



2019/20- 2022/23 Statement of Intent

Incorporating the 2019/20 Statement of Performance
Expectations

Waitematā District Health Board

Mihimihi

E ngā mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā koutou katoa
Ki wā tātou tini mate, kua tangihia, kua mihia kua ea
Rātou, ki a rātou, haere, haere, haere
Ko tātou ēnei ngā kanohi ora ki a tatou
Ko tēnei te kaupapa, 'Oranga Tika', mō te iti me te rahi
Hei huarahi puta hei hāpai tahi mō tātou katoa
Hei Oranga mō te Katoa
Nō reira tēnā koutou, tēnā koutou, tēnā koutou katoa

To the authority, and the voices, of all people within the communities
We send greetings to you all
We acknowledge the spirituality and wisdom of those who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to ensure a healthy tomorrow, greetings
This is the Annual Plan
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

*“Kaua e mahue tētahi atu ki waho
Te Tihi Oranga O Ngāti Whātua”*



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The Waitematā District Health Board 2019/20-2022/23 Statement of Intent, incorporating the 2019/20 Statement of Performance Expectations is signed for and on behalf of:

Waitematā District Health Board

A handwritten signature in black ink, appearing to read 'Judy McGregor'.

Professor Judy McGregor CNZM
Chair

A handwritten signature in black ink, appearing to read 'Kylie Clegg'.

Kylie Clegg
Deputy Chair

TABLE OF CONTENTS

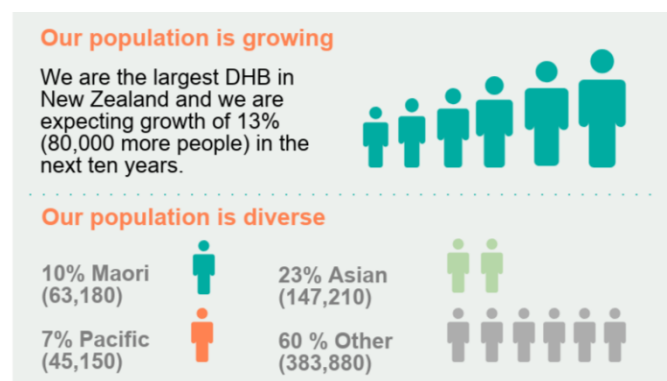
Statement of Intent 2019/20-2022/23	1
Statement of Performance Expectations 2019/20	16
Financial Performance Summary	22
Statement of Service Performance (Four-year Plan)	22
Financial Performance	23

STATEMENT OF INTENT – 2019/20 TO 2022/23

About Waitematā DHB

Who we are

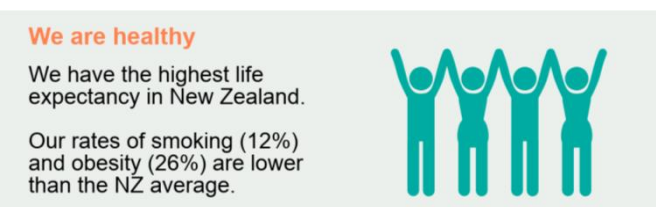
Waitematā DHB is one of 20 DHBs established under the Health and Disability Act (2000). Waitematā DHB is the Government's funder, and provider of health services to the estimated 639,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country, and are experiencing rapid population growth.



The age composition of Waitematā residents is similar to the national picture, with 19% aged less than 15 years, and 14% aged over 65.

Our population is diverse. 10% of Waitematā residents are Māori, 7% Pacific, and 23% are Asian. Our Asian population is proportionally our fastest growing population, and projected to increase to 27% of the total in the next ten years.

Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 84.2 years (2016-18), with an increase of 3.7 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and over a quarter of our adults are classified as obese (26%). Thirteen percent are current smokers. (New Zealand Health Survey 2016/17.)



Cancer is the most common cause of death (32%), and there are over 3,500 new cancer registrations in Waitematā every year. Cardiovascular disease (30%) and respiratory disease (10%) also account for a large proportion of deaths. Our 5-year survival rate for cancer is among the highest in New Zealand (68%) and our CVD

and cancer mortality rates are also very low. There is room for improvement however, as a significant proportion of all deaths in those aged under 75 are amenable through healthcare interventions (45% or 472 deaths in 2015).

The boundaries of Waitematā DHB extend to Wellsford in the north and as far south as the Auckland Harbour Bridge, incorporating Whangaparaoa in the east and the west coast beaches of Muriwai, Piha and Karekare. The North Shore and Henderson-Massey are densely populated suburban areas, while the large rural areas to the north and west have a much sparser population.

We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in twelve (8%) of our total population and 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas.

What we do

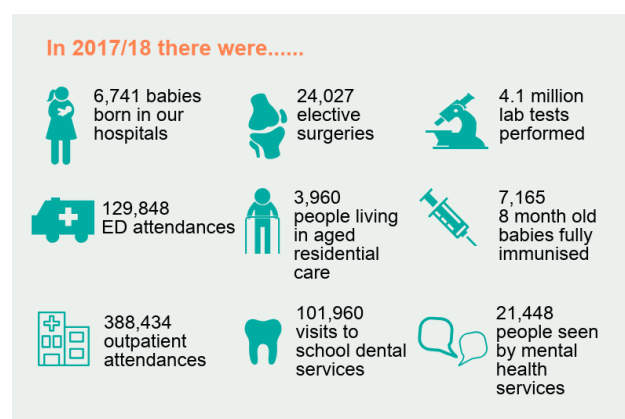
DHBs act as planners, funders and providers of health services, as well as owners of Crown assets.

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 8,136 people are employed by Waitematā DHB.

We have a budget of \$1.8 billion in 2019/20.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. Since 2013, the DHB has been the national provider of hyperbaric oxygen therapy services.

We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, and have contracts with approximately 600 other community providers.



The key challenges we are facing

Although the majority of our population enjoy very good health, a number of challenges exist as a provider and funder of health services.

Growing and ageing population – the population will increase to approximately 739,000 over the next ten years, and the 65+ population will almost double over the next 20 years; combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around half of beds).

Prevention and management of long-term conditions – the most common causes of death are cancer (32%), cardiovascular disease (30%) and respiratory disease (10%); a large proportion of all deaths are amenable through healthcare interventions (16% or 490 deaths in 2014).

Health inequities – particular populations in our catchment continue to experience differences in health outcomes. This is most starkly illustrated by the gap in life expectancy of 2.5 years for Māori and 7.1 years for Pacific compared with other ethnicities.

Patient-centred care – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it.

One system – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services.

Financial sustainability – the financial challenge facing the broader health sector and Waitematā DHB is substantial; the current trajectory of cost growth is estimated to outweigh revenue growth by 2025. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require making some hard decisions about where we commit resource including reallocation of investment into services where we know we can achieve better outcomes.

Given the challenges we are facing we have identified three key areas of risk, and the focus needed to address these.

1. Ensuring long-term sustainability through fiscal responsibility

To ensure we continue to live within our means we need to focus on:

- effective governance and strong clinical leadership
- connecting the health system and working as one system
- delivering the best evidence-based care to avoid wastage
- tight cost control to limit cost growth pressure.

2. Changing population demographics

To cope with our growing and ageing population, we need to:

- engage patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs
- assist people and their families to better manage their own health, supported by specialist services delivered in community settings and hospitals
- increase our focus on proven preventative measures and earlier intervention.

3. Meeting future health needs and the growing demand for health services

To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas, by:

- focusing on upstream interventions to improve the social and economic determinants of health, within and outside of the health system
- providing evidence-based management of long-term conditions
- working as a whole system to better meet people's needs, including regionally and across Government and other services
- addressing quality improvement in all areas
- ongoing development of services, staff and infrastructure
- involving patients and families in their care.

Our strategic direction

Best care for everyone

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

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



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

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



Community, family/whānau and patient centred model of care



Emphasis/investment on treatment and keeping people healthy



Service integration and/or consolidation



Intelligence and insight



Consistent evidence informed decision making practice



Outward focus and flexible service orientation



Operational and financial sustainability

Delivering on our strategic direction

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

We are taking a population health perspective to improve the health of the entire population and achieve health equity for all groups, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to further Māori health gain.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes. An example is the increased use of teleclinics by our services, which offers a more accessible alternative to traditional outpatient services. Our clinical leadership programme, Transforming Care, is helping build capability for care redesign and enhanced care management.

Last year we undertook a major consultation process to inform our new organisational development plan to improve staff and patient experience. Throughout 2019/20 we will focus on compassion with organisation-wide activity around wellbeing, compassion-based leadership and education. The establishment of the Waitematā DHB Consumer Council will provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population.

We expect our population to reach more than 700,000 by 2025; this significant growth in our population and

increased demand for clinical and community services provide both challenges and opportunities in the coming year. We have several major facilities developments planned this year and we are working together with the Northern Region DHBs on the NRLTHP to guide medium- to long-term planning decisions.

Environmental sustainability continues to be a priority. We have plans in place to reduce our carbon emissions and address the impact of climate change on health.

The financial challenge facing the broader health sector and Waitematā DHB is substantial. To ensure long-term sustainability we need effective governance and strong clinical leadership delivering the best evidence-based care in a connected health system.

2019/20 Strategic Intentions

At the Waitematā DHB and Ministry of Health (MoH) Strategic Conversation meeting in May 2019, several priority areas were discussed. While many of the themes are common across the country, some insights and suggestions were specific to this conversation; key themes are included below.

Equity

Significant inequalities and ill health remain, which are linked to ethnicity and deprivation, particularly for Māori and Pacific. We are working with our iwi partners to close the equity gap and improve Māori wellbeing across the region; a number of initiatives are already in place.

A workforce strategy is improving the proportion of Māori and Pacific staff employed across a number of disciplines. A shared governance group across the city oversees the implementation and monitoring of the co-developed Māori workforce development strategy. Improved recruitment of Māori and Pacific is a key focus.

Other Māori-specific projects, which are part of the Māori Health pipeline, include: abdominal aortic aneurysm (AAA) screening, self-testing of human papilloma virus (HPV) screening lung cancer screening research and community cardiac rehabilitation.

Workforce

The DHB has a number of workforce shortages, and the Northern Region Long-Term Health Plan (NRLTHP) involved analysis of issues affecting the region. MRI technologists have to undertake a post-graduate two year training programme, which is longer than elsewhere in the world. Greater influence across colleges is needed to ensure that training is appropriate and not unnecessarily long, which causes delays in growing the work force and increases costs, and to support streamlined registration.

There is a shortage of sonographers, who are often trained by the DHB and subsequently employed in the private sector. There is a potential opportunity to create a new diagnostic sonographer workforce, who are trained and accredited to undertake certain scans.

All healthcare professionals, doctors, nurses and allied health need to be working at the top of their scope. Duplication of roles needs to be avoided and a degree of flexibility needs to be achieved with colleges to allow this.

Primary care

The DHB has a good relationship with primary care and several projects are underway to ensure patients are treated in the right place. In the Emergency Department (ED), patients are triaged at the front door and, if suitable for primary care, redirected to a GP consultation paid for by the DHB. This is much more cost effective than an ED visit and focuses ED resources for more urgent cases. Currently, 400 patients per month are redirected from ED.

Additionally, a number of GP practices are funded to extend their opening hours. The DHB continues to invest in Primary Options for Acute Care (POAC), resulting in approximately 11,000 interventions per month. An on-call psychiatrist is available to GPs for support and advice.

Financial position and sustainability

The lengthy 2018/19 budget and annual planning process was discussed, having an unsigned plan for so long was not ideal. Improvement to the result was due to various wash ups, PHARMAC rebates and the sale of a property. The first draft of 2019/20 annual plan submitted a break even result, which could only be accomplished once the Crown Revenue was confirmed.

MECA increases are a pressure point and risk. The DHB was advised to assume that the funding would not be available. The Ministry acknowledged the pressures within the system, stressing that it was vital that DHBs budgeted within their allocated funding; the DHB requested guidance from the Ministry to support the decisions that will need to be made. The overall sector deficit had to be managed, and a larger deficit could potentially put capital funding at risk. This would involve careful housekeeping and some difficult decisions. Ernst and Young supported the DHB in identifying savings, but many of the projects are large and complex, involving changes to models or pathways of care and are unlikely to achieve savings within a 12-month period.

The Ministry could help with early answers to inter-district flow (IDF) pricing as we have substantial IDF out flows. The potential capital charge on the Mason Clinic land will be an issue. Revenue on electives is also a risk.

The contribution of costing and pricing work was acknowledged along with the need to strengthen this programme. The DHB made a number of suggestions on refining care pathways to reduce clinical variation. We are working with the HQSC to maintain quality and safety.

Capital

A number of capital projects were discussed that are essential for the DHB to maintain delivery of services. These include the Mason Clinic business case, infrastructure business case for remedial work at North Shore and new CSSD, and the Waitakere business case for additional ward and ICU/HDU beds, SCBU expansion, remedial work.

The NRLTHP will help to support longer-term decision on capacity planning and services in the region, including whether further development of the Waitakere site should occur. These were further discussed following this meeting and an approach is agreed.

National, regional and sub-regional strategic direction

National

Waitematā DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and align with the New Zealand Health Strategy and New Zealand Disability Strategy, as well as the health and disability system outcomes framework.

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support.

Waitematā DHB is committed to working in partnership with the Auckland Regional Public Health Service in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

The New Zealand Health Strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Waitematā DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'.

We actively work with other agencies to support at risk families and progress outcomes for children and young

people, including the Ministry for Children, Oranga Tamariki. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

Regional

The Northern Region Long-Term Health Plan (NRLTHP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed around the NRLTHP, reflecting the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2019/20.

Sub-regional

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the northern region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and healthcare outcomes and reduce unnecessary duplication.

Focus for the year

Waitematā DHB is committed to achieving healthy equity for everyone in our community, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, to plan and provide healthcare services to further Māori health gain.

We want a culturally aware workforce that reflects our communities to care for our patients. The Māori Advisory Leadership Team (MALT) oversees the implementation of the joint Waitematā and Auckland DHBs' Māori Health Workforce Development Strategy. This helped our total Māori workforce increase by more than 75% since 2015, to a total of 493 current Māori employees. By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population.

We expect our population to exceed 700,000 by 2025; this significant growth in our population and increased demand for clinical and community services provide both challenges and opportunities in the coming year.

The DHB will progress the following major developments over the next 12 months:

- Design and begin construction of a new \$220 million, four-storey surgical hospital at the North Shore Hospital campus.
- Complete and open the \$22.46 million, 15-bed

medium secure Tanekaha Unit at the Mason Clinic.

- Engage with the other northern region DHBs in the 2019/20 planning process. The regional work plan will continue to be developed around the NRLTHP.
- Establish the new Consumer Council to provide a strong voice for consumers on quality improvement and delivery of services.

Last year our senior management teams visited teams throughout the DHB and heard from around 1,500 staff. This staff and patient feedback has been used to create our new organisational development plan to improve staff and patient experience.

Throughout 2019/20 we will focus on compassion with organisation-wide activity such as: wellbeing initiatives; compassion based leadership and education programmes; collecting and sharing stories of compassion; and trialling compassion grand rounds.

Key programmes and initiatives this year

Māori Health Partnerships

We plan to establish a new Māori health committee representing Northland, Waitematā and Auckland DHBs in partnership with our iwi partners, with the intention of working together to achieve Māori health equity. A similar committee is to be formed between Counties Manukau and Waikato DHBs and their iwi partners. The two Māori governance groups will regularly meet to share regional opportunities to advance Māori health gain.

Māori pipeline projects

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

The Waitematā Experience programme

This programme encompasses all activity that seeks, collects and analyses patient and whānau feedback to inform quality improvement activity. Co-design methodology is used to redesign services and to ensure we deliver an excellent experience for patients, whānau and staff. The programme aligns all the patient experience work occurring in the DHB with the staff values programme to ensure the patient's voice is heard and patient/whānau centred care practices are embedded throughout the organisation. Key priorities for 2019/20

include programmes that focus on listening and working with our patients, whānau and staff, communicating effectively and consistently and ensuring we have a welcoming and friendly environment.

Waitematā DHB Consumer Council

The establishment of the Waitematā DHB Consumer Council will provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population. Aligning strategically with DHB priorities, the Consumer Council will enhance consumer engagement and patient experience across all services. The Consumer Council will further focus our organisation to become more patient- and whānau-centred, and transform our culture to one where working in partnership with our community is business as usual.

Waitematā 2025

We have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whānau, and will accommodate our increasing population.

Transforming Care

Transforming Care is a clinical leadership programme designed to build capability for care redesign and enhanced care management at Waitematā DHB. The programme was developed from the work led by Professor Richard Bohmer.

The Institute of Innovation and Improvement (i3)

Our i3 Institute provides expertise to support clinical teams to design and implement new models of care and best practice processes. The Institute brings together expertise in costing analysis, data analysis, digital platforms, evaluation, innovation, leadership, patient and whānau experience, population health and quality improvement.

LeapFrog programme

The Leapfrog programme is focused on accelerating the DHB's strategic innovation projects. The programme advances the support of patient care through electronic systems, the use of data and improved workflows. A series of new Phase Three projects will lead our transformation to an integrated digital environment. Underpinned by the LeapFrog programme, Waitematā DHB is recognised as a leader in the movement toward a more mobile, electronic health record.

Managing Our Business

Section 4 of our Annual Plan details how Waitematā DHB will manage our functions and operations in order to deliver on our strategic intentions, and maintain our organisational health and capability.

Improving health outcomes for our population

Waitematā DHB's performance framework demonstrates how the services that we choose to fund or provide contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government Priorities.

We have identified two overall long-term population health outcome objectives. These are:

- Life expectancy at birth continues to increase
- Inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced

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

We have identified medium-term outcome goals and short-term priorities that will support achievement of these overall objectives. Equity underpins our performance framework and our goals are focused on three key areas: Child Wellbeing, Prevention and Early Intervention and Mental Health.

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

Child Wellbeing

We want to ensure that all children in our district have the best start to life. Pregnancy and early childhood are the most effective times to intervene to reduce inequalities and improve long term health and wellbeing. Smoking is a leading risk factor for many diseases, and exposure to smoke during pregnancy and early childhood strongly influences health outcomes. Smoking rates among Māori and Pacific are double that of other ethnicities and less than half of all Māori and Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the

number of babies living in smokefree homes.

Pacific children in particular have very high rates of admission to hospital for conditions that can be potentially prevented or managed by primary and community care. We will improve immunisation rates and access to oral health services to help keep these children out of hospital.

Prevention and Early Intervention

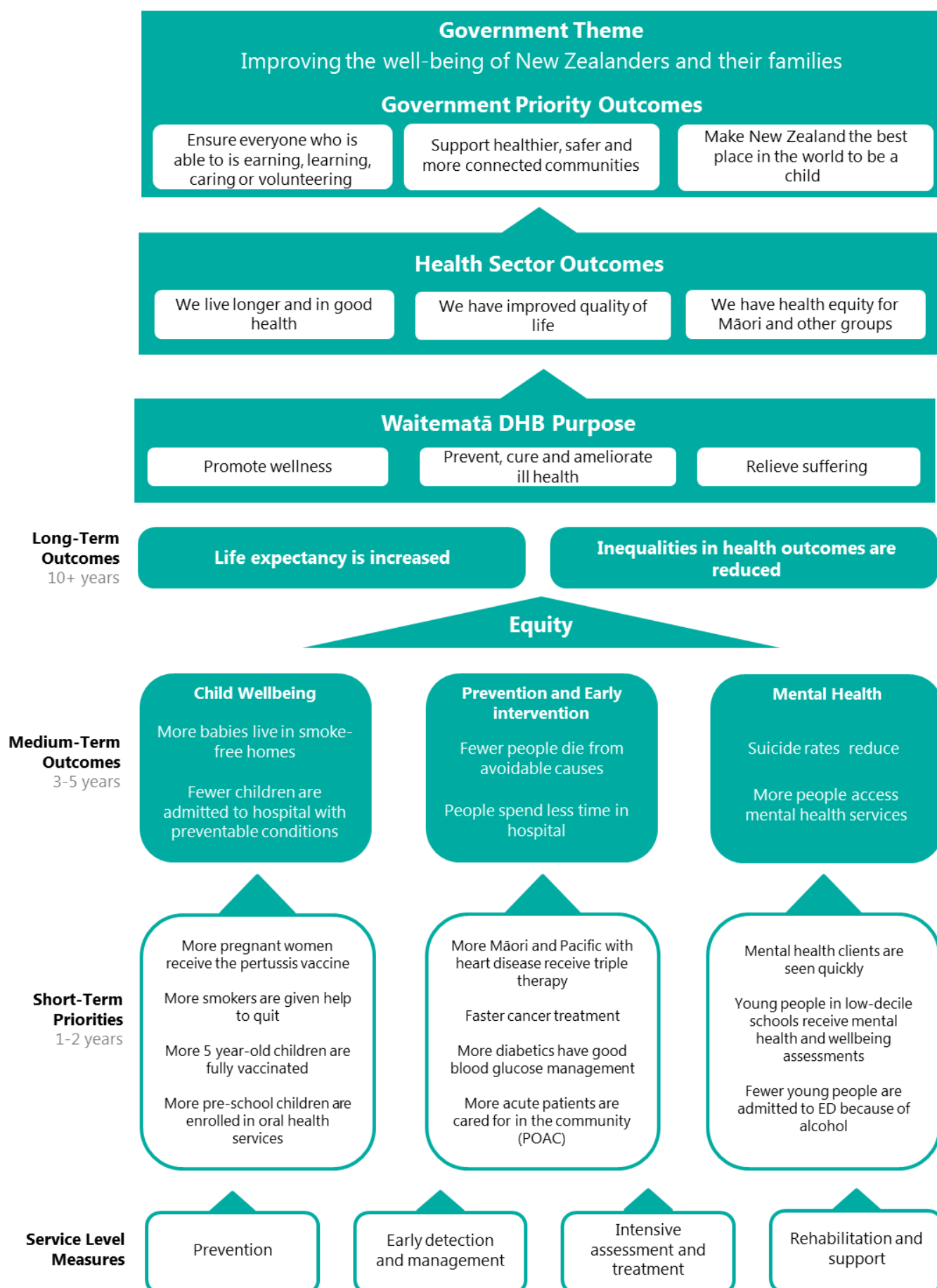
Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Māori and Pacific have a higher incidence of chronic conditions and experience poorer outcomes and we want to address this inequity. Our aim is for fewer people to die from potentially avoidable conditions. We also want to make sure that where possible, treatment and management happens in community settings and for people to spend less time in hospital when they are acutely unwell. The rates of cardiovascular disease and diabetes are higher for our Māori and Pacific populations. We need to focus on good management of these conditions through support and education and prescribing of appropriate medications, to improve the health outcomes of those most affected. Likewise, we need to continue to ensure that our cancer pathways remain timely and that there are no barriers to accessing cancer treatment.



Mental Health

Mental health and addiction problems affect the lives of many people in our district, with around 20% experiencing mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We will ensure that practical help and support is available in the community to all people who need it, but also that there is good access to acute mental health support when required. Young people in lower decile schools will be supported to receive help for mental health, alcohol and drug, sexual health, social and physical health issues.

Performance and intervention framework



Long-term outcomes

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

Increasing life expectancy

Life expectancy at birth is recognised as a general measure of population health status.

We have the highest life expectancy in the country at 84.2 years (2016-18), which is 2.4 years higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Waitematā DHB is attributed to our lower mortality rates from cardiovascular disease and cancer. Our life expectancy has increased by 3.7 years since 2001, which is 0.8 years more than New Zealand.

Over the longer term, we aim to maintain the highest life expectancy in the country and a 1.7 year increase in life expectancy over the next decade.

Outcome measure – Life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Reduce inequalities for all populations

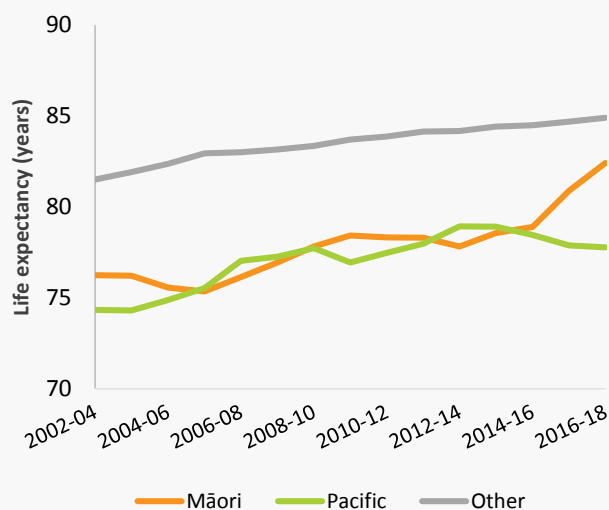
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 2.5 years for Māori and 7.1 years for Pacific (2016-18).

Life expectancy has increased in our Māori (6.7 years) and Pacific (3.2 years) populations since 2001. While the gap in life expectancy is closing for Māori, it appears to be growing for Pacific.

Mortality at a younger age from cardiovascular disease and cancers accounts for over half of the life expectancy gap in our Māori and Pacific populations.

We expect a reduction in the gap in life expectancy over the next decade, declining at the same or greater rate than that observed in the last ten years.

Outcome measure – Ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. 'Other' ethnicity includes non-Māori/non-Pacific ethnicities.

Child Wellbeing

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

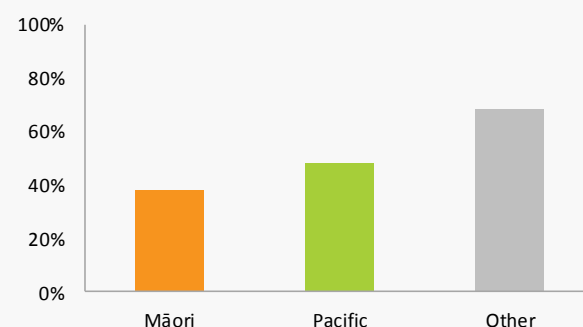
Medium-Term Outcomes

More babies live in smoke-free homes

Infants and young children are exposed to second-hand smoke more often in homes than in other places. Second-hand smoke exposure is associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure is a significant contributor to health inequalities in children.

As at June 2018, less than half of all Māori and Pacific babies were living in a smokefree household in contrast to nearly three quarters of other ethnicities.

Proportion of babies living in smokefree households at 6 weeks postnatal

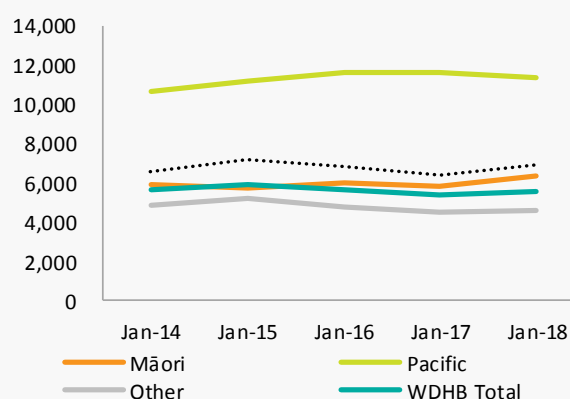


Fewer children are admitted to hospital with preventable conditions

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

In the 12 months to June 2018, there were 2,214 admissions in 0–4 year olds that were potentially avoidable. The overall rate of admissions (5,577 per 100,000) has declined slightly since 2014. Compared with other ethnicities, rates are higher in Māori (6,323 per 100,000) and over twice as high in the Pacific population (11,323 per 100,000).

Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



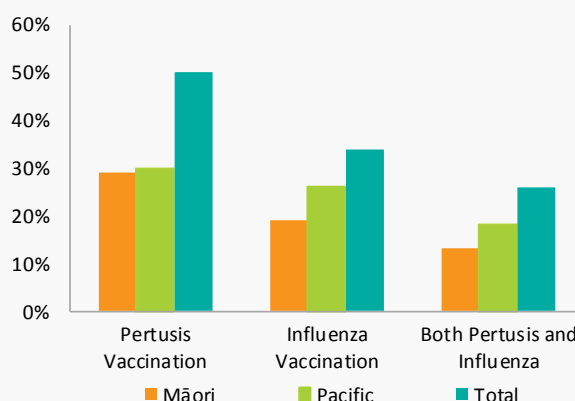
Short-Term Priorities

More pregnant women receive antenatal immunisations

Respiratory conditions are the largest contributor to ASH rates in Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine preventable and vaccination during pregnancy protects both mother and baby against these diseases for the first few months of life.

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2018, only 26% of mothers received both vaccinations during pregnancy, with the proportion much lower for Māori and Pacific.

Proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy

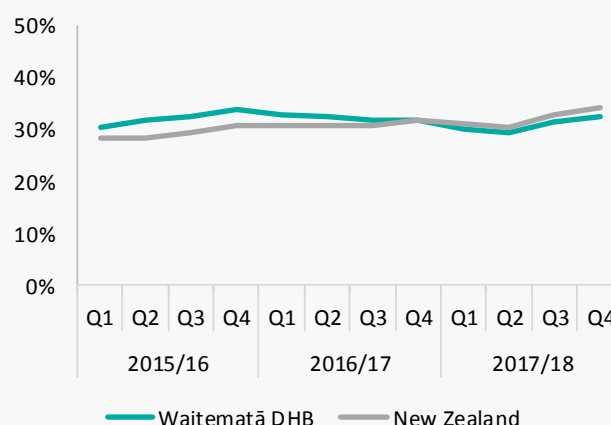


More smokers are given help to quit

Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.*

Providing smokers with brief advice to quit increases their chances of making a quit attempt. The likelihood of that quit attempt being successful increases if behavioural support, such as a referral to quit smoking services, and/or pharmacological smoking cessation aids are provided.

Proportion of smokers receiving cessation support in primary care

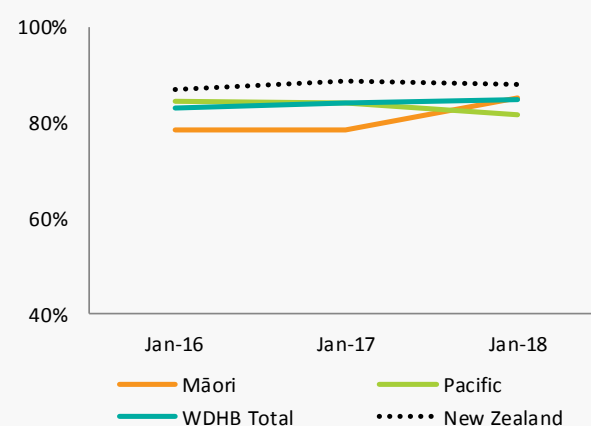


More five year-old children are fully vaccinated

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

Receiving scheduled vaccinations on time provides a good opportunity for children and families to engage with health services on a relatively regular basis.

Proportion of children fully vaccinated by five years of age

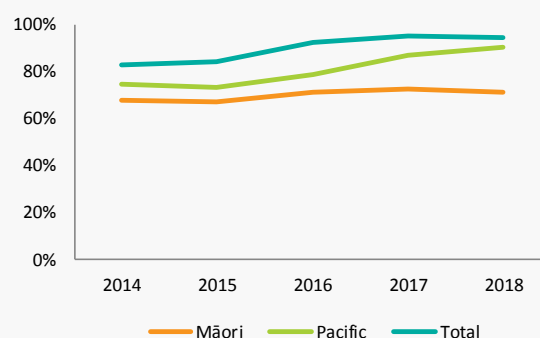


More pre-school children are enrolled in oral health services

Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry on into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions.

Dental care for preschool children is free; however, a large number of children are not enrolled in oral health services. We aim to ensure that all children are enrolled in oral health services and receiving dental care.

Proportion of pre-school children enrolled in oral health services



Prevention and Early Intervention

Chronic diseases are the leading cause of death and disability, with increasing prevalence linked to increasing health costs. Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Identifying and preventing potential problems downstream, such as addressing the socio-economic determinants of health, is one strategy to improve health outcomes. When people do become unwell, prompt diagnosis and early intervention in the initial stages can have significant impact on the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for people to spend less time in hospital when they are acutely unwell.

Medium-Term Outcomes

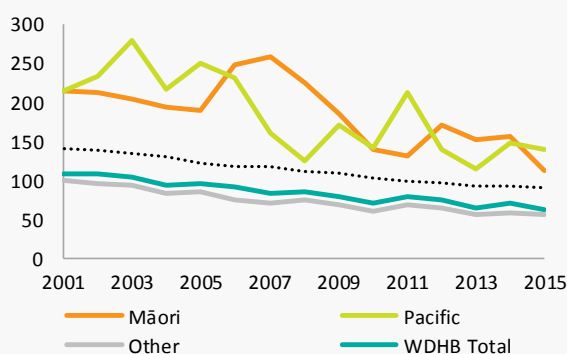
Fewer people die from avoidable causes

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

In 2015, we estimate that 472 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were potentially amenable. The rate of amenable mortality has steadily decreased over the past decade and is currently 63.2 per 100,000 population.

We aim to continue this rate of reduction in amenable mortality.

Mortality rate from conditions considered amenable, per 100,000 population

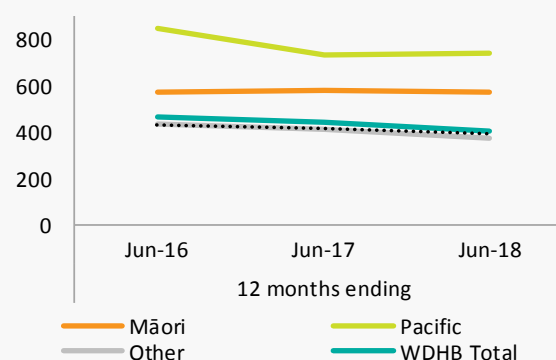


People spend less time in hospital

Acute admissions account for approximately half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities. Reductions may result from effective management in primary care, optimising hospital patient flow, discharge planning, community support services and good communication between healthcare providers.

Although our standardised rate of acute bed days has slowly declined since 2016, it remains higher than the national rate (406.8 vs. 391.7 per 1,000 population).

Acute hospital bed days rate per 1,000 population



Short-Term Priorities

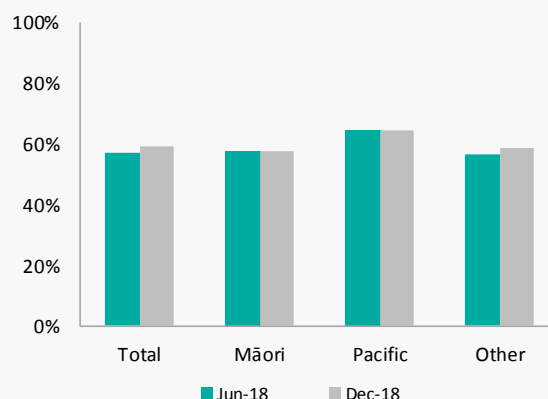
More Māori and Pacific with heart disease receive triple therapy

New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke are treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/ anticoagulant agent, a beta-blocker and a statin).

We aim to ensure that all of our patients who have had a CVD event are receiving the best possible care.

Currently, 59% of the Metro Auckland Māori and Pacific population who have had a CVD event are prescribed triple therapy medication.

Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy



Faster cancer treatment

Cancer is a leading cause of morbidity and mortality in Waitematā DHB, accounting for over one quarter of all deaths. Prompt investigation, diagnosis and treatment increases the likelihood of better outcomes for cancer patients, and assurance regarding waiting time can reduce the stress on patients and families at a difficult time.

We aim to ensure that patients diagnosed with cancer receive their first treatment or other management within 62 days.

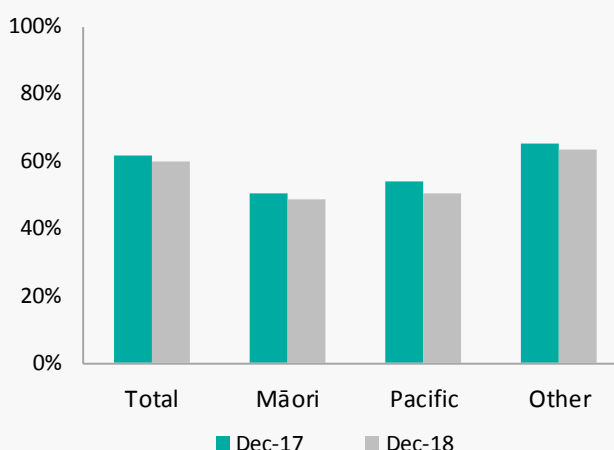
Proportion of cancer patients receiving treatment within 62 days of referral



More people with diabetes have good blood glucose management

The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to self-manage their condition and make lifestyle changes. HbA1c is a measure of an average blood glucose (average blood sugar) level over the past few months and can be used as an indicator of a patient's diabetes control. Well managed diabetes decreases the onset and progression of microvascular complications such as retinopathy, nephropathy and neuropathy.

Proportion of people with diabetes with good blood glucose management

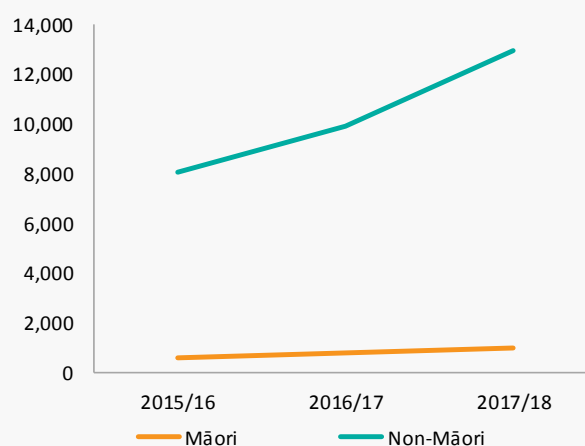


More acute patients are cared for in the community (POAC)

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting.

We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

Number of POAC referrals



Mental Health

Mental health and addiction problems affect the lives of many people in our district. Each year, around one in five of our population experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition, New Zealand has persistently high suicide rates. The responsibility for improving mental health outcomes for our population does not lie solely with the health system; there are clear links between poverty and poor mental health. We aim to ensure that practical help and support is available in the community to people who need it; our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

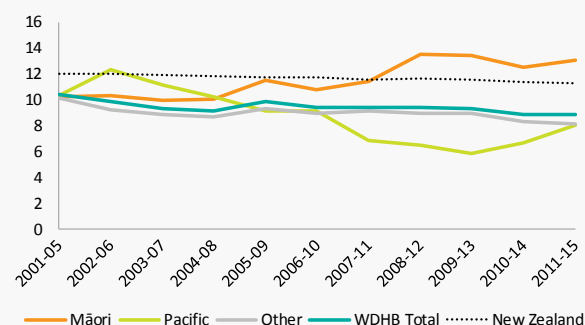
Medium-Term Outcomes

Suicide rates reduce

Suicide is a serious health and social issue. Suicide rates reflect the mental health and social wellbeing of the population. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress.

Although our suicide rates are lower than the national rate, it is unacceptably high, and we aim for zero suicide. Reducing suicide rates requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants.

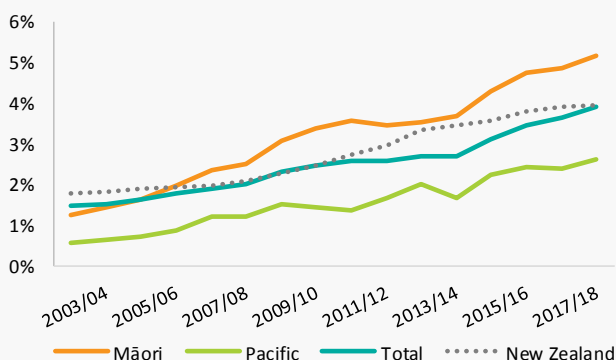
Rate of suicide per 100,000 population



More people access mental health services

Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. While not all individuals with mental health and addiction challenges need or will seek to access a specific service intervention, over time, more people should be able to access support. Given the current prevalence, the expected access rates should be higher than the current 3%.

Access rates to mental health services



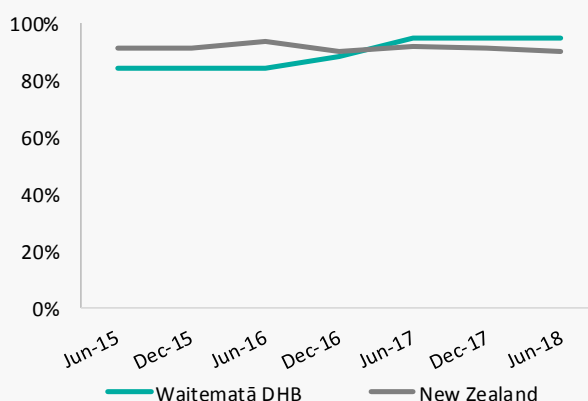
Short-Term Priorities

Mental health clients are seen quickly

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

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

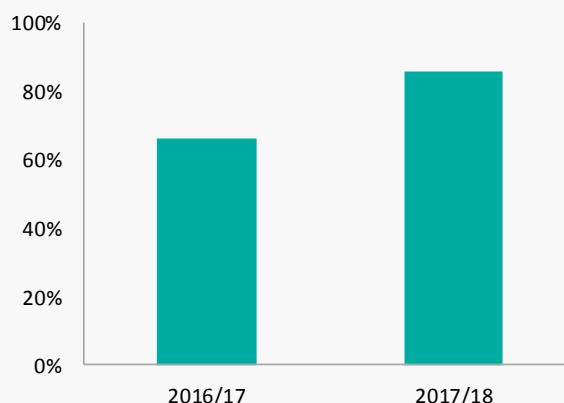
Proportion of non-urgent referrals to mental health services that are seen within three weeks



Young people in low-decile schools receive mental health and wellbeing assessments

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

HEEADSSS assessment coverage

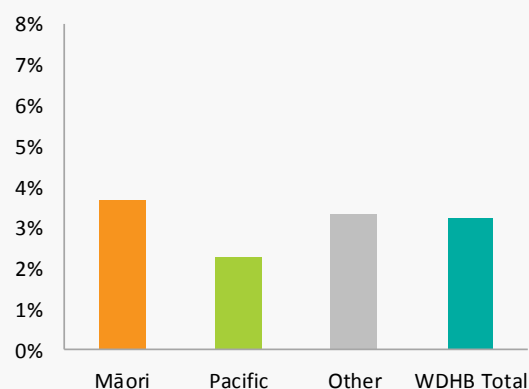


Fewer young people are admitted to ED because of alcohol

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

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

Proportion of youth Emergency Department presentations which are alcohol-related (12 months to Dec-18)



* Connor J, Kydd R, Rehm J, Shield K. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency; July 2013.

STATEMENT OF PERFORMANCE EXPECTATIONS – WAITEMATĀ DHB 2019/20

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2019/20 year. The Crown Entities Act 2004 requires the DHB's Statement of Performance Expectations (SPE) to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. The DHB's forecast financial statements for the year ended 30 June 2020 are included in Appendix C and the Financial Performance Summary table is included in Section 2 of this Annual Plan document. Both these form part of the DHB's SPE for the 2019/20 financial year.

Performance measurement framework

Our focus for 2019/20 is on delivering the key targets identified in our performance framework, which will ultimately result in better health for our population, measured by our two long term outcomes:



- an increase in life expectancy
- a reduction in the ethnic gap in life expectancy.

Measures within this SPE represent the outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators.

Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was very close to target versus those where under-performance was more significant. The criteria used to allocate these grades are as follows.

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

Key to output tables

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance
↔	Maintain current performance
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage

Output class 1: Prevention Services

Preventative services protect and promote health by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services, e.g. immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention can significantly improve health outcomes. The DHB works with the Auckland Regional Public Health Service to promote and protect wellness and prevent disease.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	89%	90%
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking	C	90%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	157 ¹	231
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	100%	95%
Number of clients engaged with Green Prescriptions	V	4,171 ²	4,861
% of clients engaged with Green Prescriptions	C		
- Māori		14 ²	13%
- Pacific		16 ²	12%
- South Asian		7 ²	9%
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy	C	50% ²	50% (or maintain if >50%)
- Māori		29% ²	
- Pacific		30% ²	
- Asian		60% ²	
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness	C	15% ²	15%
- Māori		9% ²	
- Pacific		8% ²	
% of eight months olds will have their primary course of immunisation on time	C	92%	95%
- Māori		86%	
- Pacific		93%	
% of five year olds will have their primary course of immunisation on time	C	85%	95%
- Māori		81%	
- Pacific		83%	
- Asian		91%	
Rate of HPV immunisation coverage	C	60%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	65%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	71%	80%
HEEADSSS assessment coverage in DHB funded school health services	C	88%	95%
% of 4 year olds receiving a B4 School Check	C	90%	90%
Bowel Cancer Screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit ³	Q	63%	60%
- Māori		60%	
- Pacific		46%	
- Asian		55%	

¹ Q4 2017/18 to Q3 2018/19 data.

² CY2018 data. Differs from the result published in the 2017/18 Annual Report, which is for the 2017/18 financial year (3,756).

³ Patients invited during 2018 and 2019, i.e. round 4 (this differs from previous screening rounds, which involved patients aged 50-74 years old).

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
- <i>Other</i>		66%	
% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system	T	93%	95%
Auckland Regional Public Health Service⁴			
Number of tobacco retailer compliance checks conducted	V	372	300
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into	V	2,112	Ω
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification	Q	New indicator	98%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	New indicator	95%
% of compliance assessments conducted of large and medium networked drinking water supplies	Q	100%	100%

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Primary health care			
Rate of primary care enrolment in Māori	C	83%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	13,944	10,811
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices who does not have an HbA1c recorded in the last 15 months	C	13%	<12.0%
- <i>Māori</i>		16%	
- <i>Pacific</i>		13%	
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol	Q	63%	65%
- <i>Māori</i>		49%	
- <i>Pacific</i>		53%	
% of Māori patients with prior CVD who are prescribed triple therapy	Q	59% ⁵	62%
% of Pacific patients with prior CVD who are prescribed triple therapy	Q	64% ⁵	66%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds	Q	4,235 ⁵	<4,150
- <i>Māori</i>		7,952 ⁵	<9,257
- <i>Pacific</i>		11,748 ⁵	<9,146
Average response score to the primary care survey question 'in the last 12 months, when you ring to make an appointment how quickly do you usually get to see your current GP?'	T	5.4 ⁵	6.0
Pharmacy			
Number of prescription items subsidised	V	7,401,580 ⁶	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	38,842	Ω
Number of community laboratory tests	V	4,082,639	Ω

⁴ Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.

⁵ CY2018 data.

⁶ Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Oral health⁷			
% of preschool children enrolled in DHB-funded oral health services	C	96%	95%
- <i>Māori</i>		73%	
- <i>Pacific</i>		87%	
- <i>Asian</i>		90%	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8	Q	0.61	<0.59
- <i>Māori</i>		0.76	
- <i>Pacific</i>		0.89	
- <i>Asian</i>		0.65	
% of children caries free at five years of age	Q	67%	67%
- <i>Māori</i>		55%	
- <i>Pacific</i>		48%	
- <i>Asian</i>		58%	
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	68%	85%

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as diagnostic, therapeutic and rehabilitative services. Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Acute services			
Number of ED attendances	V	129,848	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	97%	95%
% of ED admissions in 10-24 year olds where alcohol-related ED presentation status is 'Unknown'	Q	65% ⁸	<10%
% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	94%	90%
% of potentially eligible stroke patients thrombolysed	C	10%	10%
% of ACS inpatients receiving coronary angiography within 3 days	T	72%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	6,741	Ω
% of babies exclusively breastfed on discharge	Q	78.6%	75%
Elective (inpatient/outpatient)			
Number of planned care interventions	V	New indicator	22,682
% of people receiving urgent diagnostic colonoscopy in 14 days	T	97%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	71%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0%	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	83%	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	78%	90%

⁷ All oral health measures have CY2017 data as baseline.

⁸ CY2018 data.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	88% ⁹	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.06 ¹⁰	<0.11 ¹¹
% of older patients assessed for the risk of falling	Q	97%	90%
% of falls risk patients who received an individualised care plan	Q	97%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	Q	12.6 ¹²	<8.4 ¹³
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	96% ¹⁴	100%
% of hip and knee procedures given right antibiotic in right dose	Q	97%	95%
Surgical site infections per 100 hip and knee operations	Q	0.63	<0.93 ¹⁵
% occasions insertion bundle used in ICU	Q	99%	90%
% occasions maintenance bundle used in ICU	Q	94%	90%
% of 'yes, completely' responses to the national inpatient survey question 'did a member of staff tell you about medication side effects to watch for when you went home'	Q	45%	47%
% of patients audited for pressure injury risk who received a score	Q	86%	90%
% of patients with the correct pressure injury care plan implemented	Q	78%	90%
Mental Health			
% of population who access Mental Health services	C		
- Age 0–19 years		3.91%	3.49%
- <i>Māori</i>		5.13%	4.70%
- Age 20–64 years		3.57%	3.43%
- <i>Māori</i>		8.60%	7.80%
- Age 65+ years		2.07%	2.01%
- <i>Māori</i>		2.24%	2.13%
% of 0-19 year old clients seen within 3 weeks	T		
- Mental Health		77%	80%
- Addictions		91%	80%
% of 0-19 year old clients seen within 8 weeks			
- Mental Health		95%	95%
- Addictions		99%	95%

⁹ Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3 (89%).

¹⁰ This result was updated by HQSC from that published in the 2017/18 Annual Report (0.07).

¹¹ Jan 2012 to Jun 2017 national median.

¹² This result was updated by HQSC from that published in the 2017/18 Annual Report (9.71).

¹³ Sep 2014 to Jun 2017 national median.

¹⁴ Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3 (97%).

¹⁵ Sep 2015 to Nov 2017 national median.

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Home-based support			
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI)	Q	98%	95%
Palliative care			
<i>Hospice</i>			
Total number of contacts in the community	V	21,827	Ω
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	16%	<5%
<i>Hospital</i>			
Total number of referrals	V	New indicator	Ω
Average time to first contact with referrer	T	New indicator	≤6 h
Average time from referral to first face-to-face patient assessment	T	New indicator	≤24 h
Residential care			
ARC bed days	V	966,718	Ω

Financial Performance Summary

Statement of Comprehensive Income	2017/18 Audited Actual \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Revenue						
MoH	1,595,378	1,687,873	1,769,164	1,805,857	1,841,969	1,878,804
IDFs & Inter DHB Provider	86,543	92,087	94,267	95,478	97,387	99,333
Other government	11,077	30,106	29,602	30,193	30,795	31,410
Other	31,752	30,125	40,239	31,543	32,370	33,215
Total revenue	1,724,750	1,840,191	1,933,272	1,963,071	2,002,521	2,042,762
Expenditure						
Personnel	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced	74,166	85,348	86,082	86,433	88,157	89,916
Clinical Supplies	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical	54,541	52,746	19,768	7,725	9,953	12,153
Payments to Non-DHB Providers	778,915	832,520	908,105	926,265	944,788	963,681
Interest	0	0	0	0	0	0
Depreciation and Amortisation	29,508	30,229	30,000	30,258	30,558	30,928
Capital charge	36,679	36,415	36,386	36,386	36,386	36,386
Total Expenditure	1,739,535	1,853,680	1,933,272	1,963,071	2,002,521	2,042,762
Other comprehensive income	(14,785)	(13,489)	0	0	0	0
Revaluation of land and building	15,938	0	0	0	0	0
Total Comprehensive Income/(Deficit)	1,153	(13,489)	0	0	0	0

Four-year plan

Prospective summary of revenues and expenses by output class	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Early detection				
Total revenue	197,141	201,083	205,105	209,207
Total expenditure	197,141	201,083	205,105	209,207
Net surplus/(deficit)	0	0	0	0
Rehabilitation and support				
Total revenue	74,901	76,399	77,927	79,485
Total expenditure	74,901	76,399	77,927	79,485
Net surplus/(deficit)	0	0	0	0
Prevention				
Total revenue	24,948	25,447	25,956	26,475
Total expenditure	24,948	25,447	25,956	26,475
Net surplus/(deficit)	0	0	0	0
Intensive assessment and treatment				
Total revenue	1,636,282	1,669,008	1,702,388	1,736,436
Total expenditure	1,636,282	1,669,008	1,702,388	1,736,436
Net surplus/(deficit)	0	0	0	0
Consolidated surplus/(deficit)	0	0	0	0

FINANCIAL PERFORMANCE

In the 2018/19 financial year, Waitematā DHB's operating result, before Ministry of Health informed late adjustments, was \$160k favourable to plan. In the year to 30 June 2019, the DHB reported a draft result with a deficit of \$13.489m against the \$7.00m deficit budget approved by the Minister of Health on 20 May 2019. This result reflects Ministry of Health late advised, one-off authorised adjustments for holiday pay \$1.5m, FPIM Impairment \$1.624m and IDF wash-ups, which deteriorated what would otherwise have been an operating performance favourable to budget. The Annual Report for the year ended 30 June 2019 reports the DHB's performance against the deficit budget of \$14.7m in the Statement of Performance Expectations adopted by the Board in October 2018. It is a requirement of the Crown Entities Act that DHBs report their financial performance in their Annual Report against their Board's adopted budget as set out in the Statement of Performance Expectations, rather than the final Ministerial approved budget. The Annual Report for the year ended 30 June 2019 is due for finalisation in October 2019, and there may be further impacts on the result for that year and the balance sheet at 30 June 2019 due to costs associated with Holiday Pay Act.

Within each Arm of the DHB (principally Funder and Provider), different financial results were achieved, providing a partial offset. The Provider reported a deficit against budget of \$44.9m, offset by surpluses in the Funder and Governance Divisions totalling \$36.0m. This situation, of deficits in Provider divisions offset by Funder surpluses, is not uncommon in the DHB sector.

The Board recognises that these offsetting results are unacceptable and are not sustainable. Continued adverse variances in the Provider Arm of the DHB necessarily limit the options available to the Board to invest in new services and initiatives, both in the Hospital sector and in Primary Care.

Planning is progressing on a number of major facility programmes to redevelop the two hospital sites and associated infrastructure. The first of these programmes is the Elective Capacity and Inpatient Beds that will see additional theatre, inpatient wards and endoscopy capacity on the North Shore Campus.

For the 2019/20 financial year, the DHB is forecasting a breakeven budget, which reflects a breakeven in both the Provider and in the Funder.

The breakeven within the Provider assumes that a \$30.5m savings plan will be achieved, and there is a risk to meeting this plan. The budgeted result in the Funder also contains risk with regards to IDF payments, NGO demand-driven expenditure, Pay Equity and In Between Travel.

Oversight of progress against the savings plans was strengthened by an independent review of the Financial Sustainability Portfolio in May 2019. This review found the DHBs financial performance compares well and a number of further strategic opportunities are available to build on the successes of clinical transformation work undertaken to date.

The Board approves any significant savings projects and plans, especially those that are high risk. The CEO and CMO have the Board's delegation to halt any project they believe might affect quality or patient outcome.

At an operational level, the savings plan is monitored by the Financial Sustainability Governance Group, chaired by the CFO and Head of Corporate Services.

The Executive Leadership Team receives a regular report on progress against the plan.

During the 2018/19 financial year, the DHB forecasted to deliver savings of \$10m, of which some were one off and will not repeat in subsequent years.

Improving the financial performance of the Provider Arm is being delivered via a series of tactical, operational and strategic initiatives. The strategic initiatives are developed with senior management and clinicians, with a high degree of focus on improving patient care as well as improving financial performance. The Board will not compromise patient care and safety in its endeavours to improve financial performance.

The financial challenges facing the DHB are considerable, and as noted above, the current performance of the Provider Arm is not sustainable.

The challenges we face include:

- Continuing clinical wage settlement and contractual increases well above funding levels
- Reliance in the past of one-off windfalls or non-repeatable benefits, and surpluses generated within the Funder
- High population growth driving service demand with a lagging funding stream
- Critical restraint in regional IT infrastructure
- 'Hump funding' to transition/transform the organisation
- Investment in facilities to replace those not fit for purpose, and to accommodate growth.

Key assumptions for financial projections

Revenue Growth

Revenue has been based on the Ministry of Health advice received in May 2019.

For the out-years, we have assumed that the funding increase will be 2.0%. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of \$79.6m above 2018/19 actual expenditure is planned for the DHB. This is driven by: demographic growth-related cost pressure on the services we provide; demographic growth impact on demand-driven third party contracts; clinical staff volume growth to meet service growth requirements; costs for staff employment contract agreements and step increases and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions include the below.

- Impact on personnel costs of all settled employment agreements, automatic step increases and new FTEs, estimated provisions for expired employment contracts and of employment agreements expiring during the planning period
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of volume growth in services provided by us and are mitigated by the impact of procurement cost savings initiatives.
- That staff cost (MECA) increases will be aligned with planned settlements of current employment negotiations.
- The effects of the asset revaluation as at 30 June 2018 have been incorporated into this plan.

Forecast Financial Statements

The Board of Waitematā DHB is responsible for the issue of the forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The forecast financial statements have been prepared to comply with the requirements of Section 139 of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose. It is not intended for the forecast financial statements to be updated within the next 12 months.

In line with requirements of Section 139(2) of the Crown Entities Act 2004, we provide both the financial statements of Waitematā DHB and its subsidiaries (together referred to as 'Group') and Waitematā DHB's interest in associates and jointly controlled entities.

The Waitematā DHB group consists of the parent, Waitematā District Health Board and Three Harbours Health Foundation (controlled by Waitematā District Health Board). Joint ventures are with healthAlliance N.Z. Limited and Awhina Waitakere Health Campus. The associate companies are Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA) and South Kaipara Medical Centre Limited.

The tables below provide a summary of the financial statements for the audited result for 2017/18, year-end planned results for 2018/19 and plans for years 2019/20 to 2021/22. The financial statements have been prepared on the basis of the Key Assumptions for Financial Forecasts and the significant accounting policies summarised in the Statement of Accounting Policies. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Forecast Statement of comprehensive income – parent

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Government and Crown Agency Revenue	1,606,402	1,717,979	1,796,766	1,836,050	1,872,764	1,910,214
Patient Sourced and Other Income	29,510	30,125	40,239	31,543	32,370	33,215
IDFs and Inter DHB Provider Income	86,543	92,087	94,267	95,478	97,387	99,333
Total Funding	1,722,455	1,840,191	1,933,272	1,963,071	2,002,521	2,042,762
Personnel Costs	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced Costs	74,113	85,348	86,082	86,433	88,157	89,916
Clinical Supplies Costs	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical supplies Costs	120,728	119,390	86,154	74,369	76,897	79,467
Payments to Other Providers	778,915	832,520	908,105	926,265	944,788	963,681
Total Expenditure	1,739,482	1,853,680	1,933,272	1,963,071	2,002,521	2,042,762
Net Surplus/(Deficit)	(17,027)	(13,489)	0	0	0	0
Other Comprehensive Income	0	0	0	0	0	0
Gains/(Losses) on Property Revaluations	15,939	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	(1,088)	(13,489)	0	0	0	0

Historically, we have performed well financially, with surpluses generated in the past five of six years. The business transformation programme implemented in 2010/11 and continued in subsequent years contributed significantly to the achievement of surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

However, the rate of recent population growth, the ageing of the population the DHB serves, the state of our ageing infrastructure and facilities, and requirements for the development of services, facilities and Information Systems to provide high quality, safe and effective care has increased the financial pressures on the DHB, and the financial challenges are the greatest they have been for several years. However, the DHB is forecasting a breakeven in 2019/20.

Forecast Statement of comprehensive income – group

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Government and Crown Agency Revenue	1,606,455	1,717,979	1,798,766	1,836,050	1,872,764	1,910,214
Patient Sourced and Other Income	31,752	30,125	40,239	31,543	32,370	33,215
IDFs and Inter DHB Provider Income	86,543	92,087	94,267	95,478	97,387	99,333
Total Funding	1,724,750	1,840,191	1,933,272	1,963,071	2,002,521	2,042,762
Personnel Costs	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced Costs	74,166	85,348	86,082	86,433	88,157	89,916
Clinical Supplies Costs	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical supplies Costs	120,728	119,390	86,154	74,369	76,897	79,467
Payments to Other Providers	778,915	832,520	908,105	926,265	944,788	963,681
Total Expenditure	1,739,535	1,853,680	1,933,272	1,963,071	2,002,521	2,042,762
Net Surplus/(Deficit)	(14,785)	(13,489)	0	0	0	0
Other Comprehensive Income	0	0	0	0	0	0
Gains/(Losses) on Property Revaluations	15,939	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	1,154	(13,489)	0	0	0	0

Forecast Statement of comprehensive income – governance & funding administration

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Revenue	14,040	15,816	16,133	16,455	16,783	17,118
Expenditure						
Personnel	10,609	10,822	14,462	14,746	15,034	15,326
Outsourced services	6,742	7,949	8,965	9,144	9,326	9,511
Clinical supplies	0	0	3	3	3	3
Infrastructure & non clinical supplies	(5,452)	(5,396)	(7,297)	(7,438)	(7,580)	(7,722)
Total Expenditure	11,899	13,375	16,133	16,455	16,783	17,118
Surplus/(Deficit)	2,141	2,441	0	0	0	0

Forecast Statement of comprehensive income – provider

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Income						
MoH via Funder	840,616	881,467	911,159	929,382	947,969	966,928
MoH Direct	22,106	25,177	39,403	41,502	42,329	43,173
Other	48,563	49,182	58,472	49,467	50,652	51,862
Total Income	911,285	955,826	1,009,034	1,020,351	1,040,950	1,061,963
Expenditure						
Personnel	631,177	678,180	704,919	723,627	737,266	751,189
Outsourced services	67,424	77,399	77,117	77,289	78,831	80,405
Clinical supplies	123,940	127,420	133,547	137,628	140,376	143,180
Infrastructure & non clinical supplies	126,180	124,786	93,451	81,807	84,477	87,189
Total expenditure	948,721	1,007,785	1,009,034	1,020,351	1,040,950	1,061,963
Surplus / (Deficit)	(37,436)	(51,959)	0	0	0	0

Forecast Statement of comprehensive income – funder

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Income						
Revenue	1,653,963	1,765,515	1,835,367	1,872,072	1,909,510	1,947,697
Expenditure						
Personal Health	1,175,937	1,249,580	1,333,324	1,360,012	1,387,233	1,414,995
Mental Health	219,302	232,310	247,852	252,797	257,841	262,989
DSS	211,183	220,604	227,173	231,710	236,337	241,056
Public Health	9,998	8,190	7,280	7,421	7,566	7,715
Māori Health	3,111	3,303	3,635	3,707	3,780	3,854
Governance	13,922	15,499	16,103	16,425	16,753	17,088
Total Expenditure	1,633,453	1,729,486	1,835,367	1,872,072	1,909,510	1,947,697
Surplus/(Deficit)	20,510	36,029	0	0	0	0

Forecast capital costs

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Depreciation	29,508	30,229	30,000	30,258	30,558	30,928
Interest Costs	0	0	0	0	0	0
Capital Charge	36,679	36,415	36,386	36,386	36,386	36,386
Capital Costs	66,187	66,644	66,386	66,644	66,944	67,314

Capital costs are expected to increase with additional capital investments. The increase in depreciation charge is mainly due to our accelerated facilities programme and continued investment in facilities and equipment.

Waitematā DHB is required to revalue its land and building assets in accordance with the New Zealand Equivalent to International Accounting Standard 16 Land and Buildings, Plant and Equipment (NZIAS 16) every three to five years. The three-year cycle for detailed revaluation exercises for Waitematā DHB was last prepared on 30 June 2018.

Forecast statement of cashflows – parent

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Cashflow from operating activities						
MoH and other Government / Crown	1,686,859	1,803,450	1,892,951	1,928,166	1,966,721	2,006,049
Other Income	26,837	31,765	29,774	38,785	39,555	40,342
Interest received	2,076	2,267	2,149	2,858	2,915	2,973
Payments for Personnel	(624,385)	(677,605)	(716,642)	(737,663)	(751,584)	(765,793)
Payments for Supplies	(1,017,136)	(1,088,103)	(1,158,363)	(1,165,502)	(1,190,663)	(1,216,257)
Capital Charge Paid	(36,679)	(36,415)	(36,386)	(36,386)	(36,386)	(36,386)
GST Input Tax	1,523	(159)	(2,043)	0	0	0
Interest payments	0	0	0	0	0	0
Net cashflow from operating activities	39,095	35,200	11,440	30,258	30,558	30,928
Cashflow from investing activities						
Sale of Fixed Assets	0	0	31,250	0	0	0
Capital Expenditure (-ve)	(24,878)	(28,069)	(81,444)	(71,214)	(139,067)	(81,470)
Acquisition of investments	(2,952)	(813)	0	0	0	0
Net cashflow from investing activities	(27,830)	(28,882)	(50,194)	(71,214)	(139,067)	(81,470)
Cashflow from financing activities						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	0	2,200	32,580	40,947	108,509	50,542
Net cash movements	11,265	8,518	(6,174)	(9)	0	0
Cash and cash equivalents at the start of the year	17,813	29,078	37,596	31,422	31,413	31,413
Cash and cash equivalents at the end of the year	29,078	37,596	31,422	31,413	31,413	31,413

Forecast statement of cashflows – group

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Cashflow from operating activities						
MoH and other Government / Crown	1,686,859	1,803,450	1,892,951	1,928,166	1,966,721	2,006,049
Other Income	28,477	31,765	29,774	38,785	39,555	40,342
Interest received	2,076	2,267	2,149	2,858	2,915	2,973
Payments for Personnel	(624,385)	(677,605)	(716,642)	(737,663)	(751,584)	(765,793)
Payments for Supplies	(1,017,136)	(1,088,103)	(1,158,363)	(1,165,502)	(1,190,663)	(1,216,257)
Capital Charge Paid	(36,679)	(36,415)	(36,386)	(36,386)	(36,386)	(36,386)
GST Input Tax	1,523	(159)	(2,043)	0	0	0
Interest payments	0	0	0	0	0	0
Net cashflow from operating activities	40,735	35,200	11,440	30,258	30,558	30,928
Cashflow from investing activities						
Sale of Fixed Assets	0	0	31,250	0	0	0
Capital Expenditure (-ve)	(24,878)	(28,069)	(81,444)	(71,214)	(139,067)	(81,470)
Acquisition of investments	(2,952)	(813)	0	0	0	0
Net cashflow from investing activities	(27,830)	(28,882)	(50,194)	(71,214)	(139,067)	(81,470)
Cashflow from financing activities						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	0	2,200	32,580	40,947	108,509	50,542
Net cash movements	12,905	8,518	(6,174)	(9)	0	0
Cash and cash equivalents at the start of the year	19,630	32,535	41,053	34,879	34,870	34,870
Cash and cash equivalents at the end of the year	32,535	41,053	34,879	34,870	34,870	34,870

Forecast statement of financial position – parent

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Current Assets	92,948	128,952	101,315	105,901	107,851	109,751
Non-current assets	794,662	779,834	833,960	872,812	985,461	1,039,593
Total assets	887,610	908,786	935,275	978,713	1,093,312	1,149,344
Current Liabilities	241,299	252,248	245,710	246,888	251,478	255,468
Non-current liabilities	33,185	41,440	41,887	43,200	44,700	46,200
Total liabilities	274,484	293,688	287,597	290,088	296,178	301,668
Net assets	613,126	615,098	647,678	688,625	797,134	847,676
Total equity	626,849	615,098	647,678	688,625	797,134	847,676

Forecast statement of financial position – group

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Current Assets	97,914	128,952	101,315	105,901	107,851	109,751
Non-current assets	803,586	779,834	833,960	872,812	985,461	1,039,593
Total assets	901,500	908,786	935,275	978,713	1,093,312	1,149,344
Current Liabilities	241,205	252,248	245,710	246,888	251,478	255,468
Non-current liabilities	33,446	41,440	41,887	43,200	44,700	46,200
Total liabilities	274,651	293,688	287,597	290,088	296,178	301,668
Net assets	626,849	615,098	647,678	688,625	797,134	847,676
Total equity	626,849	615,098	647,678	688,625	797,134	847,676

Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Waitematā DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Waitematā DHB will comply with the relevant protection mechanism that addresses the Crown's obligations under Te Tiriti o Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of movement in equity – parent

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Balance at 1 July	614,215	613,126	601,837	634,417	675,364	783,873
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(17,027)	(13,489)	0	0	0	0
Other Comprehensive income	15,938	0	0	0	0	0
Total Comprehensive Income	(1,089)	(13,489)	0	0	0	0
Owner transactions						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	613,126	601,837	634,417	675,364	783,873	834,415

Statement of movement in equity – group

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Balance at 1 July	625,695	626,849	615,560	648,140	689,087	797,596
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(14,785)	(13,489)	0	0	0	0
Other Comprehensive income	15,939	0	0	0	0	0
Total Comprehensive Income	1,154	(13,489)	0	0	0	0
Owner transactions						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	626,849	615,560	648,140	689,087	797,596	848,138

Additional information

Capital expenditure

	2017/18 Audited \$000	2018/19 Forecast \$000	2019/20 Plan \$000	2020/21 Plan \$000	2021/22 Plan \$000	2022/23 Plan \$000
Funding Sources						
Free cashflow from depreciation	29,508	30,229	30,000	30,258	30,558	30,928
External Funding	0	2,200	32,580	40,947	108,509	50,542
Inflow from sale of fixed asset	0	0	31,250	0	0	0
Cash reserves	39,095	35,200	11,440	30,258	30,558	30,928
Total Funding	68,603	67,629	105,270	101,463	169,625	112,398
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(9,841)	(14,815)	(8,336)	(7,800)	(7,800)	(7,800)
Clinical Equipment	(7,592)	(5,306)	(14,488)	(15,600)	(15,600)	(15,600)
Other Equipment	(458)	(2,360)	(283)	(177)	(177)	(177)
Information Technology	(2,758)	(3,800)	(2,048)	(2,080)	(2,080)	(2,080)
Intangible Assets (Software)	(122)	0	0	0	0	0
Motor Vehicles	0	(1,449)	(292)	(343)	(343)	(343)
Total Baseline Capital Expenditure	(20,771)	(27,730)	(25,447)	(26,000)	(26,000)	(26,000)
Strategic Investments						
Land	0	0	(17,000)	0	0	0
Buildings and Plant	(4,107)	(339)	(38,997)	(45,214)	(113,067)	(55,470)
Clinical Equipment	0	0	0	0	0	0
Other Equipment	0	0	0	0	0	0
Information Technology	0	0	0	0	0	0
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	(4,107)	(339)	(55,997)	(45,214)	(113,067)	(55,470)
Total Capital Payments	(24,878)	(28,069)	(81,444)	(71,214)	(139,067)	(81,470)

Banking facilities

Shared commercial banking services

Waitematā DHB is in the shared commercial banking arrangements with various other DHBs, the Bank of New Zealand ('BNZ') and New Zealand Health Partnerships Limited. The BNZ provide banking services to the sector, managed by New Zealand Health Partnerships Limited. DHBs are no longer required to maintain separate standby facilities for working capital.

Statement of accounting policies

Reporting entity

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

The consolidated financial statements of Waitematā DHB for the year ended 30 June 2018 comprise Waitematā DHB and its subsidiaries (together referred to as the "Group"). The Group consists of the controlling entity, Waitematā District Health Board and Three Harbours Health Foundation.

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

The DHB's subsidiary, associates and joint ventures are incorporated and domiciled in New Zealand. The DHB has reported in note 29 on the patient trust monies which it administers. The financial statements for the DHB and the Group are for the year ended 30 June 2019, and were approved for issue by the Board on 31 October 2019.

Basis of preparation

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

Statement of compliance

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

Measurement base

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

Presentation currency and rounding

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

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

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

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. When applied, this standard supersedes parts of PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Compared with PBE IPSAS 29, PBE IFRS 9 introduces a number of changes to the recognition and measurement of financial instruments. The DHB and Group has applied PBE IFRS 9 retrospectively.

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

The main changes under PBE IFRS 9 that are relevant to The DHB and Group are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- A new impairment model for financial assets based on expected credit losses.

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

- The classification of Financial Assets has been revised and there have been no classification changes due to the adoption of IFRS 9.
- The expected credit loss model has been applied as outlined by the standard. This has impacted the valuation of both the current year and prior year receivables balances through the provision for impairment. In the 2017/18 Financial Statements the provision for impairment was \$2,273,000. The application of PBE IFRS 9 has changed the assumptions around valuation of this provision and the provision for the 2017/18 year has been reassessed to be \$2,736,000. This increase in cost of \$463,000 has been recognised directly in equity as a prior period adjustment. The valuation of the 2018/2019 provision for impairment is \$3,239,000 when applying the same methodology as prescribed by PBE IFRS 9.

Standards issued and not yet effective, and not early adopted

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

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

- (a) Control: The new standards introduce an amended definition of control including extensive guidance on this definition. The DHB does not expect the new standards to result in the consolidation of additional entities. These requirements do not apply to the DHB, as neither the DHB nor any of its controlled entities meet the definition of an investment entity.
- (b) Joint arrangements: PBE IPSAS 37 Introduces a new classification of joint arrangements, sets out the accounting requirements for each type of arrangement (joint operations and joint ventures), and removes the option of using the proportionate consolidation method. The DHB will not reclassify any joint arrangements under the new standards, and will continue to account for this interest using the equity method in the consolidated financial statements of the Group and at cost in the DHB's separate financial statements.
- (c) Disclosures on interests in other entities: The standards disclosure of information about their interests in other entities, including some additional disclosures that are not currently required under PBE IPSAS 6, 7 and 8.

This will result in additional disclosures for the Group and DHB regarding controlled entities, associates and joint arrangement. Waitematā DHB is not early adopting these standards.

PBE IPSAS 39 Employee Benefits

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

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

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

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

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

Subsidiaries

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

Joint ventures

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

Associates

An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The investment in an associate is recognised at cost. The DHB's interest in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) is not accounted for in the DHB financial statements as it is not material to the group. The DHB is party to a Limited Partnership agreement, with 20% share of initial capital contributed to the South Kaipara Medical Centre Limited Partnership established on 1 November 2013.

Revenue

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

Revenue from exchange transactions

MoH population-based revenue

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

MoH contract revenue

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

substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contracted revenue

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

Revenue from other DHBs

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Non exchange transactions

Donated services

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

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).

Expenses

Capital charge

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

Borrowing costs

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

Leases

Finance leases

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

Operating leases

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

Foreign currency transactions

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

Cash and cash equivalents

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

Receivables

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

Investments

Bank term deposits

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

Inventories

Inventories held for distribution at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Property, plant, and equipment

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

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

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

Revaluations

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

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

Additions

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

Disposals

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

Subsequent costs

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

Depreciation

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

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

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

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised

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

Amortisation

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

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

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

National Oracle Solution

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

Impairment of property, plant, and equipment and intangible assets

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

Non-cash generating assets

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

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

Payables

Short-term payables are recorded at their face value due to the short-term nature of them they are not discounted.

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
- likelihood that staff will reach the point of entitlement and contractual entitlement information; and
- present value of the estimated future cash flows.

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

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

Provisions

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

ACC Accredited Employers Programme

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

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

Equity

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

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

Property Revaluation reserve

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

Land and building revaluations

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