") programme. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

13 Intangible assets (continued)

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

HBL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares;

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net surplus after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

There are no restrictions over the title of the DHB's intangible assets; nor are any intangible assets pledged as security for liabilities.

14 Payables

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Creditors and accrued expenses	117,516	113,567	117,549	113,944
Revenue in advance	1,785	2,087	1,785	2,087
GST payable	6,712	6,863	6,712	6,863
Capital charge payable	0	302	0	302
Total payables	**126,013**	**122,819**	**126,046**	**123,196**

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

15 Borrowings

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Current portion				
Finance leases	339	339	339	339
New Zealand Debt Management Office loans	25,710	127,198	25,710	127,198
Total current portion	**26,049**	**127,537**	**26,049**	**127,537**
Non-current portion				
Finance leases	852	720	852	720
New Zealand Debt Management Office loans	250,996	132,208	250,996	132,208
Total non-current portion	251,848	132,928	251,848	132,928
Total borrowings	**277,897**	**260,465**	**277,897**	**260,465**
Borrowing facility limits				
New Zealand Debt Management Office loan facility limit	277,820	262,820	277,820	262,820
Overdraft facility	0	0	0	0
Total borrowing facility limits	**277,820**	**262,820**	**277,820**	**262,820**

New Zealand Debt Management Office (NZDM) loans
The NZDMO loans are secured by a negative pledge.

Without the NZDMO's prior written consent, the DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances;
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- make a substantial change in the nature or scope of its business as presently conducted;
- dispose of any of its assets except disposals in the ordinary course of business or disposal for full fair value; or
- provide or accept services other than for proper value and on reasonable commercial terms.

All financial covenants have been waived by the NZDMO.

The fair value of NZDMO borrowings is $285.104m (2014: $261.795m). Fair value has been determined using the contractual cash flows discounted by the Government bond rate plus 15 basis points.

15 Borrowings (continued)

Finance leases

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

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Minimum lease payments payable:				
No later than one year	256	423	256	423
Later than one year and not later than five years	1,250	941	1,250	941
Later than five years	0	0	0	0
Total minimum lease payments	1,506	1,364	1,506	1,364
Future finance charges	(315)	(305)	(315)	(305)
Present value of minimum lease payments	1,191	1,059	1,191	1,059
Present value of minimum lease payments				
No later than one year	339	339	339	339
Later than one year and not later than five years	852	720	852	720
Later than five years	0	0	0	0
Total present value of minimum lease payments	**1,191**	**1,059**	**1,191**	**1,059**

Description of finance leasing arrangements

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

16 Employee entitlements

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Current portion				
Accrued salaries and wages	7,267	5,308	7,267	5,308
Annual leave	63,757	58,709	63,757	58,709
Sick leave	1,100	639	1,100	639
Sabbatical leave	3,620	1,263	3,620	1,263
Continuing medical education	7,905	6,956	7,905	6,956
Work related entitlements	1,824	1,054	1,824	1,054
Unpaid payroll	9,109	8,619	9,109	8,619
Payroll provisions	9,974	5,577	9,974	5,577
Unsettled CEAs	3,347	2,064	3,347	2,064
Accrued long service awards	3,285	3,285	3,285	3,285
Long service leave	461	417	461	417
Retirement gratuities	2,149	1,839	2,149	1,839
Total current portion	113,798	95,730	113,798	95,730
Non-current portion				
Continuing medical education	10,061	8,853	10,061	8,853
Long service leave	7,642	6,308	7,642	6,308
Retirement gratuities	14,503	12,412	14,503	12,412
Sick leave	2,200	1,717	2,200	1,717
Total non-current portion	34,406	29,290	34,406	29,290
Total employee entitlements	**148,204**	**125,020**	**148,204**	**125,020**

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and future likely settlement rates for Waitemata DHB specific employment groups. An inflation factor of 4% (2014: 3.5%) was used.

17 Provisions

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Current portion				
ACC Partnership Programme	619	736	619	736
Total current portion	619	736	619	736
Total provisions	**619**	**736**	**619**	**736**

Movements for each class of provision are as follows:

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Balance at 1 July	736	478	736	478
Movement in provisions	0	258	0	258
Amounts used	(117)	0	(117)	0
Balance at 30 June	**619**	**736**	**619**	**736**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2015. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 11% (2014: 11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability.

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

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

- an average assumed rate of inflation of 2.1% (2014: 2.5%);
- a weighted average discount factor of 3% (2014: 2.95%) has been applied.

Insurance risk

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

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

18 Equity

	Group		Parent	
	Actual 2015 $000	Actual 2014 (restated) $000	Actual 2015 $000	Actual 2014 (restated) $000
Crown equity				
Balance at 1 July	103,015	103,015	103,015	103,015
Capital contributions from the Crown	0	0	0	0
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	103,015	103,015	103,015	103,015
Accumulated surpluses/(deficits)				
Balance at 1 July	(44,872)	(57,495)	(44,872)	(57,495)
Prior year adjustments	0	6,740	0	6,740
	(44,872)	(50,755)	(44,872)	(50,755)
Surplus/(deficit) for the year	3,018	7,286	2,087	5,883
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(931)	(1,403)	0	0
Balance at 30 June	(42,785)	(44,872)	(42,785)	(44,872)
Revaluation reserves				
Balance at 1 July	190,248	151,417	190,248	151,417
Impairment loss	0	0	0	0
Revaluations	54,245	38,831	54,245	38,831
Balance at 30 June	244,493	190,248	244,493	190,248
Revaluation reserves consist of:				
Land	180,074	156,579	180,074	156,579
Buildings	64,419	33,669	64,419	33,669
Total revaluation reserves	244,493	190,248	244,493	190,248
Trust funds				
Balance at 1 July	8,068	6,665	0	0
Movement	931	1,403	0	0
Balance at 30 June	8,999	8,068	0	0
Total equity	**313,722**	**256,459**	**304,723**	**248,391**

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

	Group		Parent	
	Actual 2015 $000	Actual 2014 (restated) $000	Actual 2015 $000	Actual 2014 (restated) $000
Net surplus/(deficit)	3,018	7,286	2,087	5,883
Add/(less) non-cash items				
Loss/(Gain) on Derivatives	0	(204)	0	(204)
Depreciation and amortisation expense	23,517	23,390	23,517	23,390
Total non-cash items	23,517	23,186	23,517	23,186
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/ loss investments	0	0	0	0
Investments in associates – healthAlliance	0	0	0	0
Investments in associates – FPSC Rights	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	0	631	0	631
Total items classified as investing or financing activities	0	631	0	631
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(3,757)	(7,833)	(3,100)	(7,536)
Inventories	(912)	(120)	(912)	(120)
Creditors and other payables	4,460	16,309	4,226	16,661
Provisions	(117)	258	(117)	258
Employee entitlements	23,184	16,987	23,184	16,987
Net movements in working capital items	22,858	25,601	23,281	26,250
Net cash flow from operating activities	**49,393**	**56,704**	**48,885**	**55,950**

20 Capital commitments and operating leases

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Capital commitments				
Property, plant and equipment	31,241	19,991	31,241	19,991
Intangible assets	0	226	0	226
Total capital commitments	**31,241**	**20,217**	**31,241**	**20,217**

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

20 Capital commitments and operating leases (continued)

Non-cancellable operating leases as lessor

The future aggregate receipts to be received under other non-cancellable contractual operating leases are as follows:

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Not later than one year	180	180	180	180
Later than one year and not later than five years	445	445	445	445
Later than five years	0	0	0	0
Total non-cancellable operating leases as lessor	**625**	**625**	**625**	**625**

The majority of these commitments relate to leasing out sites to third parties.

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 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Not later than one year	8,677	9,740	8,677	9,740
Later than one year and not later than five years	15,011	12,990	15,011	12,990
Later than five years	574	295	574	295
Total non-cancellable operating leases as lessee	**24,262**	**23,025**	**24,262**	**23,025**

The DHB leases a number of buildings under operating leases, the largest of which is a mental health unit in West Auckland with an expiry date of 29 March 2016, with a right of renewal for a further two periods of five years each, and a review to market rent every three years.

21 Contingencies

Contingent liabilities

Lawsuits against the DHB

Waitemata DHB and its associates have been notified of three potential legal claims at 30th June 2015 which creates a contingent liability totalling approximately $275k (2014: two claims approximately $222k).

At balance date, Unitec Institute of Technology have granted $435k (2014: $435k) towards the refurbishment of Awhina Health Campus which was completed on 2 November 2011. If certain conditions in the joint venture agreement are not fulfilled, Waitemata DHB would need to repay some, or all, of this amount.

22 Related party transactions

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

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

Significant transactions with government-related entities

The DHB has received funding from the Crown and ACC of $1.423b (2014: $1.367b) to provide health services in the Waitemata area for the year ended 30 June 2015.

Transactions with key management personnel

Key management personnel compensation	Actual 2015 $000	Actual 2014 $000
Board members:		
Remuneration	371	367
Full-time equivalent members	11	12
Salaries and other employee benefits of Executive Leadership Team	3,025	2,579
Full-time equivalent members	9	7
Total key management personnel remuneration	**3,396**	**2,946**
Total full-time equivalent personnel	**20**	**19**

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board Members.

Key management personnel include the Chief Executive and the other nine members of the management team (2014: six members).

No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2014: $nil).

There were no commitments with related parties, except for the purchase of B class shares in HBL as detailed in note 13 Intangibles which has a commitment of $0k (2014: $226k)

23 Board member remuneration

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

	Actual 2015 $000	Actual 2014 $000
Dr Lester Levy (Chair)	69	70
Prof Max Abbott	31	33
Pat Booth	28	30
Sandra Coney	30	29
Rob Cooper - appointed until 8th December 2013	0	11
Warren Flaunty	31	31
Wendy Lai - appointed until 8th December 2013	0	13
James Le Fevre	28	27
Anthony Norman (Deputy Chair) - appointed from 9th December 2013	36	20
Morris Pita - appointed from 9th December 2013	29	16
Christine Rankin	30	30
Allison Roe	29	29
Gwen Tepania–Palmer	30	28
Total board member remuneration	**371**	**367**

Co-opted committee members

Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $4k (2014: $2k) - Norman Wong (Audit and Finance Committee), Rev Featunai Liuaana (CPHAC) and Prof Elsie Ho (CPHAC).

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

No Board members received compensation or other benefits in relation to cessation (2014: $nil).

24 Employee remuneration

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

Total remuneration paid:

	Actual 2015	Actual 2014		Actual 2015	Actual 2014
$100,000 – 109,999	180	200	$340,000 – 349,999	9	9
$110,000 – 119,999	121	98	$350,000 – 359,999	10	5
$120,000 – 129,999	64	66	$360,000 – 369,999	6	1
$130,000 – 139,999	33	29	$370,000 – 379,999	5	4
$140,000 – 149,999	22	24	$380,000 – 389,999	5	2
$150,000 – 159,999	22	26	$390,000 – 399,999	5	1
$160,000 – 169,999	20	34	$400,000 – 409,999	2	2
$170,000 – 179,999	16	25	$410,000 – 419,999	3	1
$180,000 – 189,999	24	15	$420,000 – 429,999	2	5
$190,000 – 199,999	21	28	$430,000 – 439,999	1	0
$200,000 – 209,999	32	15	$440,000 – 449,999	1	0
$210,000 – 219,999	24	30	$450,000 – 459,999	1	0
$220,000 – 229,999	21	19	$460,000 – 469,999	1	1
$230,000 – 239,999	23	18	$470,000 – 479,999	0	1
$240,000 – 249,999	12	9	$480,000 – 489,999	0	0
$250,000 – 259,999	17	24	$490,000 – 499,999	0	1
$260,000 – 269,999	16	17	$500,000 – 509,999	0	0
$270,000 – 279,999	24	23	$510,000 – 519,999	2	1
$280,000 – 289,999	16	20	$520,000 – 529,999	0	0
$290,000 – 299,999	16	11	$530,000 – 539,999	0	1
$300,000 – 309,999	10	16	$540,000 – 549,999	1	0
$310,000 – 319,999	8	10	$550,000 – 559,999	0	0
$320,000 – 329,999	11	8	$560,000 – 569,999	1	0
$330,000 – 339,999	8	8			
			Grand Total	**816**	**808**

During the year ended 30 June 2015 there were 96 (2014: 87) employees who received compensation and other benefits in relation to cessation totalling $1.326m (2014: $1.615m).

25 Events after the balance date

On 1 July 2015, all assets and liabilities of Health Benefits Limited were transferred to NZ Health Partnerships Limited under the Health Sector Transfers (NZ Health Partnerships Limited) Order 2015. NZ Health Partnerships Limited was incorporated on 16 June 2015 and is a multi-parent subsidiary of the 20 District Health Boards, including Waitemata DHB.

26a Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the NZ IAS 39 categories are as follows:

	Group		Parent	
	Actual 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
Loans and receivables				
Cash and cash equivalents	144,900	124,647	143,393	123,403
Debtors and other receivables	39,593	36,318	39,240	36,319
Investments	7,106	6,448	0	0
Total loans and receivables	191,599	167,413	182,633	159,722
Financial liabilities measured at amortised cost				
Creditors and other payables (excl revenue in advance & GST)	117,516	113,869	117,549	114,246
Borrowings – NZDMO loans	276,706	259,406	276,706	259,406
Finance leases	1,191	1,059	1,191	1,059
Total financial liabilities measured at amortised cost	**395,413**	**374,334**	**395,446**	**374,711**
Financial liabilities measured at fair value				
Derivative Financial Instruments – Bond FRA's	0	0	0	0
Total financial liabilities measured at fair value	**0**	**0**	**0**	**0**

26b Financial instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk

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

- Two Bond FRAs entered into to manage the interest re-pricing risk inherent in the NZDMO debt of $83.5m matured in April 2015. The close out cost of $3.291m is being taken as an expense during the year and included under Other Expenses in the Statement of Comprehensive Revenue and Expense for the Year.

26b Financial instrument risks (continued)

Cash flow interest rate risk
Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits and NZDMO borrowings. The exposure to interest rate risk was managed by the bond FRAs until they were closed out in April 2015. The exposure on the on-call deposits and floating rate borrowings is not considered significant and is not actively managed.

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end Waitemata DHB had no direct exposure to foreign currency risk (2014: nil).

Sensitivity analysis
As at 30 June 2015, if the NZ 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.

The DHB has no outstanding foreign denominated payables at balance date (2014: $nil).

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 Health Benefits Limited who invest with registered banks.

In the normal course of business, exposure to credit risk arises from demand funds with Health Benefits 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 Health Benefits 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 55%). 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.

26b Financial instrument risks (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 2015 $000	Actual 2014 $000	Actual 2015 $000	Actual 2014 $000
COUNTERPARTIES WITH CREDIT RATINGS				
Cash, cash equivalents and investments				
AA	160	239	0	0
AA -	2,488	2,422	0	0
A+	328	205	0	0
A	0	0	0	0
A-	0	101	0	0
BBB+	78	78	0	0
BBB	0	200	0	0
BB+	203	0	0	0
Total counterparties with credit ratings	3,257	3,245	0	0
COUNTERPARTIES WITHOUT CREDIT RATINGS				
Cash, cash equivalents	143,393	123,403	143,393	123,403
Investments	5,356	4,447	0	0
Total counterparties without credit ratings	148,749	127,850	143.393	123,403
Total cash, cash equivalents and investments	**152,006**	**131,095**	**143,393**	**123,403**
Debtors and other receivables				
Existing counterparty with no defaults in the past	37,593	36,318	37,240	36,319
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**37,593**	**36,318**	**37,240**	**36,319**

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 Health Benefits Limited. The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the treasury services agreement with Health Benefits Limited who maintain an overdraft facility. The DHB also receives funding from the Ministry of Health in advance of the 4th of each month.

Contractual maturity analysis of financial assets

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

26b Financial instrument risks (continued)

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2014						
Cash on hand	123,419	123,419	123,419	0	0	0
On call deposits	1,228	1,228	1,228	0	0	0
Debtors and other receivables	36,318	36,318	36,318	0	0	0
Investments	6,448	6,448	1,633	3,631	1,184	0
Total	**167,414**	**167,414**	**162,599**	**3,631**	**1,184**	**0**

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2015						
Cash on hand	143,410	143,410	143,410	0	0	0
On call deposits	1,490	1,490	1,490	0	0	0
Debtors and other receivables	39,593	39,593	39,593	0	0	0
Investments	7,106	7,106	1,936	4,129	936	105
Total	**191,599**	**191,599**	**186,429**	**4,129**	**936**	**105**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2014						
Cash on hand	123,403	123,403	123,403	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	36,319	36,319	36,319	0	0	0
Investments	0	0	0	0	0	0
Total	**159,722**	**159,722**	**159,722**	**0**	**0**	**0**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2015						
Cash on hand	143,393	143,393	143,393	0	0	0
On call deposits	0	0	0	0	0	0
Debtors and other receivables	39,240	39,240	39,240	0	0	0
Investments	0	0	0	0	0	0
Total	**182,633**	**182,633**	**182,633**	**0**	**0**	**0**

26b Financial instrument risks (continued)

Contractual maturity analysis of financial liabilities

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

Group	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2014						
Creditors and other payables	113,567	113,567	113,567	0	0	0
Finance leases	1,059	1,059	339	331	256	133
NZDMO loans	259,406	261,795	130,598	21,716	23,901	85,580
Total	**374,032**	**376,421**	**244,504**	**22,047**	**24,157**	**85,713**
2015						
Creditors and other payables	117,516	117,516	117,516	0	0	0
Finance leases	1,191	1,191	256	256	679	0
NZDMO loans	276,706	285,104	25,746	0	89,257	170,101
Total	**395,413**	**403,811**	**143,518**	**256**	**89,936**	**170,101**

Parent	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2014						
Creditors and other payables	113,944	113,944	113,944	0	0	0
Finance leases	1,059	1,059	339	331	256	133
NZDMO loans	259,406	261,795	130,598	21,716	23,901	85,580
Total	**374,409**	**376,798**	**244,881**	**22,047**	**24,157**	**85,713**
2015						
Creditors and other payables	117,549	117,549	117,549	0	0	0
Finance leases	1,191	1,191	256	256	679	0
NZDMO loans	276,706	285,104	25,746	0	89,257	170,101
Total	**395,446**	**403,844**	**143,551**	**256**	**89,936**	**170,101**

27 Capital management

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

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

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

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

28 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary, Three Harbours Health Foundation (THHF). The DHB's investment in THHF is accounted at cost of $nil (2014: $nil).

For the year ended 30 June 2015, THHF had total revenue of $1.157m (restated 2014: $1.605m) and a net surplus of $931m (2014: $1.403m surplus). THHF had assets of $9.013m (2014: $8.074m) and liabilities of $14.7k (2014: $5.7k) as at 30 June 2015.

29 Patient trust monies and restricted funds

	Actual 2015 $000	Actual 2014 $000
Balance at 1 July 2014	69	80
Monies received	1,040	1,062
Payments made	1,034	1,073
Balance at 30 June 2015	**75**	**69**

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

30 Explanation of major variances against budget

The budget figures are those approved by the Board at the beginning of the period in the initial Statement of Intent.

The budget figures have been prepared in accordance with Generally Accepted Accounting Practice and IPSAS, and are consistent with the Accounting policies adopted by the Board for the preparation of the financial statements.

Explanations for major variances from the DHB's budgeted figures in the statement of intent are as follows:

The major variances in the Statement of Comprehensive revenue are due to –

- Total revenue for the year was $13.7m greater than budget due largely to additional funding received for services from the Crown after the finalisation of the budget, including new contracts for Mental Health, perinatal service and for additional discharges above production plan. Additional revenue was also received during the year for capital charge as a result of revaluations of land and buildings and for interest as a result of higher than budgeted cash balance in the Westpac sweep account held by Health Benefits Limited.
- Expenditure for the year was $12.6 m greater than budget which is mostly due to the additional volumes and services purchased by the Crown and capital charge as stated in the point above.

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

- Debtors and other receivables were higher than planned due to higher than anticipated levels of accrued revenue
- Creditors and other payables were higher than planned due to higher than anticipated levels of accrued expense largely from IDF positions and demand driven payments
- Increased cash from operating activities
- A re-classification between term and current debt due to loan rollovers
- Revaluation of land and buildings in both the June 2014 and 2015 financial years which were not anticipated and occurred after the budget was set.

30 Explanation of major variances against budget (continued)

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

- Increased operating cash flow of $21 m due to:
  - Increased receipts from patient care
  - A similarly higher variance in payments to suppliers
  - Increase in outstanding creditors and other payables.
- Increased cash from borrowing $9m
- Improved investing cash flow of $7m due to timing of invoicing and delays to requirements for capital expenditure on major projects.

31 Adjustments arising on transition to the new PBE accounting standards

Reclassifications adjustments

PBE IPSAS 23: Revenue from Non-Exchange Transactions prescribes the financial reporting requirements for revenue arising from non-exchange transactions. There was no specific equivalent financial reporting standard for accounting for revenue arising from non-exchange transactions under NZ IFRS (PBE).

Previously, Waitemata DHB made an assessment of revenue activity and where Management deemed a future obligation could exist, the amount was not recognised as revenue and as such recorded as a liability.

With the introduction of PBE IPSAS 23, Management have made a reassessment of these amounts and deemed it appropriate to now recognise these amounts as revenue in accordance with PBE IPSAS23. The change in accounting policy in compliance with PBE IPSAS 23, has been accounted for retrospectively, and the comparative financial statements for the year ended 30 June 2014 have been restated. The effect of the change on the Financial Statements is disclosed below:

Effect on Financial Statements for the Year ended 30 June 2014

	$ 000
Increase in revenue – Patient care revenue: Health and disability Services (MoH contracted revenue)	1,587
Reduction in Expenses – Non-health board provider expenses	2,165
Increase in Comprehensive Revenue	3,752
Decrease in Liabilities	10,492
Increase in Comprehensive Revenue	3,752
Increase in Opening Retained Earnings	6,740
Increase in Equity	10,492

31 Adjustments arising on transition to the new PBE accounting standards (continued)

Recognition and measurement adjustments

The table below explains the recognition and measurement adjustments to the 30 June 2014 comparative information resulting from the transition to the new PBE accounting standards.

	GROUP			PARENT		
	NZ IFRS (PBE)	Adjust-ment	PBE accounting standards	NZ IFRS (PBE)	Adjust-ment	PBE accounting standards
	2014	2014	2014	2014	2014	2014
	$000	$000	$000	$000	$000	$000
Balance as at 1 July						
Statement of financial position						
Assets						
Current Assets	168,212	0	168,212	165,336	0	165,336
Non-current assets	597,287	0	597,287	592,472	0	592,472
Liabilities						
Current Liabilities	357,314	(10,492)	346,822	357,691	(10,492)	347,199
Non-current liabilities	162,218	0	162,218	162,218	0	162,218
Equity	245,967	10,492	256,459	237,899	10,492	248,391
Statement of comprehensive revenue and expense						
Surplus/deficit	3,534	3,752	7,286	2,131	3,752	5,883
Other comprehensive revenue	38,831	0	38,831	38,831	0	38,831
Statement of changes in equity						
Balance 1 July	203,602	6,740	210,342	196,937	6,740	203,677
Total comprehensive revenue and expense	42,365	3,752	46,117	40,962	3,752	44,714
Capital contribution	0	0	0	0	0	0
Balance at 30 June	**245,967**	**10,492**	**256,459**	**237,899**	**10,492**	**248,391**

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Waitemata District Health Board and group's financial statements and performance information for the year ended 30 June 2015

The Auditor-General is the auditor of Waitemata District Health Board and its subsidiaries and other controlled entities. The Auditor-General has appointed me, Karen MacKenzie, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the group consisting of Waitemata District Health Board and its subsidiaries and other controlled entities (collectively referred to as 'the Group'), on her behalf.

We have audited:

- the financial statements of Waitemata District Health Board and the Group on pages 43 to 86, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, statement of changes in net assets/equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of Waitemata District Health Board and the Group on pages 9 to 39.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of Waitemata District Health Board and the Group:
  - present fairly, in all material respects:
    - the financial position as at 30 June 2015; and
    - the financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers

Some significant performance measures of Waitemata District Health Board and the Group, (including some of the national health targets), rely on information from third-party health providers, such as primary health organisations and general practices. The Waitemata District Health Board and Group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on performance information of Waitemata District Health Board and the Group for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of Waitemata District Health Board and the Group on pages 9 to 39:

- presents fairly, in all material respects, the Waitemata District Health Board and Group's performance for the year ended 30 June 2015, including:
  - for each class of reportable outputs:
    - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 30 October 2015. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and the performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Waitemata District Health Board and Group's financial statements and performance information 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 Waitemata District Health Board and Group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Waitemata District Health Board and Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and the performance information. Also, we did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Reporting Standards;
- present fairly the Waitemata District Health Board and Group's financial position, financial performance and cash flows; and
- present fairly the Waitemata District Health Board and Group's performance.

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.

The Board is responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and the performance information, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and the performance information and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Waitemata District Health Board or any of its subsidiaries and other controlled entities.

Karen MacKenzie
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

Waitemata
District Health Board

Best Care for Everyone