Waitematā
District Health Board
Best Care for Everyone

Waitematā DHB

ANNUAL REPORT 2021/22

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

Contents

Who we are and what we do

Waitematā DHB is the Government's funder and provider of health services to an estimated 641,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and one of the fastest growing DHBs in Aotearoa New Zealand, and expect an extra 103,000 people by 2035.

We have an ethnically diverse population, with over one third of our population born overseas. We are relatively affluent, with a large proportion living in areas of low deprivation. However, one in ten of our population live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those who reside in more affluent areas.

We employ more than 9,600 people.

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

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

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

Our budget for 2021/22 is $2.2 billion.

Our population in 2021/22

641 thousand Waitematā DHB residents

103,000 more people by 2035

84.3 years life expectancy at birth

10% Māori

7% Pacific

28% Asian

55% Other

A unified approach to pae ora

E ngā iwi, e ngā karangatanga maha, tēnā koutou

E ngā mate kua mene ki te pō, haere, haere, haere

Ka huri mātou ki te hunga ora, tēnā koutou katoa

Ngā mihi maha hoki ki a koutou, mānawatia a Matariki

Tēnā koutou, tēnā koutou, tēnā koutou katoa

A new future awaits as DHBs transition into one single national entity, Te Whatu Ora – Health New Zealand, which will work directly alongside Te Aka Whai Ora – Māori Health Authority.

The underlying spirit of this Tiriti-based partnership reflects the same principles that initially led to the formation of Kōtui Hauroa, a desire to put iwi at the same table as those entrusted with the planning and delivery of healthcare to Māori to ensure equity is a key consideration of all decision-making.

I am proud to reflect on yet another year of that kaupapa in action throughout Te Tai Tokerau, including, for the purpose of this report, Waitematā DHB, the largest DHB catchment in Aotearoa New Zealand.

COVID-19 again dominated the landscape, particularly with the emergence of the more highly transmissible Omicron variant.

With the support of Kōtui Hauora, our iwi partners provided necessities and home-based care to many thousands of households, employing 90 kaimanaaki to engage with whānau across the greater northern region. This, in turn, enabled them to provide whānau with evidence-based vaccination information to counter some of the myths circulating in various communities. Ngā kaimanaaki also initiated over 5,000 wellbeing assessments and helped whānau to access healthcare and social support.

Meanwhile, Māori-led pop-up clinics, outreach support services and community-based testing sites worked tirelessly with some of our most remote whānau to ensure as many people as possible had access to the same opportunities as their city-based whānau.

As of 30 June 2022, 88% of the eligible Māori (aged 12+ years) living in our catchment area had received their initial two doses of COVID-19 vaccination, and 58% of Māori over the age of 18 years had received a booster. This important work to lessen the impact of COVID-19 and reduce the possibility of hospitalisation will continue and we are also focusing attention on influenza and MMR vaccinations for our tamariki and rangatahi.

It is important mahi and I extend my thanks to everyone involved: DHBs, primary care and NGO stakeholders, iwi representatives and role models in our communities who continually strive to break down the various barriers to full engagement with the health system.

Much is being achieved and I am especially pleased to see the Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) screening programme being extended to Northland DHB, as requested by Kōtui Hauora. This innovative programme was first trialled by Waitematā DHB in Warkworth in 2015 and later expanded into Auckland DHB. It is among the Māori pipeline projects being developed and implemented by a specialist team to improve health outcomes for Māori.

Another pipeline initiative to gain traction in the last 12 months is the new Te Oranga Pūkahukahu Lung Cancer Screening Research Programme, which achieved a milestone point in May with the completion of its first 50 screens. Among these was the first-ever screen-detected lung cancer in Aotearoa New Zealand.

This Māori-led programme has a chronic obstructive pulmonary disease (COPD) component to it and also involves Auckland DHB and the University of Otago. Like AAA/AF screening, it targets specific health concerns known to have a disproportionate impact on Māori.

Early detection, coupled with swift intervention, saves lives and we are pleased to see projects of this nature attract funding and gain traction in our communities.

With that in mind, I acknowledge and thank Gwen Tepania-Palmer for her dedication to whānau, hapū and iwi in her role as Independent Chair to Kōtui Hauora and its inaugural beginnings, and in steering the course for Board members to where we are now. I also acknowledge all those who will continue this work under the auspices of a new health system and a unified vision of pae ora.

Kia pūmau tā tātou hononga, kia haere tonu ā tātou mahi (our partnership will endure and our work will continue).

Nicole Anderson
Acting Chair, Kōtui Hauora

The end of an era

Kia ora koutou and welcome to this, our last-ever Waitematā DHB Annual Report foreword. We begin by acknowledging and thanking every single member of our staff, both past and present, for their incredible service and commitment to the many thousands of people entrusted to our care over the last 21 years.

When our DHB was established in 2001, we had around 4,500 staff, 380 inpatient beds, and a budget of $134 million.

Now, in 2022, we have more than 9,600 staff, 660 beds, and a budget of $2.2 billion; our population has grown by 200,000 people.

Our staff's contribution to this DHB since its inception has been nothing short of extraordinary and their legacy will live on as we transition to a new single national health service over the coming months.

Te Whatu Ora – Health New Zealand will work alongside Te Aka Whai Ora – Māori Health Authority and our people will continue their hard mahi under its auspices, ensuring our community continues to receive the best-possible care through our hospitals and community-based services.

CEO Dr Dale Bramley and Board Chair Dame Judy McGregor with Prime Minister Rt Hon Jacinda Ardern during a visit to the Albany-based community vaccination centre in February 2022

COVID-19

2021/2022 was another extraordinary year in which our DHB contributed greatly to the national COVID-19 response and vaccination programme.

Tried-and-true systems and processes enabled us to transform our hospitals and services into COVID-19-ready environments at fast pace, refining our management of the virus and its impact, as and where required, to ensure the safe delivery of 'business-as-usual' healthcare wherever possible.

The fast stand-up and staffing of multiple community-based vaccination options was, just like the year prior, impressive and highly effective when Auckland shifted to Alert Level 4 in August 2021 following an outbreak of the Delta variant.

A switch to the national 'traffic light' alert system in December preceded the arrival of the more transmissible Omicron variant when our focus on vaccination, particularly among our more vulnerable communities, intensified.

We met the Government's 90% double-dose target (for those aged 16+ years) in quick time, being one of the first DHBs to do so in early December.

As of 30 June 2022, around 91% of eligible people aged 12 and over living within our catchment have received two doses of COVID-19 vaccination. We also provided boosters to 73% of eligible people (aged 18+ years).

We achieved double-dose rates of 88% and 90% in our Māori and Pacific communities, respectively.

The COVID-19 landscape is, of course, very different to a year or so ago, and widespread community transmission is now commonplace.

However, there is no doubt that our impressively high vaccination rates have lessened the impact of this virus on our population, enabling our hospitals and services to avoid some of the more devastating scenarios endured by our colleagues overseas during the earliest days of this pandemic.

Our thanks to all those who helped make this happen, especially our community partners.

Better, best, brilliant

The total capital value of projects approved and underway is now over $500 million. This represents the largest capital programme in the DHB's history, leaving our DHB in good stead to meet the needs of our fast-growing population and future-proof the region for many years to come. Major projects include:

- The ongoing construction of Tōtara Haumaru, a new four-storey $312 million state-of-the-art hospital facility scheduled for completion on our North Shore Campus in December 2023 and opening in April 2024,
- Continued development of plans to build a new $65.1 million Intensive Care Unit (ICU) and 30-bed inpatient at Waitakere Hospital from the end of 2022.
- The completion of an upgraded $9.9 million Special Care Baby Unit at Waitakere Hospital.
- Government go-ahead for the building of E Tū Wairua Hinengaro, a $162.8 million, three-storey facility at Mason Clinic containing a total of 60 inpatient beds. The building, due for completion in 2025, will include: a high-secure unit; a negative-pressure environment of up to 15 beds; two new low-secure units; one new medium-secure unit; secure internal courtyards; therapeutic activity spaces; and facilities for staff training. Works are expected to start in the first half of 2023.
- The $10.8 million relocation of the Medically Managed Withdrawal Inpatient Service to the new multi-storey Auckland City Mission - Te Tāpui Atawhai (Mission) HomeGround facility. Our DHB is contracted to run the service on behalf of all three Metropolitan Auckland DHBs through our Community Alcohol and Drug Service (CADS).
- A $12.6 million government cash injection to upgrade the Central Sterile Services Department (CSSD) at North Shore Hospital, which is due for completion in the second half of 2023.

In closing, we again thank the many people who worked with and for Waitematā DHB and its various predecessors over time.

We include the community-based stakeholders who joined us on the frontline of service delivery to provide the best and most equitable care possible to our diverse and fast-growing community.

The input of our energetic and proactive Consumer Council and Waitakere Healthlink ensured the meaningful presence of a community voice and participation in decisions about the way we do things in our hospital and community settings.

Sincere thanks are due to our Memorandum of Understanding (MOU) partners, Ngāti Whātua and Te Whānau o Waipareira, who worked alongside us over the years to keep equity at the forefront of our thinking and planning. We particularly want to thank Dame Rangimarie Naida Glavish, whose work and counsel around tikanga best practice has guided our DHB and its predecessors for over 30 years.

All of these organisations and people were united in their drive to relieve suffering, promote wellness and prevent, cure and ameliorate ill-health; all have helped to make a difference in countless lives.

We offer them out heartfelt thanks.

Ngā mihi nui.

Dr Dale Bramley

Chief Executive
Waitematā District Health Board

Dame Judy McGregor

Board Chair
Waitematā District Health Board

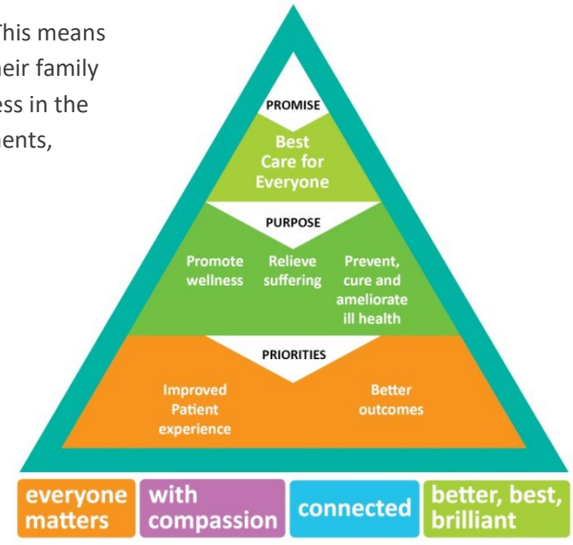
Best care for everyone

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 each 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 every day is based on our **values** of **everyone matters**; **with compassion**; **better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure progress and continue to improve.

Equity

Waitematā DHB is committed to achieving health equity for all those in our community, in particular Māori, who make up 10% of our population. Māori are guaranteed rights under Te Tiriti o Waitangi, which means attention to our Tiriti obligations as a Crown entity is paramount to securing Māori health gain.

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

We are proud of our progress towards health equity, demonstrated by the increase in life expectancy observed for all population groups. Waitematā DHB has one of the highest Māori life expectancies in the motu, at 79.6 years, and the rate of increase in Māori life expectancy is similar to that of non-Māori.

Our established Te Tiriti o Waitangi-based partnership board, Kōtui Hauora, with iwi from Tāmaki and Te Tai Tokerau, lead work to improve local and regional Māori health outcomes for Northland, Waitematā and Auckland DHBs. The current focus is on regional initiatives and major system change projects across the priority areas of child and youth health, mental health, and primary health care (both prevention and screening).

We want our patients to be cared for by a culturally aware workforce that reflects our communities. Our Māori workforce development strategy increased our total Māori workforce to a current total of 595 permanent and 170 casual Māori employees, or 7.4% of our workforce. By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population.

The Māori Health Pipeline, one of the three prioritised areas of focus for Kōtui Hauora, is a dedicated group of projects that focuses on identified areas to accelerate Māori health gain. It is currently expanding in terms of project scale and staff. The pipeline provides an opportunity to develop a more streamlined process for proposals, project implementation and robust evaluation. The pipeline work programme includes: Te Oranga Pūkahukahu Lung Cancer Screening Research Programme, Abdominal Aortic Aneurysm and Atrial Fibrillation (AAA/AF) screening, HPV self-testing implementation studies, and the Hepatitis C Lookback and Reoffer programme.

Key achievements

Waitematā DHB is one of the healthiest communities in Aotearoa New Zealand, and despite the pressures COVID-19 placed on the health system, we performed well against our key indicators in 2021/22.

Our achievements in the last year include:

- The life expectancy of our population is the highest in New Zealand, and is increasing for all ethnicity groups.
- Our smoking rate is among the lowest in New Zealand (2018 Census), with only one in ten in our population regularly smoking; we continue to help more smokers to quit.
- Amenable mortality has steadily declined over the past decade, and our rate is the lowest in New Zealand at 64.4 per 100,000 population.
- Waitematā DHB has one of the highest 5-year cancer survival rates in New Zealand, and although the delivery of some services was impacted by COVID-19, we achieved the Faster Cancer Treatment 90% target, in quarter four of 2021/22.
- Our children receive a great start to life, resulting in fewer hospitalisations. The number of preschool children admitted to hospital for conditions that are considered ambulatory sensitive (i.e. potentially avoidable though primary healthcare), such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall, and are reducing.
- We delivered 33,897 elective surgical procedures in 2021/22, exceeding our target for Planned Care interventions.
- Our patients are cared for by a culturally diverse workforce that reflects our communities. Our Māori workforce has increased to a current total of 707 Māori employees, or 7.4% of our workforce. We are on track to reach parity with the proportion of Māori and Pacific people in our working age population by 2025.
- We are working hard to manage COVID-19. As at June 2022, 91% of our residents aged 12 years and over are fully vaccinated (two doses), and 73% of those eligible have received a booster (MoH data).

84.4 YEARS

Our life expectancy is higher than NZ as a whole

64.4 DEATHS PER 100,000

Our amenable mortality rates are among the lowest in the country

10%

Our smoking rate is among the lowest in NZ

405 BEDDAYS PER 1000

Our population is spending less time in hospital

87%

Most of our children (aged 8 months old) are fully vaccinated

Avoidable hospital admissions for children lower than national rates, and remain below pre-covid levels

Our COVID-19 response

Meeting the challenge

The arrival of new COVID-19 strains during the year brought significant challenges to the health sector. Throughout the Delta outbreak of August-December 2021 and the Omicron surge in January-March 2022, our systems were constantly adapted to manage new risks and keep patients and staff safe.

Operational plans across all of our services were refined to account for variations in best practice as more became known about each new strain. In areas such as child community dental care, services were reduced in line with national guidance. In other areas, such as Planned Care, high priority treatment continued with additional safeguards in place.

Recovery work is underway to reschedule those whose care was disrupted due to the pandemic, though this will take time due to the length of lockdowns and number of deferred treatments.

A concerted effort saw high rates of vaccination among our workforce and community, with Waitematā DHB demonstrating leadership in taking vaccination to the people via a range of fixed and pop-up centres.

Working as part of the coordinated Northern Region COVID-19 response, we continued to take a consistent approach to decision making across the city, including the use of personal protective equipment, protocols for staff potentially exposed to COVID-19 and minimised visitation to our facilities.

Community vaccination

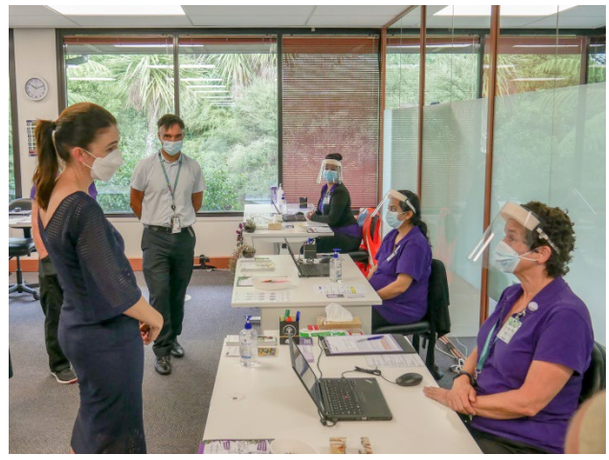
A series of community vaccination centres were stood up and operated by Waitematā DHB to ensure people in all corners of our district could take advantage of the free opportunity to be immunised.

Staff in areas where services were wound down due to pandemic restrictions on safe care volunteered to be seconded to the vaccination effort.

Retired nurses and other health staff who had recently left the workforce returned to assist in the rapid roll-out of vaccination sites across the district.

The DHB operated fixed vaccination centres at Birkenhead, Albany, Orewa, North Shore Airport and the Eventfinda Stadium in Glenfield, and partnered with community providers, Te Whānau o Waipareira and The Fono, to run facilities in Henderson and Westgate, respectively. The centres achieved their goal of ensuring large numbers of the population could to be vaccinated quickly and safely, according to national sequencing priorities. As vaccination levels rose and the vaccine became available to primary care for delivery, the DHB centres were no longer required.

The Birkenhead vaccination centre delivered 140,862 doses of the vaccine, with 81,898 doses at Albany, and 23,109 at Orewa. These and other vaccination sites were also instrumental as rapid antigen test (RAT) collection sites during the latter part of the Omicron surge.



Prime Minister Rt Hon Jacinda Ardern meets staff at the Albany community vaccination centre

Across our district, more than 1.23 million doses of the COVID-19 vaccine were administered from 1 July 2021 to 30 June 2022, demonstrating the success of the partnership model with NGOs and primary care providers.

Waitematā DHB Director of Pacific Health, Dr Josephine Aumea Herman with Westgate vaccination clinic staff at the Super Saturday national mass vaccination event

Our staff vaccination campaign was also a success, with more than 8,750 members of our workforce immunised.

Staff vaccination clinics were run at North Shore and Waitakere hospitals, offering our people the chance to walk in without needing to book.

Workforce resilience

As the prevalence of Omicron in the community rose sharply, so did the rate of infection within our workforce. Around 40% of Waitematā DHB staff (3,177) were reported to have contracted COVID-19 between 1 August 2021 and 30 June 2022.

Of these, all but 19 cases were recorded during the Omicron surge, which began affecting the workforce in mid-February 2022.

This created challenges for the staffing of key services and often saw our people working flexibly outside of their normal areas to ensure continuity of care.

Staff were provided with RATs and clear guidance on stand-down periods in the event of a positive result. Some teams worked in alternating groups, including dedicated periods of working from home where possible.

Our EDs managed 5,330 COVID-19-positive presentations from 1 July 2021 to 30 June 2022, with robust systems in place to screen and stream people on arrival to help prevent avoidable spread of the virus.

A total of 5,720 COVID-19 inpatient events were managed at our hospitals over the same period, with 150,477 people living within our district contracting COVID-19 (during 2021/22).

Responding to patient needs

Within our facilities, roving vaccinators enabled patients to be vaccinated against COVID-19 while in our care. This was a highly successful initiative and saw many people from our hard-to-reach and vulnerable populations vaccinated.

Some patients, such as those who are needle phobic or those requiring assistance, consented to vaccination while under sedation. Once the vaccination campaign was largely complete, the work of our Oranga coordinators became focused on ensuring that the cultural and welfare needs of our COVID-19-positive Māori inpatients were met.

This team worked with patients and their whānau at the bedside on the wards and supported patients as they returned home, with a focus on equitable outcomes.

Although fewer than 5% of people in our district who contracted COVID-19 required hospital-level care, our DHB provided wrap-around care and support to those well enough to be recovering at home.

Under our 'COVID-19 Care at Home' programme, we ensured patients who were discharged home, and those who did not require hospital-level care, had appropriate ongoing monitoring and supports in place, plus coordination of their ongoing needs with other care providers.

Patients received a care pack and had regular phone contact from the DHB to monitor for signs of deterioration, and were offered welfare and cultural support, where appropriate. COVID-19 Care at Home will continue to play an important role in our longer-term pandemic response.

Kathie Fruish is a He Kamaka Waiora (Māori Health Services) COVID-19 Oranga coordinator at North Shore Hospital

Adapting our facilities

Changes were made to our hospital facilities as the outbreaks evolved to assist in the management of COVID-19 patients.

Our Elective Surgery Centre was used on multiple occasions as a standalone COVID-19 unit, while Wards 2, 10 and 11 at North Shore Hospital were pressed into action, when required, as dedicated spaces for COVID-19 patients. At the peak of the Omicron surge, Huia and Wainamu Wards at Waitakere Hospital were also used.

Additional negative pressure capacity was added to several clinical areas to help meet demand and this capacity was managed on a city-wide basis, ensuring those who needed this level of care could access it.

As a result of this work and the lessons learned from managing the Delta and Omicron outbreaks, the DHB is in a stronger position to adapt to any future strains of COVID-19 that may emerge.

Delivering the best care for everyone

'Best care for everyone' is our promise to the Waitematā community and the standard for how we work. 2021/22 saw some great examples of how we deliver the best care for everyone in line with our values.

Robotic surgical excellence

"better, best, brilliant"

Waitematā DHB became the first DHB in New Zealand to offer robot-assisted prostate cancer surgery when it launched a two-year pilot of the da Vinci robotic surgical system at North Shore Hospital in November.

The robot, named Toa, combines 3D camera technology with computer-controlled instruments to complete high precision, minimally invasive procedures.

Toa, the new da Vinci surgical robot, pictured with staff shortly after installation at North Shore Hospital

Expansion for forensic psychiatry

"with compassion"

Additional Government funding of $102.8 million was approved for four new inpatient units at the Mason Clinic in Point Chevalier.

This will allow us to better care for patients with serious mental illness who are involved with the criminal justice system, their whānau who visit and our staff.

The Mason Clinic is the forensic psychiatry service operated by Waitematā DHB for the Metro Auckland and Northland populations. The funding is in addition to $60 million announced in 2020 for the new E Tū Wairua Hinengaro building, and will almost double the existing facilities. New features include a high-secure unit, negative pressure rooms for COVID-19 patients, secure internal courtyards and therapeutic activity spaces.

Design features will support contemporary models of care, with greater emphasis on privacy, dignity and wellbeing, with access to elements of the natural world. The build will be carried out to Greenstar Level 5 specifications, the highest sustainability rating, with the design incorporating cultural elements to support the wellbeing of tāngata whai i te ora (service-users).

Protecting our community

"everyone matters"

Equity was a primary consideration at every point of the vaccination rollout across Waitematā DHB.

The DHB worked closely with Pacific health providers, The Fono and Te Whānau o Waipareira, to ensure our Pacific and Māori communities were properly cared for.

Pop-up vaccination clinics across the catchment contributed to both communities surpassing the 90% double-dose target set by the Government, assisting further once boosters became available. Asian Health Services provided invaluable assistance with the Asian community, particularly among older residents who had language difficulties.

Telehealth maintaining momentum

"connected"

Multiple training sessions were held throughout the year to support clinicians who offer telehealth services to their patients.

Outpatient clinic rooms at North Shore and Waitakere Hospitals are equipped with digital technology, allowing clinicians to connect with patients and hold confidential non-urgent consultations. A soundproof pod is available in the outpatient area of North Shore Hospital.

See further information on telehealth in the next section on innovation and improvement.

Chief Medical Officer Dr Jonathan Christiansen in the telehealth pod at North Shore Hospital

Innovation and improvement

Innovative online appointment system

A new booking system that allows patients to choose, reschedule and cancel their outpatient appointment times was introduced in our cardiology clinics. The system is expected to expand to all outpatient services by the end of 2022, a significant step forward in patient experience.

Malcolm Stoneman (fourth from the right), pictured with staff, Waitematā DHB's first patient to use the online appointment booking system for patients

The first patient to use the service, Malcolm Stoneman, was a big fan of its convenience, saying: "After the invitation email arrived, it took a few clicks of the mouse to show available appointment options. I chose the day and time I wanted and received a confirmation all within minutes. It was very easy to understand and use."

Another benefit of this patient-centred approach to booking is that the staff resources usually invested in scheduling can be re-focused on other improvements to the quality and efficiency of our outpatient systems.

Community telehealth

Telehealth appointments have become vital in continuing patient care, keeping our people connected with health services, and allowing wider access to health services.

Patients now have the option to 'see' their healthcare professional by video to enable consultations that would otherwise have been postponed due to the pandemic.

With digital health appointments becoming our new normal, we are excited to have the first community telehealth pod in place at Helensville, in collaboration with Helensville District Health Trust.

The pod is a soundproof space fitted with telehealth technology. Patients can use the community pod to connect with their health professional without worrying about having the right technology or the cost of data.

The pods provide a private space for consultations, and are large enough for whānau members to join. Telehealth appointments save patients time and money by not having to travel to appointments, take time off work or pay for data and devices. Patients can access the care they need closer to home when they are feeling unwell or when travelling to hospital is difficult.

Patients have embraced telehealth, with the DHB delivering just over 19,000 virtual appointments between January and May 2022, compared with 11,485 for the same period in 2020, and 2,938 in 2019.

This equates to patients saving over 72,000 kilometres in travel and nearly $3 million in travel costs and loss of earnings over the first four months of the year. The placement of two more pods in the community is expected this year.

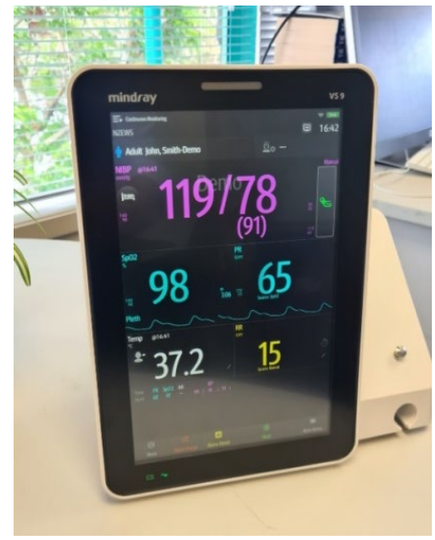
Better monitoring and communication

A remote digital monitoring system was introduced to support staff to deliver high quality, patient-centred care for COVID-19 patients.

Wireless monitors were installed in isolation rooms and COVID-19 wards, giving staff real-time vital patient observations (e.g. oxygen saturation levels, heart rate, blood pressure) without entering the patient's room.

The data is transmitted to central stations, giving staff immediate access to critical information, while significantly reducing the risk of COVID-19 exposure and the use of PPE.

In addition, iPads were installed for video conferencing to support patient ward rounds and connect patients with their whānau.



Sustainability

At Waitematā DHB, we work collectively for all life, with an aim to create positive value for our people and planet.

The challenges over the last 12 months reinforced our efforts to reduce our environmental footprint and achieve long-term health outcomes for our staff and communities.

A key element is our approach to sustainability in the organisation. The implementation of the Sustainability Steering Group assisted in shaping our sustainability strategy and approach. Plans are in place to reduce our footprint and further embed sustainability into the organisation.

The Sustainability Champions group supports initiatives at all levels. Working together, we are progressing work on our key target areas of sustainable procurement, energy and carbon management, waste and water management, and designing the built environment.

Decarbonising our DHB

Waitematā DHB completed its sixth annual carbon certification audit with Envirocare Toitū in December 2021. We continue to update and refine our carbon inventory to meet the requirements of the Carbon Neutral Government Programme and better reflect Waitematā DHB's carbon footprint. From July 2022, the carbon audit requirements from Envirocare Toitū will change to align with the revised ISO 14064-1:2018 standard, which will include a wider assessment of Scope 3 emissions related to supply chain.

An energy transition programme is underway with the aim of decarbonising key elements of our enabling infrastructure and operations. Energy efficiency projects in progress include the following.

- Fleet decarbonisation with the first tranche of the transition began with the purchase of 62 electric vehicles for the light vehicle fleet, expected to be in service later in the year.
- The review with Energy NZ assisted finalising the plan to decarbonise our hospital facilities. Work is underway on some of these projects.
- Lighting Efficiency Programme: a multi-year programme of work is underway to accelerate existing lighting replacement activities across hospitals and facilities, and is supported by a significant investment in LED fittings.

Working with our peers

There is an intrinsic link between planetary health and human health. Decarbonising our DHB requires everyone to be on board to drive change in the healthcare sector. Assessing climate-related risk (e.g. extreme weather events, sea level rises, increasing temperatures) and developing a framework for adaptation is critical.

Working collaboratively with our DHB peers in the Northern Region Climate Change Risk Assessment (NCCRA) project was launched in 2022, with the purpose of adopting a unified approach to assess climate change risks. The outcomes of the project will provide direction related to climate change risk and establish a pathway for adaptation strategies. The final report, shared with relevant stakeholders in June 2022, outlined the risks identified and a proposed adaptation framework for the Northern Regions districts.

Cutting waste

Over the past year, our waste management programmes were affected by the COVID-19 response. PPE use resulted in more waste to landfill, and recycling programmes were impacted by lockdown restrictions. Responding to a rapidly changing environment with COVID-19 and associated disruptions in supply chain resulted in more medical waste. However, general waste volume remains similar to the overall 2020/21 tonnages.

Despite these challenges, we achieved positive results with over 400 tonnes of waste diverted from landfill. Recycling and resource recovery activity contributing to this include:

- 44 tonnes of recovered items (furniture, equipment and consumables) donated to community groups and charities
- 131 tonnes co-mingled waste to recycling
- 223 tonnes paper, cardboard and compostables to recycling
- 5 tonnes e-waste to recycling.

Working with Compass, we transitioned the staff cafeterias across the DHB to use of bamboo cutlery, compostable containers and cups that can now be diverted to a recycling stream. The organisation will continue to seek opportunities to adopt more circular processes and material flows through our activities.

Improving outcomes

Making a difference to the health of our population

Our performance framework demonstrates how the services we fund or provide contribute to achieving our longer-term outcomes and the expectations of the Government. Our progress against these indicators suggests we are a high performing DHB and are improving the health of our population.

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

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

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

Our medium-term outcome goals and short-term priorities support these overall objectives. Equity is an over-arching priority in our performance framework, and our goals focus on three priority areas: child wellbeing, prevention and early intervention, and mental health. For each measure, annual improvement milestones were set, and local progress will be tracked.

Our medium-term outcomes define our priorities for the next 3 to 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 monitor all medium-term outcomes by ethnicity.

Overall, the progress against our medium- and long-term performance measures shows we are delivering on our promise of 'best care for everyone' and are making a positive difference to the health of our population.

The COVID-19 pandemic had a significant impact on the performance of many of our shorter-term priorities. Restrictions imposed by the lengthy Delta lockdown in the second half of 2021, and the capacity constraints as a result of the increased workload and staff sickness due to the Omicron variant in 2022 meant that many improvement milestones were not reached.

WAITEMATĀ DHB RESIDENTS HAVE THE HIGHEST LIFE EXPECTANCY IN THE MOTU, AT 84.4 YEARS

Our life expectancy continues to improve, reaching 84.4 years (2019-21), the highest in the motu and an increase of 1.4 years over the last decade. Life expectancy for our Māori population increased by 1.2 years over the past decade and the gap in life expectancy continues to gradually close. Life expectancy for our Māori (79.6 years) and Pacific (77.9 years) populations remains significantly lower than other ethnicities. The life expectancy gap between Pacific and other (non-Māori, non-Pacific) groups has increased 1.3 years since 2011.

OUR AMENABLE MORTALITY RATE REDUCED BY 21% OVER THE LAST 10 YEARS AND IS THE LOWEST IN NEW ZEALAND

Waitematā DHB has the lowest rate of amenable mortality (deaths potentially avoidable through healthcare intervention) in New Zealand. In 2018 (the latest available data), 64.4 deaths per 100,000 population were considered amenable, which is lower than the national rate of 88.9 per 100,000. An estimated 506 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were amenable in 2018.

OUR CHILDREN STAY OUT OF HOSPITAL WITH LOW AND DECREASING ASH RATES

Our children receive a great start to life, resulting in fewer hospitalisations. The number of preschool children admitted to hospital for conditions that are considered ambulatory sensitive (i.e. potentially avoidable though primary healthcare) such as respiratory illnesses, gastroenteritis, dental and skin conditions, are low compared with New Zealand overall, and are reducing. Although it has decreased significantly, the rate of ASH admissions for our Pacific children is nearly three times as high as that for other ethnicities in Waitematā DHB.

Understanding our performance

Performance against our framework measures is reported in the following section. For our medium-term outcomes, movement over three years is shown in the highlight boxes. For our short-term priorities, movement from the previous year is reported. The arrows indicate the direction of the movement, and the colour indicates whether performance has improved or worsened:

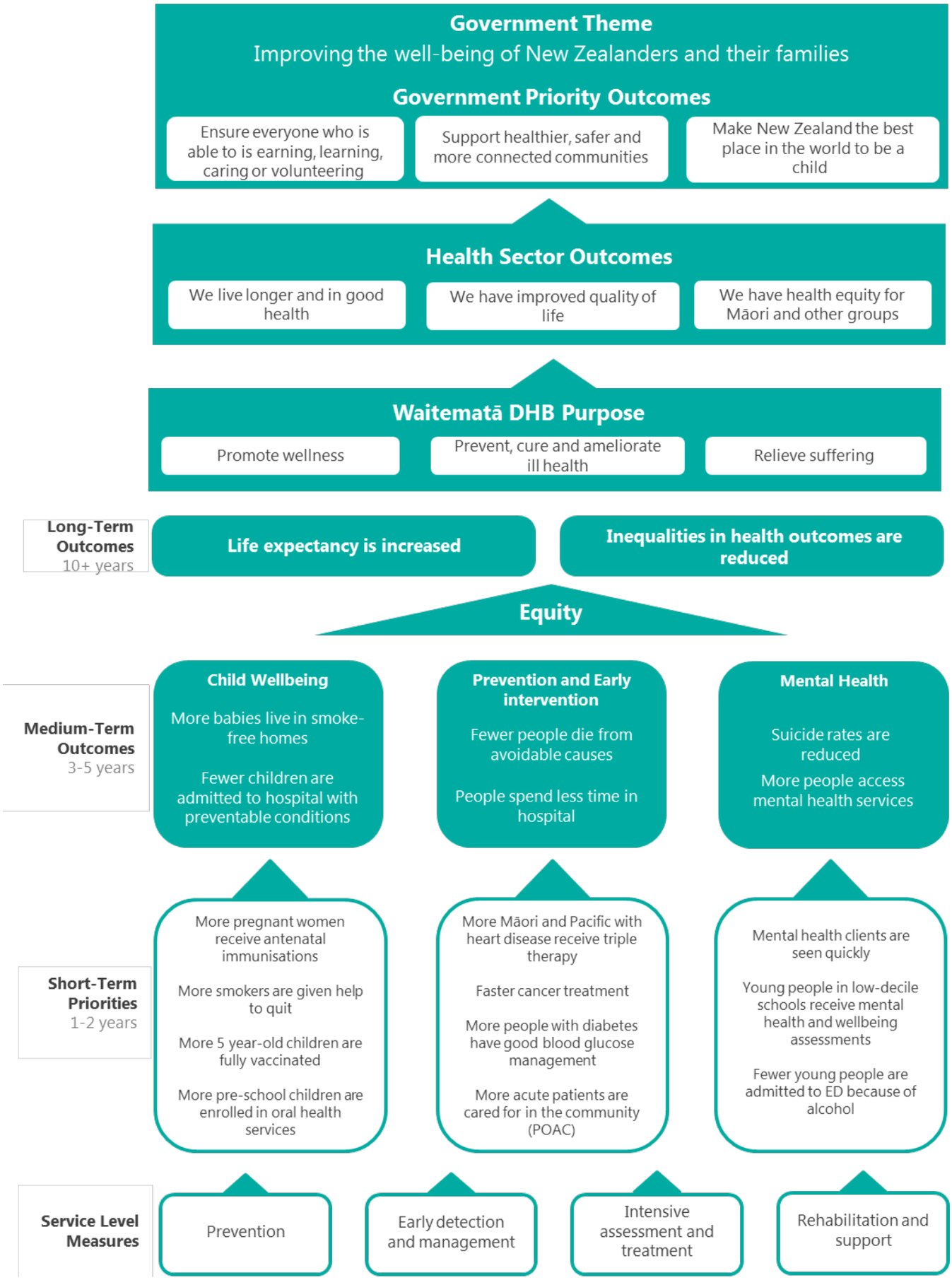

performance has improved


performance has worsened


no change in performance.

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

Performance and intervention framework



Improving population health

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

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

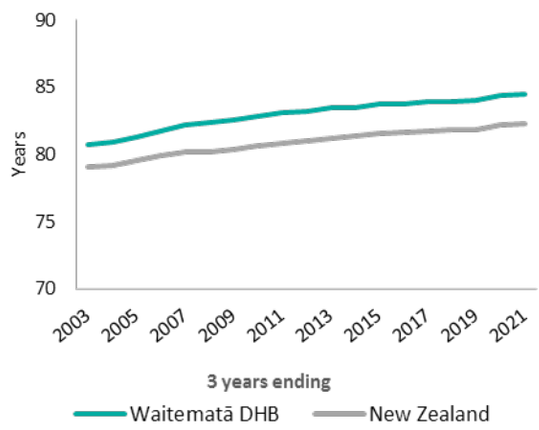
PEOPLE IN WAITEMATĀ DHB LIVE 2.2 YEARS LONGER THAN NEW ZEALAND OVERALL

We have the highest life expectancy in New Zealand at 84.4 years (2019-21[1]), which is 2.2 years longer than New Zealand as a whole.

LIFE EXPECTANCY HAS INCREASED BY 3.7 YEARS SINCE 2001

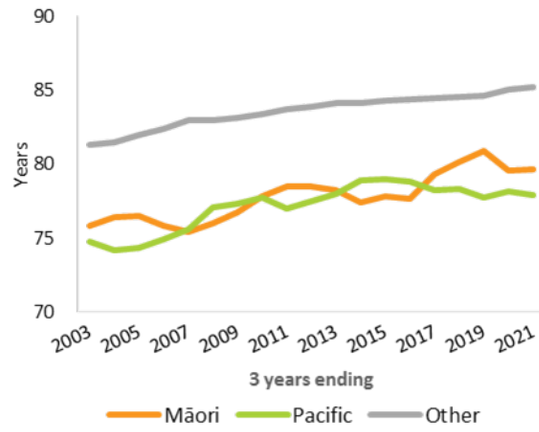
In Waitematā DHB, life expectancy has increased by 3.7 years since 2001, a greater increase than that for New Zealand as a whole (3.2 years).

LIFE EXPECTANCY AT BIRTH:
3-YEAR COMBINED ESTIMATE



Life expectancy differs significantly between ethnicity groups in our district. Māori and Pacific people have a lower life expectancy than other ethnicity groups, with a gap of 5.6 years for Māori and 7.4 years for Pacific.

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



Māori have a life expectancy of 79.6 years, and Pacific 77.9 years, significantly shorter than the 85.2 years experienced by other ethnicities.

INEQUALITIES EXIST: LIFE EXPECTANCY OF OUR MĀORI AND PACIFIC POPULATIONS IS 5 TO 8 YEARS SHORTER THAN OTHER ETHNICITY GROUPS

Life expectancy for our Māori and Pacific populations has increased at a similar rate to all other ethnicities over the past decade, but this means the life expectancy gap between Māori and other ethnicities is closing very slowly, and has increased for Pacific.

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

The life expectancy gap between Māori and other populations is largely due to mortality from cancers, in particular lung cancer, and chronic conditions, including cardiovascular disease. Smoking is a major contributory factor to these conditions, and the Māori smoking rate is more than double that of the total DHB rate (22% vs. 10%).

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

[1] The most recent life expectancy data available is based on deaths occurring in the 2021 calendar year). Three-year combined estimates were produced to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

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.

Children grow up smoke free

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

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

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

Smoking rates among our Māori and Pacific populations are reducing, but the prevalence remains at least twice that of other ethnicities, with 22% of Māori living in Waitematā DHB reporting daily smoking in the 2018 Census, compared with 9% of non-Māori.

The rate of smoking in pregnancy and likelihood of worse pregnancy outcome for mothers and babies is higher among Māori women and those living in areas of high deprivation. Census data shows that younger Māori women (aged 20-34 years) are a group of particular concern, with nearly 40% of this group reporting regular (daily) smoking.

More babies living in smokefree homes

65% of babies live in smokefree homes ↑ 4%

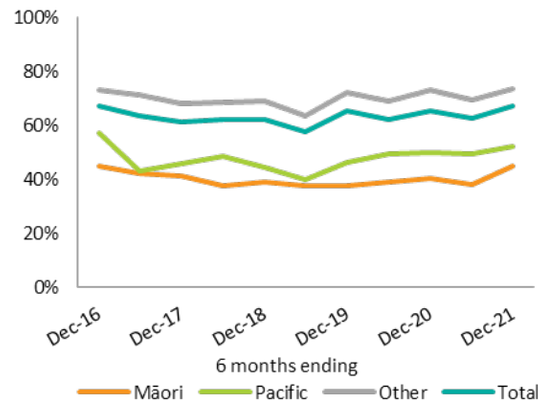
Well Child Tamariki Ora (WCTO) service providers ask about smoking status at babies' 6-week postnatal check.

A home is considered to be smokefree if no person living there is a current tobacco smoker.

In the 12 months to December 2021 (the latest available data), 65% of all 6-week-old babies born in our district lived in smokefree homes. This is a relative 4% improvement from the 12 months to December 2018 result of 62%.

Note: only babies registered with WCTO are counted towards this measure. Any baby not registered with WCTO will be considered to be not smokefree, regardless of the household's smoking status.

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



More Māori and Pacific babies are exposed to smoking in their homes, with only 41% of Māori and 51% of Pacific babies living in smokefree homes. Programmes like the maternal incentives smoking cessation programme aim to improve performance against this indicator and reduce inequities for our Māori and Pacific populations.

Child wellbeing

Keeping children out of hospital

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

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

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

Paediatric and maternal immunisation, smoking cessation and improving the housing environment are important for improving this milestone. This year, we chose to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to ASH in 0-4 year olds across the three Metro Auckland DHBs.

Fewer young children are admitted to hospital with preventable conditions

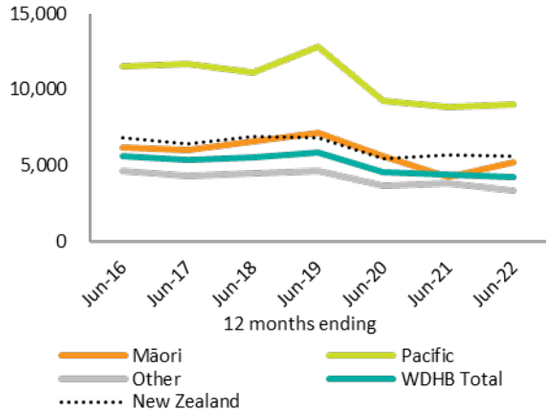
4,233 PER 100,000 ambulatory sensitive admissions ↓ 28%

In the 12 months to June 2022, there were 4,233 admissions per 100,000 children in our 0-4 year-old population (1,677 events) that were considered to be ambulatory sensitive.

Ambulatory sensitive hospitalisation events, children aged 0-4 years old, year ending 30 June 2022

	Māori	Pacific	Other	Total
Asthma and respiratory infections	212	233	551	996
Gastroenteritis	45	34	205	284
Skin conditions	38	43	68	149
Dental conditions	45	42	86	173
Other	9	8	58	75

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



The COVID-19 lockdown period in March-April 2020 saw a significant decrease in acute hospital admissions, as many people avoided seeking treatment at healthcare facilities, including hospitals. This included admissions for ambulatory sensitive conditions, resulting in a reduction in ASH rates for the 2019/20 year. While rates are rising again, they have not reached pre-COVID-19 levels.

ASH rates for our total population are now 28% lower than in June 2019 and rates have decreased even further for our Pacific children (30%). Despite this significant reduction, Pacific ASH rates are nearly three times as high as those for other ethnicities, and Māori rates are one and a half times higher than other ethnicities.

23% of smokers were helped to quit

13%

55% of pregnant women vaccinated against pertussis

2%

38% of pregnant women were vaccinated against influenza

8%

80% of five year olds were fully vaccinated

8%

99% of pre-schoolers were enrolled with oral health services

1%

Delivering on our priorities

To reduce the number of infants exposed to cigarette smoke, we are focusing on the wider family/whānau environment and encouraging an integrated approach between maternity, community and primary care.

Primary care offers support to quit, including referral to a smoking cessation programme and prescribing nicotine replacement therapy. In the 15 months to June 2022, 23% of smokers received cessation support in primary care. COVID-19 (lockdown restrictions, staff shortages due to redeployment and sickness, fewer face-to-face patient contacts) has significantly impacted the ability of primary care to provide routine smoking cessation services.

More than half (59%) of all avoidable hospital admissions for Waitematā DHB children in 2021/22 were for respiratory conditions. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine-preventable conditions and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Antenatal vaccination rates are increasing. For babies born in the 12 months to June 2022, 55% of mothers received a pertussis vaccination during pregnancy and 40% received an influenza vaccination; however, the rates are much lower for Māori and Pacific.

In the year ending March 2022, 80% of five-year-old children received all of their scheduled childhood vaccinations. This is higher than the national rate, but vaccination rates have declined since the beginning of the COVID-19 pandemic and the equity gap has widened. Greater Auckland was under lockdown restrictions for 16 weeks (40%) of the 2021/22 year, leading to a reduction in primary care activity and more children overdue for immunisations. The ongoing Omicron outbreak created a new level of pressure for practices and communities and a continued decline in child immunisation coverage; however, there is strong commitment to improve child immunisation rates.

Dental conditions account for 10% of preventable hospital admissions in pre-school children. Engagement with oral health services facilitates prevention and early treatment of dental problems. Our data reports high levels of enrolment overall*, but Māori children in particular miss out on dental care, with only 77% estimated to be enrolled.

* The numerator is the actual number of children enrolled with oral health services and the denominator is an estimated population projection (from Stats NZ). The projected population is likely to be less accurate at the ethnicity level.

Collaboration helps get kids back to school

Children and young people in greater Auckland experienced the highest number of days in lockdown, missed more in-person days of schooling, and experienced a higher burden of COVID-19 illness and isolation than young people in other regions.

One of the major lessons of the pandemic to date is the importance of minimising disruption to young people's lives, buffering them from negative impacts on their learning, socialisation, well-being, mental and emotional health.

The COVID-19 in Schools group was established in November 2021 to ensure children could return to schools as safely as possible after the 3-month lockdown in Auckland. A group of community and infectious diseases paediatricians, public health physicians and primary care physicians met weekly and established a formal COVID-19 in Schools group. Using existing relationships, the group collaborated with school and other education sector leaders, child and adolescent psychiatrists, and school nurse leads across the region.

During the Delta outbreak in Auckland, schools needed to adapt quickly to new guidance on COVID-19 mitigations in schools. The timeline to adapt was tight due to the nature of the outbreak and the growing recognition of the indirect harms to children from cumulative learning loss. This pressure was compounded by intense scrutiny from the public and media on schools during this time.

To support schools, the group led educational seminars for school principals to understand the importance of, and evidence for, COVID-19 prevention measures in schools. These seminars were very well attended. Similar seminars were held with the ECE sector through the ECE Council.

The group responded to a very large number of media requests, promoting awareness of COVID-19 measures in schools, vaccination, and the importance of in-person schooling. Support was also provided for NRHCC's communication strategy on the COVID-19 vaccine for 5-11 year-old children. The group also generated a large number of science communication articles for mainstream media outlets and public health blogs, and education resources for parents and caregivers, available via Kidshealth.

The group played a role in providing independent advice to the Ministry of Health, Ministry of Education, and Cabinet, including a critical role in writing an evidence report of recommendations to support schools reopening in early 2022. This evidence report was cited by Prime Minister Ardern as the basis for subsequent school policy in media interviews in January 2022.

The close collaboration between Education and Health during the Delta outbreak in Auckland made this response successful. Governance of this group is being transferred to Education, focusing on supporting students to re-engage with their learning.

Paediatrician Alison Leversha visited schools to talk about the importance of ventilation. Here, she is helping students at Glen Taylor School learn about monitoring carbon dioxide levels.

Prevention and early intervention

Chronic diseases are the leading cause of death and disability in our region, with increasing prevalence linked to increasing health costs. Preventative care is centred on individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. When people become unwell, prompt diagnosis and early intervention in the initial stages can significantly improve the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for our population to require fewer and shorter stays in hospital.

People live longer, healthier lives

Amenable mortality rates measure the number of deaths in people aged under 75 years that could be avoided through effective health prevention, detection and management interventions at an individual or population level.

Fewer people die from avoidable causes

64 DEATHS PER 100,000

amenable mortality rate

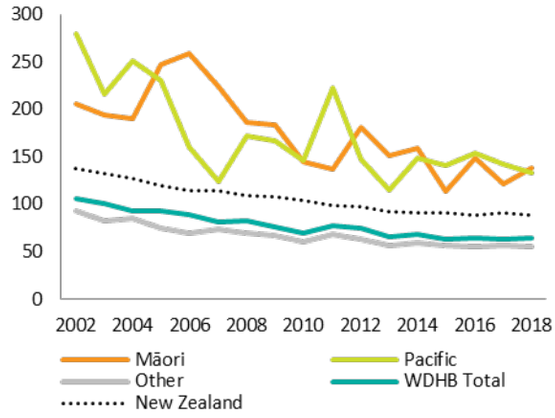
2%

Waitematā DHB's rate of amenable mortality is declining and is one of the lowest in New Zealand.

In 2018 (the latest available data*), an estimated 506 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were amenable; this is a rate of 64 deaths per 100,000 population. The rate has increased slightly since recording an all-time low in 2015, but the overall trend shows the proportion of amenable deaths is in decline.

The largest contributors to amenable mortality are heart diseases (30% of all amenable deaths) and those cancers considered to be amenable (26%). Cerebrovascular disease (e.g. stroke), diabetes and respiratory conditions are also significant contributors.

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



Since 2010, the rate of decline has slowed. This is largely due to an increasing number of deaths related to coronary disease, mainly in those aged over 65 years.

Amenable mortality rates in Māori and Pacific are significantly higher than in other ethnicities, but are decreasing at a similar rate.

The rates for Māori and Pacific are subject to fluctuation, as the smaller numbers of Māori and Pacific people in our community mean any natural variation appear to be more obvious.

*It can take several years for some coronial cases to return verdicts meaning data for this indicator is delayed by up to three years. The release of the 2019 mortality data has been further delayed by a large number of outstanding coronial cases; therefore there is no update to the amenable mortality results reported in 2020/21.

Prevention and early intervention

Reducing the demand for acute care

Acute admissions account for approximately half of all hospital admissions in New Zealand. The demands on New Zealand's acute care services are increasing due to our growing and ageing population, and long-term conditions, such as cardiovascular disease and diabetes.

Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities.

The demand for acute care can be reduced by effective management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between healthcare providers.

People spend less time in hospital

405 acute hospital bed days

PER 1,000 POP

7%

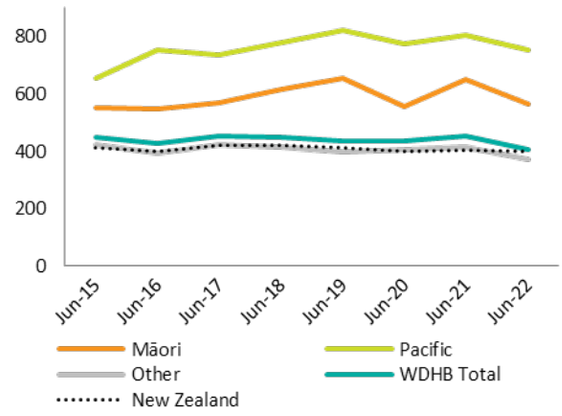
Acute hospital bed days per capita is a measure of the demand for unplanned care in hospitals.

In the 12 months to June 2022, Waitematā DHB residents spent more than 258,000 days in hospital receiving acute care, with 75,000 acute admissions. This equates to 405 days in hospital for every 1,000 people in our population (standardised for age).

Although our overall standardised rate of acute bed days is slowly declining (i.e. improving), it remains higher than the national rate (398 per 1,000 population). The rate of acute bed day use is significantly higher for Māori (563 per 1,000) and Pacific people (753 per 1,000). The 7% improvement is calculated against the rate for the 12 months ending June 2019 of 436 per 1,000 population.

A reduction in acute bed days, in particular for Māori and Pacific populations, was observed in the 12-month period ending June 2020. This is largely because some people avoided seeking treatment at healthcare facilities, including hospitals, during Alert Level 4 in March-April 2020. Acute care utilisation began to return to pre-COVID-19 levels, but declined again in 2021/22, likely due to the Delta and Omicron COVID-19 outbreaks.

STANDARDISED ACUTE HOSPITAL BED DAYS PER 1,000 POPULATION



Given the inequity in acute bed day utilisation, we implemented targeted initiatives to improve the health status of our Māori and Pacific populations.

Our focus is on the populations most likely to be admitted or readmitted to hospital, and targeted prevention and treatment of conditions that contribute the most to acute hospital bed days.

Priority areas in 2021/22 included alcohol harm reduction, cardiovascular disease management, influenza vaccination for high risk groups and effective use of Primary Options for Acute Care (POAC). Conditions identified as highest priority include congestive heart failure and chronic obstructive pulmonary disease.

63% (M)
68% (P)

of Māori and Pacific people received triple therapy

2%(M)
4%(P)

89%

of cancer patients were treated quickly

1%

63%

of people with diabetes have good blood sugar management

10,854

acute patients were cared for in the community

8%

Delivering on our priorities

In 2018, 172 people in the Waitematā DHB region aged under 75 years died from cardiovascular disease (CVD), i.e. disorders of the heart and blood vessels, including heart attack and stroke. CVD contributed to one in ten of every acute day in hospital.

New Zealand guidelines recommend that people who experienced a heart attack or stroke should be treated with medication known as triple therapy, a combination of blood pressure, cholesterol and anti-clotting medications.

As at June 2022, 63% of all those with a previous CVD event were dispensed triple therapy medication. The rate for Pacific was higher, at 68%. The use of triple therapy decreased by relative 2% for Māori and relative 4% for Pacific compared with the previous year, likely a result of COVID-19 impacting on primary care service delivery. In November 2021, a pilot programme trialled the delivery of CVD risk assessments at two COVID-19 vaccination centres, with a focus on younger Māori and Pacific who access GPs infrequently. The pilot was successful and will be continued in 2022.

Diabetes is a major and increasing cause of disability and premature death. Poorly controlled diabetes can lead to serious damage to the heart, kidneys, eyes and nerves.

The management of diabetes is multi-faceted and includes patient education, lifestyle intervention and pharmacological treatments. Managing blood sugar (HbA1c levels) can reduce a patient's risk of complications associated with diabetes. As at June 2022, 63% of patients with diabetes had an HbA1c level of less than 64 mmol/mol, indicating their diabetes is well managed. Diabetes is less well managed in our Māori and Pacific communities, with only half of Māori and Pacific people with diabetes recording ideal blood sugar levels.

Prompt investigation, diagnosis and treatment of cancer increase the likelihood of better outcomes. Care of cancer patients continued as usual throughout the lockdown in the later part of 2021. In the twelve months to June 2022, 89% of cancer patients received their first treatment within 62 days of referral, narrowly missing the 90% target. Recruitment is underway for additional nursing and administrative support to help address any delays to cancer treatment.

Primary Options for Acute Care (POAC) provides access to investigations, care or treatment in the community so that patients can be safely managed by primary care at home, avoiding or shortening hospital stays. In 2021/22, 10,854 patients benefitted from POAC-funded community care.

Providing breast screening closer to home

Breast Cancer is the leading cause of cancer deaths for women in the Waitematā DHB catchment. Two significant developments were designed to improve outcomes for patients by focusing on early detection.

Kia Ū Ora BreastScreen NorthWest

For women living in west Auckland, travel to North Shore Hospital is relatively easy if they have access to a car (with the means to pay for petrol) or alternative transport. However, not all women have these transport options.

The opening of the Kia Ū Ora BreastScreen NorthWest Clinic at Westgate in July 2021 is welcome news to many women who might otherwise have needed to travel to North Shore Hospital for a follow-up assessment after their initial mammogram results.

The easy-to-access facility brings both services under one roof, removing the cost and burden of a journey that, for some, may be a significant barrier to a potentially lifesaving early diagnosis.

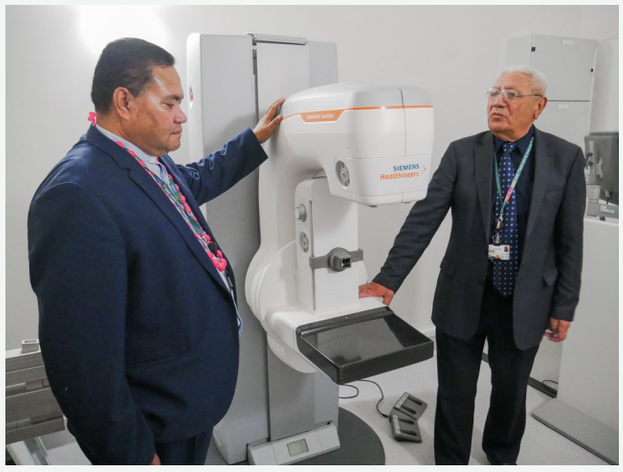
Kaumātua Cherie Povey and Waitematā DHB Board Deputy Chair Kylie Clegg cut the ribbon to officially open the new Kia Ū Ora BreastScreen NorthWest Clinic at Westgate

The clinic replaced a screening-only facility that previously ran at full capacity on the grounds of Waitakere Hospital.

The new clinic is larger than its predecessor, is specifically designed to meet the needs of a fast-growing population, and is more centrally located to care for those living in the DHB's north-western areas.

The clinic has screened 12,534 women since it opened and completed 424 assessments. Thirty-one cancer cases were detected.

The number of women aged between 45 and 69 years who are eligible for free screening is expected to increase by 11% to 109,000 by 2030. The Westgate clinic will go a long way to help meet that demand.



Waitakere Hospital Chaplain Sione Tu'ungafasi and kaumatua Fraser Toi bless equipment during the opening of the Kia Ū Ora BreastScreen NorthWest Clinic at Westgate

Kia Ū Ora – Waitematā Breast Service

The Kia Ū Ora – Waitematā Breast Service opened at North Shore Hospital in 2021, bringing multiple procedures and clinics together under one roof to improve access and health outcomes for patients.

Nearly 700 patients attended first speciality appointments at the facility in the 2021/22 year.

The service worked within the parameters of various COVID-19 restrictions throughout this same period, carrying out 3,999 mammograms, 3,229 ultrasounds and 806 biopsy and hookwire procedures.

The facility provides a world-class level of assessment, diagnosis and multidisciplinary treatment for people with breast cancer and breast disorders.

"This co-located approach, combined with other services across our catchment, contributes to improved diagnosis and treatment times, helping us make a dramatic difference in the lives of our patients, their families and whānau," says Waitematā DHB CEO Dr Dale Bramley.

Waitematā DHB is contracted by the Ministry of Health to provide the national BreastScreen Aotearoa programme to its own population and the women living in Northland. The DHB is home to the BreastScreen Waitematā Northland Regional Centre in Takapuna and runs a Greenlane-based screening clinic in collaboration with Auckland DHB. A mobile screening clinic is also available.

Improving mental health and wellbeing

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 aim to ensure that practical help and support is available in the community to all people who need it, with good access to mental health support when required.

Improving mental health outcomes

Suicide rates reflect the mental health and social wellbeing of the population.

Fewer deaths from suicide

8.6 deaths from suicide

PER 100,000

4%

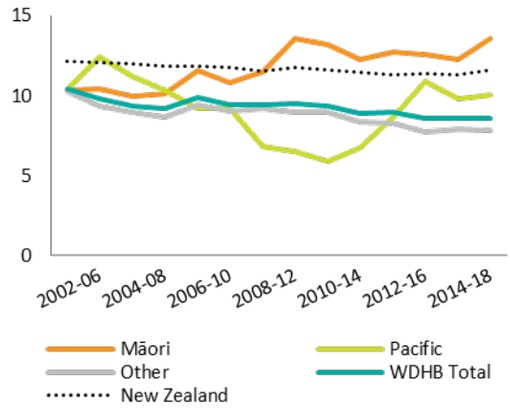
While suicides occur across the lifespan, some groups are disproportionately affected. New Zealand has some of the highest youth suicide rates in the developed world, and Māori have significantly higher rates of suicide than any other ethnicity group in the motu. The suicide rate in men is nearly three times that in women.

The most recent data available is based on deaths occurring in the 2018 calendar year*. Five-year combined estimates are used to reduce the effect of year-to-year variations in death rates, especially when considering the smaller numbers seen at ethnicity level.

In the five years to December 2018, an average of 53 lives were lost to suicide each year in our district, at a rate of 8.6 deaths per 100,000 population. This is lower than the national rate and is declining. Māori are disproportionally affected by suicide, and their rate is increasing.

Our long-term aim is to reduce, if not eliminate, the number of suicides that occur in our communities.

SUICIDE RATE
DEATHS FROM SUICIDE, PER 100,000 POPULATION



The Waitematā and Auckland DHBs Suicide Prevention and Postvention Action Plan 2020-2023 *Tārai Kore Whakamomori* takes a population health and community development approach to suicide prevention, and highlights priority actions for suicide prevention and postvention in our districts. The plan, developed by the Suicide Prevention and Postvention Governance Group has four key work areas: promoting wellbeing, responding to suicidal distress, responding to suicidal behaviour, and postvention response.

The Governance Group was restructured and the group's role is to provide effective leadership, strategic oversight and advisory input in the implementation of our suicide prevention and postvention programme. The plan reflects ownership by the community, along with commitment from key stakeholders for its implementation.

Members of the work streams represent the diversity within our community and other agencies, and align with 'Every Life Matters', the National Suicide Prevention Strategy. DHBs have a role in promoting the integration of health services, especially primary and secondary care services, fostering community participation in health improvement and resilience development, and taking action to eliminate health disparities by improving health outcomes for Māori and other population groups. This can only be achieved by engaging with the health and other sectors. Therefore, the plan sees DHBs taking a lead role in coordinating or collaborating with a range of health and social sector agencies.

The disruption related to COVID-19 affected a number of suicide prevention activities in our suicide prevention and postvention plan. Suicide prevention-related training, such as 'Lifekeepers' and 'Mental Health 101', was put on hold. However, aspects of these programmes could be done online, and we continue to promote the online training to our wider community.

*It can take several years for some coronial cases to return verdicts, meaning data for this indicator is delayed by up to three years. The release of the 2019 mortality data was further delayed by a large number of outstanding coronial cases; therefore, there is no update to the amenable mortality results previously reported in 2020/21.

Improving mental health and wellbeing

Better access to mental health support

Each year, around one in five individuals experience mental health challenges. We are expanding our services so that more people with mental health and addiction needs can access support when and where they need it.

More people are helped by mental health services

3.2% of people accessed mental health services ⇩ 9%

In the 12 months to June 2022, 3.2% of the total Waitematā DHB population (20,066 people) were seen by DHB and NGO specialist mental health services.

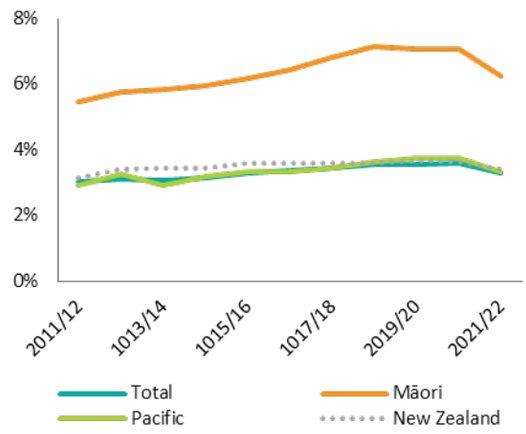
The prevalence of mental distress is much higher in Māori than in other ethnicities, and 6.0% of our Māori population accessed mental health services in 2021/22. The proportion of all people accessing mental health services has decreased by 9% over the last three years, with a marked decline observed in the last year. This is likely due to a reduction in referrals from primary care during the Delta lockdown in the second half of 2021 and additional pressures due to the Omicron outbreak in 2022.

Our Specialist Mental Health and Addiction Services comprise community hubs, acute inpatient units, a Liaison Psychiatry team, Whītiki Maurea (Māori services); Takanga a Fohe (Pacific services); Child Youth and Family Mental Health Services; Regional Forensic Psychiatry Services and Community Alcohol and Drug Services (CADS). Our addictions services operate across Metro-Auckland and our forensic services cover the Northern Region.

We contract around 20 community mental health service providers, who saw over 5,000 clients in in 2021. In addition, Waitematā DHB works with primary care to deliver mental health support programmes through general practice and other community support services.

The Access and Choice initiative evolved from 2019's Wellbeing Budget with a focus on building the wider system to provide free support early to those with low to moderate mental health, wellbeing, or addiction needs.

PROPORTION OF POPULATION ACCESSING MENTAL HEALTH SERVICES



A key work stream, and the first to be implemented, is the Integrated Primary Mental Health and Addiction (IPMHAS) service. The IPMHAS model provides easy access to mental wellbeing support available in GP sites. Other work streams focus on the expansion and development of kaupapa Māori, Pacific and youth specific services. The IPMHAS model has three roles: health improvement practitioners (HIPs), health coaches (HCs), and Awhi Ora NGO peer and community support workers. HIPs and HCs are members of the primary care team who work in the clinic and see patients on the day they present. Awhi Ora is the expansion of existing NGO walk-alongside support directly matched to GP practices. They sit outside of the practice to provide community and outreach support.

In Waitematā DHB, 17 practices have gone live as at the end of April 2022 and 10,569 people have accessed support. Rollout to 12 more practices is funded through the end of the 2022/23 financial year, and those with high volumes of priority populations are targeted first.

94% of mental health clients were seen quickly

2%

66% of young people received wellbeing assessments at school

20%

551 youth ED presentations were alcohol related

36%

Delivering on our priorities

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.

In the 12 months to June 2022, 94% of clients referred non-urgently to DHB-provided mental health services were seen within 8 weeks, and 75% were seen within 3 weeks.

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 dangerous time of experimentation. HEEADSSS is a validated assessment tool commonly used to help assess youth wellbeing through a series of questions relating to home life, education/employment, eating, activities, drugs, sexuality, suicide/depression 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.

Due to school closures during the lengthy Delta lockdown in Auckland in the 2021 school year, only 66% of eligible Year 9 students in decile 1-5 schools received a HEEADSSS wellbeing assessment. School nurses continue to complete assessments for all Māori, Pacific and high risk students who missed out on HEEADSSS in 2021.

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. Our hospitals implemented alcohol data collection in ED. All (but two) of the 76,785 young people aged 10-24 years old and admitted to our EDs were screened for alcohol in the 12 months to June 2022, with 551 (3%) admissions a result of excessive alcohol consumption. This is a decrease from 862 alcohol related admissions in 2020/21.

Safe care in a holistic setting

In early May, our specialised service providing medically supervised withdrawal from alcohol and other drugs relocated to a modern new city-based Auckland location.

Waitematā DHB is contracted to run the Medically Managed Withdrawal Inpatient Service on behalf of all three Metropolitan Auckland DHBs though its Community Alcohol and Drug Service (CADS).

The relocated service was opened by Minster of Health Andrew Little after shifting from its former home in Pt Chevalier. It now occupies an entire purpose-built floor of the new multi-storey Auckland City Mission - Te Tāpui Atawhai (Mission) HomeGround facility, to be officially opened later in the year.

Minister of Health Andrew Little at the relocation opening

The referrals-only service will work closely with a Social Withdrawal Service managed by the Mission in the same complex.

Patients are now able to transfer to the social withdrawal floor as soon as it is clinically safe and appropriate for them to do so, potentially decreasing the average length of stay within the medically managed unit and increasing throughput while reducing wait times.

“The medically managed service is for people who are at high risk of a complicated withdrawal due to their level of drinking or other drug use,” said Waitematā DHB Executive Director, Tier 1 Community Services, Tim Wood. “The subsequent shift to a social detoxification setting is often considered more appropriate after around seven days when the use of medication at such a level is no longer necessary.

Photo courtesy of Auckland City Mission

Photo courtesy of Auckland City Mission

“Co-location of both services is designed to enable a more seamless transition for patients and initial projections suggest it could result in an increase of around 172 admissions per annum on top of the approximately 500 patients who are currently admitted to the unit each year.”

The relocation of the medically managed service was made possible by a $10.8 million Government funding package in 2018.

“The opportunity for us to provide medical detoxification care in a modern facility right alongside other services offered by the Mission is a major step forward in how this type of treatment is delivered,” Waitematā DHB CEO Dr Dale Bramley says.

“This initiative will help to address the sustained high demand in Auckland for detoxification services. It also presents the opportunity for a new co-located model of care with other services that has the potential to reduce preventable ED presentations and hospital admissions.”


Our people,
our performance
The symptoms of COVID-
Please tell us if you have any of these symptoms
Fever
Cough
Shortness of breath
Headache

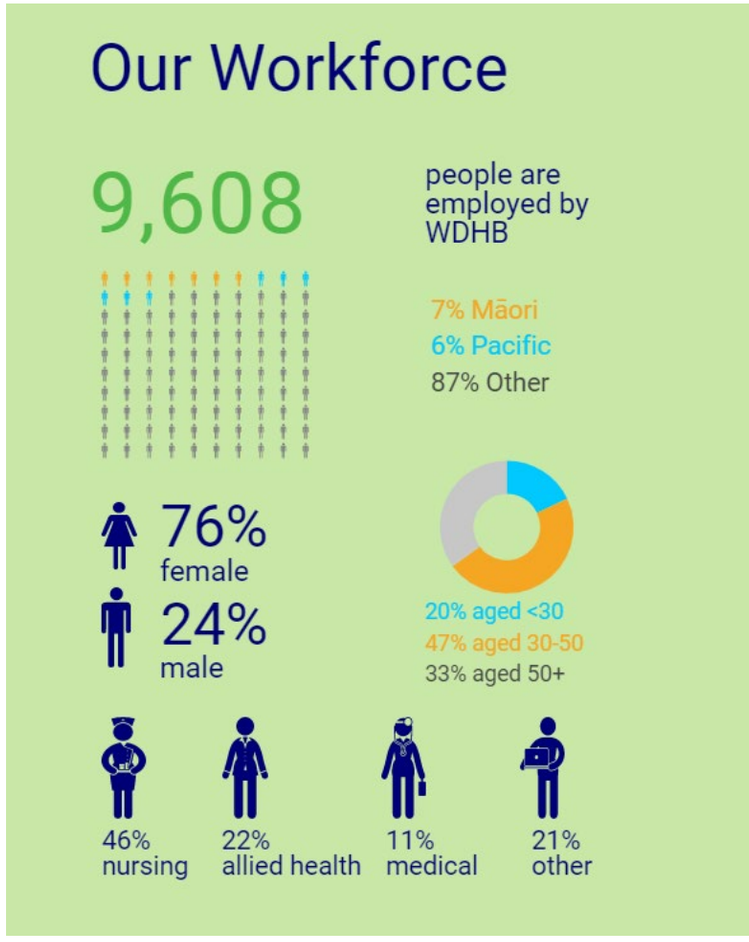
Our people, their stories

At Waitematā DHB, we take great pride in all of our employees. Here are just a few of the amazing people on our team.

Dr Josephine Aumea Herman, former Secretary for Te Mārae Ora Cook Islands Ministry of Health, was appointed the Director of Pacific Health at Waitematā DHB in March 2021.

Growing up in the Cook Islands, it was at 11 years old that Dr Herman decided to work in healthcare, a decision that would set her on an impressive career path.

The public health physician and general practitioner also holds a PhD in epidemiology from the University of Auckland.



She is a past recipient of the Pasifika Medical Association Service Award for her contribution to Pacific Health and was a Medical Officer of Health with Auckland Regional Public Health Service from 2017 to 2018, assisting with the response to the wider region's mumps outbreak.

Dr Herman helped to lead the national emergency health response to COVID-19 in the Cook Islands. She also worked closely with Waitematā DHB and the wider Metropolitan Auckland area on regional COVID-19 vaccination initiatives.

Along with a wealth of clinical experience, Dr Herman brings strong Pacific leadership and engagement capabilities to Waitematā DHB.

"A healthier future for our Pacific population can be achieved when our people know what to expect from the health system and they understand their role in contributing to designing a health system that best addresses their needs."

Dr Herman says better health outcomes for Pacific people are the responsibility of all, not just the Pacific health team.

"We have many employees at Waitematā and we need to involve each of them, so we all understand that improving health services for Pacific peoples, Māori and other populations is everyone's job."

Growing our Māori workforce

New Waitematā DHB employee Helen Kearns had a later-in-life call to become a doctor. Helen always had a passion for health care and first started training as a nurse. Helen, who is of Ngāti Kurī and Te Rarawa descent, is one of 100 new-graduate doctors who have just started work at Waitematā DHB.

"Waitematā DHB was my first calling," she says. "I've lived my whole life in west Auckland. It has a diverse population which I love. These are my people. They can be complex and many of them are struggling in a variety of ways. I have an affinity for them and I want to give back to my community."

Looking after mental health

Ofa Taufoou works with our most vulnerable mental health clients when they come into the Emergency Department. "The best thing about my role as a therapeutic observation coordinator is that I have time to sit down with, have a conversation and listen to their concerns. I do my best to make sure they feel valued, respected and listened to. This leads to a good rapport and de-escalates anxiety and stress levels while they are waiting to be assessed."

Ofa's coordination role was implemented in 2021 as part of a new pilot project that works on looking after our mental health patients in an environment where they feel safe and respected. Ofa trains ED health care assistants how to safely perform therapeutic observation as part of their duties.

Gaining trust through te reo

Elizabeth Brookbanks is a pharmacist at North Shore Hospital. She learned te reo to provide better care for her Māori patients. This sparked a passion to work alongside Māori who lack trust in western medicine and explore using rongoā (traditional Māori medicine) with modern medications.

"Completing the course provided by Te Whare Wānanga o Awanuiārangi has helped me reach out to my patients. Improving my pronunciation and confidence with speaking te reo has helped me build trust with patients and break down barriers. Learning te reo has been the start of a partnership and a goal of being able to connect better with my Māori patients and ultimately get the best outcomes we can for them."

He Kāmaka Waiora

Tikanga Māori is at the core of daily practice within He Kāmaka Waiora, the Māori Health Service that operates across Waitematā and Auckland DHBs. It is applied with a strong Ngāti Whatua lens, in keeping with the status of Ngāti Whatua as mana whenua and is overseen by Chief Advisor Tikanga, Dame Rangimarie Naida Glavish.

Tikanga guides all efforts to: achieve better health outcomes for Māori; recruit and retain a strong Māori workforce; develop Māori leadership; and enable equity through every aspect of service delivery.

The role of the He Kāmaka Waiora team is important in working with Māori patients and their whānau to ensure ready access to hospital services when required, in a way and manner that is culturally appropriate and inclusive.

This includes coordinating whānau accommodation, providing social, cultural and advocacy services, and working with DHB clinicians and other staff to ensure that services respond to the needs of Māori health gain.

Dame Naida prepares for an interview with Māori TV during a visit by the Prime Minister to the Albany vaccination centre

Dame Naida is supported by Te Kaunihera Kaumātua (Council of Elders), kaumātua, the Directors of Māori Research and Māori Clinical Nursing, and the General Manager of the Māori Provider Service.

She maintains strong relationships with the Coroner, Police and Te Arai Kapua (Auckland City Hospital, the mortuary whānau room), and leads the management of relationships with mana whenua, iwi Māori and multiple other stakeholders, from a tikanga perspective. She also assists in upholding the DHBs' obligations to Te Tiriti o Waitangi and its four articles.

Te Kaunihera Kaumātua

Reporting to the Chief Advisor Tikanga, this select group of esteemed elders oversees matters of Māori cultural significance across Waitematā and Auckland DHBs.

Throughout different stages of the COVID-19 pandemic, our Kaumātua continued their commitment to our DHB. They isolated when required and provided support, such as blessings and mihi whakatau via zoom or phone. The easing of COVID-19 restrictions in the second half of the year allowed for more in-person activity, complete with physical distancing and mask wearing when needed.

Kaumatua played a key role in planning and implementing multiple key events, activities and powhiri throughout the year, including:

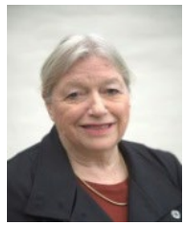
- The blessing, opening and closure of community-based testing and vaccination centres and pop-up clinics across the catchment.
- Our kaumatua also provided a face to the vaccination programme for Māori, as trusted community figures, working to encourage participation among whānau through example and counsel.
- Visits from Government officials to our sites.
- Openings and blessings associated with new projects and services, completed facilities and commissioning of new equipment (e.g. the new surgical robot, Toa).

Matua Fraser Toi starts proceedings with a mihi during the May 2022 opening of the Medically Managed Withdrawal Inpatient Service in the Auckland City Mission - Te Tāpui Atawhai HomeGround building

He Kāmaka Waiora maintains an integral role in many key work programmes. The contribution to the pandemic response includes the design and development of the Waitematā DHB COVID-19 vaccination plan and the introduction of Oranga Co-ordinators to support Māori COVID-19 patients and their whānau during peak periods. Other work streams include: Kōtui Hauora, our iwi-DHB Partnership Board; the development of our DHB's equity plan; the development of our Māori-led lung cancer screening study and the design, development and building of new DHB facilities to ensure that they embrace Te Ao Māori, including site works at Waitakere Hospital, Whānau Ora accommodation, developments at Mason Clinic and the new Tōtara Haumaru hospital facility.

Waitematā DHB Board members

Dame Judy McGregor, DNZM
Chair



Sandra Coney, QSO

Allison Roe, MBE

Kylie Clegg
Deputy Chair

Warren Flaunty, QSM

Renata Watene

Edward Benson-Cooper

John Bottomley

Hon. Chris Carter

David Lui

Eru Lyndon

Congratulations to our Chair – Dame Judy McGregor

The Chair of our Board, Dr Judy McGregor, was recognised in the 2022 Queen's Birthday Honours and was appointed as a Dame Companion of the New Zealand Order of Merit for services to journalism and health.

It is just recognition of Judy's incredible advocacy and service to New Zealand over several decades, firstly as a pioneering journalist, then as a lawyer, academic and public servant. Judy was first recognised in the 2004 Honours as a Companion of the New Zealand Order of Merit for services to journalism.

Throughout her career, Judy championed the causes of those in society who are not getting a fair deal. She is renowned for her life-long work on gender equality and was a staunch campaigner for the rights of women in the workplace.

She was also an advocate of eliminating health inequities, for Māori in particular, and gave strong support to the establishment of Kōtui Hauora, our Iwi-DHB Partnership Board.

Judy is a wonderful New Zealander and her steady hand over the last four years has helped our DHB to navigate the twin challenges of COVID-19 and continuing growth in demand for care. It is particularly timely that this latest recognition should arrive now, with our Board nearing the end of its tenure as the new national health agencies are established.

Meeting attendance

	Board (9 meetings)	**Hospital Advisory Committee** (4 meetings)	**Audit and Finance Committee** (8 meetings)	**Community and Public Health Advisory Committee** (1 meeting*)	**Disability Support Advisory Committee** (1 meeting*)
Board					
Judy McGregor, Board Chair	9	3	8	1	1
Chris Carter	7	4	x	1	x
Edward Benson-Cooper	8	4	7	x	1
John Bottomley	8	4	x	1	x
Kylie Clegg, Deputy Chair	9	x	8	1	x
Sandra Coney	9	3	x	1	1
Warren Flaunty	9	4	7	1	x
David Lui	8	4	8	1	x
Eru Lyndon	8	4	x	x	x
Allison Roe	4	3	x	1	1
Renata Watene	9	4	8	1	x
Independent committee					
Norman Wong, Chair	x	x	8	x	x
Tony Howe	x	x	x	x	1
Kaeti Rigarlsford	x	x	x	x	1
Jade Farrar	9	3	8	1	1

*** Note**

Scheduled DiSAC, CPHAC and HAC meetings in August 2021 and meetings scheduled in 2022 were cancelled due to the staff/DHB response to the COVID-19 Pandemic – during 2022 the Committee updates were prepared in accordance with what was the original meeting schedule and these were submitted to the Board.

Being a good employer

At Waitematā DHB, our promise is the best care for everyone. We believe that our patients receive the best care from our people when our people receive the best care from us as their employer. We are committed to being an Equal Employment Opportunities (EEO) employer through our organisation-wide good employer practices relating to the recruitment, development, management and retention of all staff. We have been an employer member of Diversity Works for the last ten years and were awarded the Accessibility Tick in December 2019. Our values programme won a 2015 Institute of Public Administration New Zealand (IPANZ) award and the 2016 Human Resources Institute of New Zealand Talent Development and Management award.

Our Good and Equal Employment Programmes

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

Haemodialysis team, North Shore Hospital, winners of a Waitematā DHB Health Heroes award

Staff wellbeing

Waitematā DHB is committed to fostering a positive culture and living our values every day.

We acknowledge that our healthcare systems face significant challenges, especially during the COVID-19 pandemic, and that our people work hard to advocate for and provide exceptional patient care. The need to look after our staff has never been greater. We acknowledge the importance of ensuring that our intention (our talk) matches the lived experience of our staff (our walk).

Our work in 2021/22 focused on wellbeing activities and support, and included: staff listening and appreciative enquiry sessions, which helped to inform the rollout of our COVID-19 support work; our self-managed work-related injury programme (ACC Partnership Programme); contact tracing for reportable diseases; on-site Employee Assistance; regular welfare calls to staff impacted by COVID-19, mindfulness sessions, locally donated treats and lunches distributed to staff; and our popular wellbeing and leader check ins.

Our Oranga Coordinators were pivotal in supporting staff welfare during our COVID-19 response, delivering food parcels and RATs to staff with COVID-19.

Strategically, the DHB is committed to achieving ISO standard 45003 to help us manage psychosocial health in the workplace, starting with capturing psychosocial impacts as part of our incident management process.

Although set up in 2021, in June 2022, we launched Schwartz rounds, which focuses on giving health professionals an opportunity to express their social and emotional feelings around complex-care case studies.

In support of our rainbow workforce, we are working on a gender affirmation policy, as well as inclusive workplace and facility design and construction.

Health equity

Evidence shows improved outcomes for patients when they are treated with a higher level of cultural understanding and awareness, and cared for by a skilled workforce that reflects our community's demographic.

To support our health equity efforts, we set employment growth targets to match Māori and Pacific working age district populations with levels of staff employment. We are progressing well with employment targets for 2021/22, with over 700 staff identifying as Māori and around 500 staff as Pacific.

Our current Tiriti o Waitangi programme pivoted to focus on professional cross-cultural practice in the workplace. Patient-centric manawhenua narratives are used to demonstrate the impact of indigenous attitudes and values on how Māori receive health services, along with practical strategies to reduce inequities. The revised programme was well received by learners. In the next three months, we have capacity to enrol 210 staff in this professional development.

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

Since 2009, we supported over 400 Māori and Pacific students through their tertiary study via scholarship grants. Since 2017, 97% of scholarship graduates who applied for roles gained employment in the health sector. Waitematā DHB runs a paid programme to support Māori and Pacific candidates into Health Care Assistant (HCA) roles. The 'New to HCA' programme was a finalist in the 2018 Diversity Awards NZ.

Our award winning eCALD programme continues to build capability in cultural awareness and development across the DHB.

Recruitment and selection

The DHB continues to improve the recruitment experience for our candidates and our hiring managers, with a specific focus on identifying and addressing cultural awareness and competency within services. Highlights for 2021/22 include:

- Launching Māori Workforce Recruitment Hiring Manager Guidelines to grow, retain and develop the capacity and capability of our health workforce.
- Being an employer of choice for disabled healthcare professionals and those looking to work in healthcare. We launched a new recruitment toolkit for managers to support selection of disabled staff, we are supporting the establishment of an employee-led network to contribute to workplace improvements, and we embedded disability considerations into our construction design and build policies.
- The quick build of a vaccination workforce of over 100 staff, including pre-employment training.

Building capability

Waitematā DHB is committed to growing our digital capability. In 2019, we launched our first digital academy to develop clinical staff to design people-centred digital solutions. The ongoing success of the programme saw an increase in clinical development of digital technologies that benefit our staff and patients.

We have a comprehensive training programme to equip new graduates with clinical and professional skills. Extensive coaching and teaching programmes support the transition of post-graduate allied health, nursing and medical staff from their student to intern year and into pre-registration training.

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

We support our staff through NZQA accredited training via Careerforce. More than 413 cleaning and orderly staff and over 180 health care, dental, and therapy assistants completed these programmes in the last 8 years.

Waitematā DHB provides extensive management and leadership training, launching a new programme, 'Growing Authentic Leadership', in 2021, that connects staff peer learning groups with a leadership coach over 10 months. We added to this programme in 2022, including a quality improvement component and management skills modules.

We are reviewing our people and culture training modules, with the first new education on anti-bullying and harassment provided to our management teams from May 2022.

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

Volunteers

We are assisted by approximately 300 volunteers who support our patients and their whānau. Volunteer groups include Volunteer Stroke Service, St Johns – Friends of Emergency and Ward 2, Hospital Auxiliary, Volunteer Chaplain Assistants, Front of House (Green Coats), Asian Health Services Support, ward volunteers, outpatient volunteers, Justice of Peace, Radio Lollipop volunteers and Westlake Girls and Boys High Schools.

Our volunteers are highly valued by the organisation, patients and visitors. They provide assistance in many ways, including a friendly face to help with way finding as visitors enter our hospitals, collecting patient feedback, supporting our ward patients and attending to their needs, and providing assistance to our culturally and linguistically diverse community. City Impact Church and the North Harbour Rose Society also volunteer their time to attend to our gardens.

From left: Waitematā DHB Volunteer Coordinator Genevieve Kabuya, with auxiliary members Gloria Holt, Noelene Coppell and Linda Smalley, as they receive the Volunteers in a Health Care Provider Service Award from Minister of Health Hon Andrew Little.

Remuneration and recognition

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

- Health Excellence awards recognise innovation in patient outcomes or patient/staff experience.
- Chief Executive awards recognise staff for a specified activity or action that demonstrates a DHB goal, priority or value.
- Health and COVID-19 Hero awards. A bi-monthly award to a staff member or team who demonstrates outstanding achievement of DHB values, standards and behaviours.
- House Officer of the month, hosted by our Medical Education Unit/Director of Clinical Training to recognise the work or value displayed.
- Long service awards, which recognise staff who have 15 years or more service with the DHB.
- Pay equity. We are involved in finalising gender pay equity claims for a number of our staffing groups. We recently agreed to actions to help us reduce the gap between high and low income earners. Work to address any ethnicity based pay gap is ongoing.

Staff with a patient from the Dialysis Unit, Waitakere Hospital, part of our COVID-19 Health Heroes series

Living within our means is central to our success as an organisation. We actively participate in national bargaining, establishing parameters to ensure bargaining will deliver organisational and sector expectations. Any agreements negotiated nationally or locally are approved by MoH as per protocols and include Public Service Association pay restraint guidance.

In partnership with unions

We value our relationships with our union partners, establishing partnership agreements for health and safety and engaging in regular bipartite committees, both nationally and locally. Programmes of work discussed in the last 12 months include: COVID-19 response, wellbeing, occupational health and safety, facility development, change, leave and deployment.

Workplace flexibility and design

A large facility development programme is underway across our sites, guided by the Northern Region Health Services Plan. Staff are involved in planning discussions on construction and design to enable accessible workplaces and future-proofed spaces that are safe and deliver contemporary patient care.

We offer our staff flexible hours, as noted by our large part-time workforce, and have remote working arrangements in place to enable working anywhere in the country.

We completed significant work on a staff deployment platform, originally stood up to support our COVID-19 response. We are now looking to leverage this platform for use over winter and other instances where deployment is best co-ordinated via a central system.

Policies

In 2021/22, we reviewed key people-based policies, including anti-bullying, anti-harassment and discipline processes, and many new occupational health and safety policies and guidance to respond to COVID-19. Key employee policies are sent to union partners for their feedback and endorsed by our Executive Leadership Team.

Health, safety and wellbeing

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

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

Our working environment is an important component of wellbeing for patients and staff, with the DHB focusing improvements on COVID-19 health and safety, construction management, psychosocial factors, hazardous substances, community workers, incident and risk management, security and governance. We are also participating in a national fatigue survey to gain a better understanding of the factors associated with fatigue for different groups of DHB health workers, which will inform further work on how we can manage staff fatigue.

Waitematā DHB is working towards ISO 45001 Health and Safety standards and our work plans and self-audits are oriented to achievement of these milestones. Our staff health, safety and wellbeing committee is driving the worker participation actions.

Overview

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

Measuring our outputs helps us to understand how we are progressing towards our system level measure targets and overall outcome goals, set out in the Improving Health Outcomes section of this report. The two high level health outcomes we want to achieve are an increase in life expectancy and a reduction in the difference in life expectancy between population groups. Life expectancy for the Waitematā DHB population is now 84.4 years, an increase of 1.4 years over the last decade. The life expectancy gap is 5.6 years for Māori and 7.4 years for Pacific, compared with all other ethnicities.

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

Output class measures

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

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

The following tables include our output measures from the 2021/22 Statement of Performance Expectations by Output Class. The 'measure type' symbols define the type of measure and are included in brackets after the measure description. Some indicators expected performance directions rather than set quantitative targets, and these were assigned with the below symbols in the target column.

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

Impact of COVID-19

The COVID-19 pandemic had a significant impact on the performance of many of our output measures. Restrictions imposed by the lengthy Delta lockdown in the second half of 2021 in Auckland meant that fewer patients were seen face-to-face in primary care, and for a time many non-urgent services were unable to operate at all. Many staff were deployed to work on the vaccination rollout. During the Omicron outbreak in 2022, many staff were diverted away from routine health promotion/prevention work to focus on the care of COVID-19 patients, and the large number of both patients and staff infected and/or isolating led to delays in the provision of some services.

Output Class 1: Prevention Services

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Health promotion					
% of PHO-enrolled patients who smoke are offered brief advice to stop smoking in the last 15 months (C)	79%	77%	70%[2]	90%	🔴
% of PHO-enrolled patients who smoke and are referred to smoking cessation providers (Q)	5%	1.5%[3]	0.8%[2]	6%	🔴
% of PHO-enrolled patients who smoke and are prescribed smoking cessation medications (Q)	7%	11.7%[3]	10.3%[2]	12%	🔴
Number of pregnant women smokers referred to the stop smoking incentive programme (Q)	193	199	96[4]	231	🔴
Number of clients engaged with Green Prescriptions (V)	4,900	5,080	2,854[5]	4,618	🔴
% of clients engaged with Green Prescriptions (C)					
- Māori	13%	15%	16%	13%	🟢
- Pacific	15%	15%	14%	12%	🟢
- South Asian	6%	8%	11%	9%	🟢
Immunisation					
% of pregnant women receiving pertussis vaccination (C)	54%	54%	55%	50%	🟢
- Māori	32%	30%	28%[6]	50%	🔴
- Pacific	39%	37%	29%[6]	50%	🔴
- Asian	66%	66%	70%	50%	🟢
% of pregnant women receiving influenza vaccination (C)	43.7%	43.5%[3]	40%[6]	50%	🔴
- Māori	26.2%	27.9%	21%[6]	50%	🔴
- Pacific	38.2%	33.7%	24%[6]	50%	🔴
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness[7] (C)	18%	30%	13.8%[8]	30%	🔴
- Māori	10%	20%	7.7%[8]	30%	🔴
- Pacific	9%	19%	5.8%[8]	30%	🔴
% of eight months olds will have their primary course of immunisation on time (C)	93%	90%	87%[9]	95%	🔴
- Māori	87%	78%	71%[9]	95%	🔴
- Pacific	92%	91%	83%[9]	95%	🔴
% of five year olds will have their primary course of immunisation on time (C)	89%	87%	80%[9]	95%	🔴
- Māori	86%	82%	69%[9]	95%	🔴
- Pacific	88%	87%	78%[9]	95%	🔴
- Asian	93%	92%	86%[9]	95%	🔴
HPV immunisation coverage (for girls born in 2008) (C)	68%	71%	53%[10]	75%	🔴

[2] COVID-19 (lockdown restrictions, staff shortages due to redeployment and sickness, fewer face-to-face routine patient contacts) has significantly impacted the ability of primary care to provide routine smoking cessation services.
[3] This measure was not included in the 2020/21 Annual Plan therefore the result was not reported in the 2020/21 Annual Report and is unaudited.
[4] The COVID-19 outbreak and ongoing response in the Auckland region since August 2021 significantly affected the services that usually refer, in addition a number of key roles were re-deployed to help with the response or were vacant for a period of the year.
[5] Result is due to a significant decrease in referrals from primary care due to their focus on the COVID-19 response.
[6] Coverage was affected by COVID-19 as many clinic appointments were delivered virtually, removing the opportunity for vaccination. Health promotion campaigns were launched to raise awareness for Māori and Pacific pregnant mothers.
[7] All results are for the calendar year preceding the financial year.
[8] Low uptake due to winter illnesses; we continue to support PHOs with lists of eligible children to recall. Hospital-level services are actively checking for this cohort of children and engaging with families.
[9] Lockdowns, COVID-19 restrictions and high demand on workforce capacity affected immunisation coverage. Some families were fearful to attend GPs, and winter illnesses led to a high volume of cancellations/re-bookings. A recovery plan targeting Māori and Pacific was approved by MoH and is being implemented.
[10] The School-based Immunisation Programme roll out was limited by COVID-19 related school closures and student absenteeism.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Population-based screening					
% of women aged 45-69 years having a breast cancer screen in the last 2 years (C)	66%	64%	62%[11]	70%	🔴
% of women aged 25-69 years having a cervical cancer screen in the last 3 years (C)	69%	70%	66%[11]	80%	🔴
HEEADSSS assessment coverage in DHB-funded school health services (C)[7]	90%	82%	66%[12]	95%	🔴
% of four year olds receiving a B4 School Check (C)	68%	78%	50%[13]	90%	🔴
Bowel cancer screening					
% of people aged 60-74 years invited to participate who returned a correctly completed kit[14] (Q)	61%	59%	58%	60%	🔵
- Māori	63%	61%	54%	60%[15]	🔴
- Pacific	49%	47%	42%	60%[15]	🔴
- Asian	55%	52%	49%	60%[15]	🔴
- Other	64%	63%	62%	60%	🟢
% 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)	95%	99%	96%[16]	95%	🟢
Auckland Regional Public Health Service (ARPHS)[17]					
Number of alcohol licence applications and renewals (on, off club and special) that were processed (V)	3,625	2,921	3,011	Ω	n/a
Number of tobacco/vaping retailer compliance checks conducted (V)	184	5	0[18]	300	🔴
% of smear-positive pulmonary tuberculosis cases contacted by a public health nurse within 3 days of clinical notification (T)	95%	98%	96%	90%	🟢
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol (Q)	96%	100%	100%	90%	🟢
% of COVID-19 confirmed cases that started isolation/quarantine within 48 hours after notification (time case notification to isolation/quarantine of contact P002) (T)	New indicator	New indicator	n/a[19]	80%	n/a

[11] Screening continues to be affected by COVID-19, including staff availability. Although inequity remains significant, work continues to prioritise high risk women.
[12] Extended school closures during the Auckland COVID-19 delta lockdown Aug-Dec 2021 meant the provision of school-based health services were significantly reduced in 2020/21.
[13] COVID-19 has had a significant impact on the performance of this indicator. B4 school checks were unable to be performed during the Delta lockdown and the ongoing Omicron COVID-19 outbreak has seen many checks delayed as whānau or staff were sick or isolating.
[14] % of people invited to take part in the programme who were screened in the two years prior to the end of the reporting period.
[15] Our communications campaigns have had to compete for attention with COVID-19 and influenza health promotion messages. We continue to promote the importance of screening via targeted publicity using ethnic-specific languages for priority populations.
[16] Result as at May 2022.
[17] Services delivered by Auckland Regional Public Health Service on behalf of the three Metro Auckland DHBs; results are for all three DHBs.
[18] During the COVID-19 response, public health staff resources were prioritised. Re-engagement with tobacco retailers, with a focus on high deprivation areas (NZ Dep 7-10), is to be reinitiated in 2022/23.
[19] This indicator is no longer applicable as ARPHS is not solely responsible for the delivery of this service due to national changes in approaches to manage COVID-19 outbreaks throughout the reporting period.

Output Class 2: Early Detection and Management

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Primary health care					
Rate of primary care enrolment in Māori (C)	83%	81%	79%[20]	95%	🔴
% of newborn babies enrolled with a general practice or primary health organisation (PHO) at 3 months of age (C)	93%	90.8%[3]	88.9%	85%	🟢
- Māori	79%	77.5%	72.6%[21]	85%	🔴
- Pacific	82%	84.3%	81.9%[21]	85%	🔴
Primary Options for Acute Care (POAC) utilisation rate (V)	1.60%	1.68%[3]	1.68%[22]	3%	🔴
% 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)	12%	11%	12.9%[23]	<8%	🔴
- Māori	19%	17%	18.4%[23]	<8%	🔴
- Pacific	14%	14%	14.9%[23]	<8%	🔴
% 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%	63%	63%	60%	🟢
- Māori	49%	51%	51%[23]	60%	🔴
- Pacific	49%	50%	49%[23]	60%	🔴
Volume of highest priority (priority 1) patients who are not known to retinal screening, in Waitematā DHB clinics[24] (C)	300	304[3]	358[25]	≤151	🔴
- Māori	77	63	106	≤39	🔴
- Pacific	110	115	138	≤55	🔴
- Asian	46	54	52	≤23	🔴
- Other	67	72	62	≤34	🔴
% of patients with prior CVD event who are prescribed triple therapy (Q)					
- Māori	59%	64%	63%[23]	70%	🔴
- Pacific	67%	68%[3]	68%	70%	🔵
Pharmacy					
Number of prescription items subsidised (V)	8,165,354	9,241,220	9,157,229	Ω	n/a
Community-referred testing and diagnostics					
Number of radiological procedures referred by GPs to hospital (V)	34,003	39,775	33,296	Ω	n/a
Number of community laboratory tests (V)	4,013,632	4,516,955	4,357,690	Ω	n/a

[20] Primary care enrolment has historically been lower for Māori than other ethnicities. We continue to work with providers that serve communities with low levels of primary care enrolment.
[21] Competing demands of COVID-19 continue and particularly affected Māori and Pacific providers and whānau. We are working with the Northern Region and Te Whātua Ora on strategies to reduce the barriers for newborn enrolment.
[22] Data for calendar year 2021. The 3% referral target is arbitrary, and was intended to support awareness of variations in POAC referrals in primary care, rather than aiming for each practice (or the DHB as a whole) to meet the target.
[23] The Delta lockdown and ongoing Omicron COVID-19 outbreak has impacted the ability of primary care to provide routine diabetes and CVD care. Work continues to re-engage in BAU where possible.
[24] This measure was incorrectly described as a % in the 2021/22 Annual Plan
[25] COVID-19 (Delta lockdown and on-going Omicron COVID-19 outbreak) has impacted the ability of primary care to provide routine diabetes and CVD care, including engaging and activating retinal screening referrals. We are continuing to work with PHOs to encourage referrals into retinal screening and undertake data match every three months to identify people with diabetes who are enrolled with a GP practice but are not known to retinal screening services.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Oral health[7]					
% of children 0-4 enrolled in DHB-funded oral health services (C)	98%	98%	99%	95%	
- Māori	75%	74%	77%[26]	95%	
- Pacific	96%	97%	100%	95%	
- Asian	93%	91%	91%	95%	
Ratio of mean decayed, missing, filled teeth (DMFT) at Year 8 (Q)	0.61	0.48	0.33	<0.52[27]	
- Māori	0.85	0.71	0.48	<0.52[27]	
- Pacific	0.79	0.68	0.51	<0.52[27]	
- Asian	0.63	0.51	0.34	<0.52[27]	
% of children caries free at five years of age (Q)	58%	50%	55%	60.7%[27]	
- Māori	49%	41%	42%[28]	60.7%[27]	
- Pacific	38%	28%	36%[28]	60.7%[27]	
- Asian	47%	43%	51%[28]	60.7%[27]	
Utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including age 17 years (C)	68%	58%	51%[29]	85%	

[26] Community engagement, including with Māori, was affected by lockdowns in 2021. Work continues to target tamariki not enrolled with oral health services.
[27] Target differs from that published in our 2021/22 Annual Plan, as changed by MoH.
[28] Despite service interruptions and challenges related to COVID-19, ARDS continues to improve service delivery and community awareness, including a focus on high risk children.
[29] COVID-19 restrictions and school closures in 2021 affected service delivery. Initiatives continue to improve utilisation, including ARDS following priority booking model to continue to maximize the use of mobile facilities in high-needs areas where children experience more barriers to accessing the service.

Output Class 3: Intensive Assessment and Treatment

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

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

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Acute services					
Number of ED attendances (V)	122,215	121,481	114,932	Ω	n/a
% of ED patients discharged, admitted or transferred within six hours of arrival (T)	96%	92%	83%[30]	95%	🔴
% 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)	89%	90%	89%	90%	🔵
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7) (C)	12.9%	15%	12.2%	12%	🟢
% of ACS inpatients receiving coronary angiography within 3 days (T)	76%	69%	76%	70%	🟢
Maternity					
Number of births in Waitematā DHB hospitals (V)	6,627	6,730	6,950	Ω	n/a
% of babies exclusively breastfed on discharge (Q)	75%	72%	76%	>75%	🟢
Elective (inpatient/outpatient)					
Number of Planned Care interventions (V)	32,032	36,167 (111%)	33,897 (102%)	33,096[31] (100%)	🟢
- Inpatient surgical discharges	19,413	21,931	19,148	21,729[31]	n/a
- Minor procedures	12,619	14,235	14,615	11,033[31]	n/a
- Non-surgical interventions	0	1	134	334[31]	n/a
% of accepted referrals receiving their CT scan within 6 weeks (T)	63%	73%	66%[32]	95%	🔴
% of accepted referrals receiving their MRI scan within 6 weeks (T)	83%	68%	62%[32]	90%	🔴
% of people receiving urgent diagnostic colonoscopy in 14 days (T)	99%	96%	96%	90%	🟢
% of people receiving non-urgent diagnostic colonoscopy in 42 days (T)	42%	42%	38%[33]	70%	🔴
% of patients waiting longer than 4 months for their first specialist assessment (T)	15.4%	6.9%	21.3%[34]	0%	🔴

[30] Barriers to achieving the target include delayed patient processing due to screening and testing for COVID-19, and the impact of COVID-19 on staffing levels.
[31] Target is updated from our 2021/22 Annual Plan, as agreed with MoH.
[32] Staff shortages impacted internal capacity for elective scans. Although outsourcing was utilised, staff shortages and sickness also impacted private provider capacity. We continue to focus on service improvements and outsourcing referrals.
[33] Staff and capacity continues to be affected by COVID-19. We continue to prioritise patients who have waited the longest, and have a plan in place to increase capacity and outsourcing.
[34] As we accommodate COVID-19 into our business-as-usual workflows, both Medical and Surgical Specialties continue to focus on our long wait patients with a priority and ethnicity lens, as we work to bring the services back into compliance.

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Quality and patient safety					
% of opportunities for hand hygiene taken (Q)	89%[35]	91%[36]	91% [37]	80%	●
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision (Q)	99%[38]	98%[39]	n/a[40]	100%	n/a
% of hip and knee procedures given right antibiotic in right dose (Q)	100%[38]	98%[39]	n/a[40]	95%	n/a
% of positive responses to the National Adult Hospital Survey question: 'Did those involved in your care ask you how to say your name if they were uncertain?' (Q)	79%[41]	77%[3,42]	77%[43]	80%	●
Palliative care, in-hospital					
Total number of referrals (V)	1,387	1,374	1,458	Ω	n/a
Referral to response (mean time from referral to first contact with referrer) (T)	7.6 h	6.7 h	6.4 h	≤6 h	●
Referral to assessment (mean time from referral to first face-to-face patient assessment) (T)	9.25 h	12.9 h	10.6 h	≤24 h	●
Mental health					
% of population who access mental health services (C)					
- Age 0-19 years	3.69%	4.28%	3.74%	≥3.76%	●
- Māori	5.09%	5.66%	4.63%[44]	≥5.43%	●
- Age 20-64 years	3.83%	3.62%	3.28%	≥3.72%	●
- Māori	9.03%	8.61%	7.43%	≥8.86%	●
- Age 65+ years	2.19%	2.20%	2.08%	≥2.16%	●
- Māori	2.40%	2.28%	2.15%	≥2.26%	●
% of people aged 0-24 years old who access specialist mental health services within 3 weeks of referral[45]	73%	58%	59%	n/a	n/a

[35] July 2019 to February 2020 result. This is updated from our 2021/22 Annual Plan.
[36] November 2020 to June 2021 result.
[37] June 2021 to May 2022 (this data not reported according to financial quarters).
[38] Q1 to Q3 result. This is updated from our 2021/22 Annual Plan.
[39] Only Q1 result was available at the time of publication.
[40] Waitematā DHB was moved by HQSC to 'light surveillance' and this indicator is currently not actively monitored.
[41] Result for the 3 months to February 2021.
[42] Result for the 6 months to May 2021.
[43] Result for the 9 months to March 2022.
[44] Referrals from primary care decreased during the Delta lockdown in the second half of 2021 and the Omicron surge in early 2022.
[45] This indicator was not included in the 2021/22 Annual Plan, nor was a target; therefore, only results are reported here.

Output Class 4: Rehabilitation and Support Services

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

Outputs measured by	2019/20 baseline	2020/21 result	2021/22 result	2021/22 target	Rating
Home-based support					
% of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) (Q)	n/a[46]	98%	97%	95%	●
Palliative care, hospice					
Total number of contacts in the community (V)	19,940	18,151	12,906	Ω	n/a
Proportion of patients acutely referred who waited >48 hours for a hospice bed (T)	0.5%	2.9%	4.6%	<5.0%	●
Residential care					
ARC bed days (V)	982,979	1,002,882	1,024,940	Ω	n/a

[46] Due to COVID-19, service provision in Q4 2019/20 was reduced to minimise transmission risk, and providers were switched to fixed funding rather than fee for service, thus accurate data is not available for 2019/20.

Cost of Service Statement – for year ended 30 June 2022

	Early Detection and Management		Intensive Assessment and Treatment		Prevention Services		Rehabilitation and Support	
	$000		$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**468,949**	**494,356**	**1,317,998**	**1,289,305**	**48,890**	**49,739**	**368,810**	**393,659**
Expenditure								
Personnel	90,373	83,163	765,020	703,984	18,609	17,124	46,222	42,535
Outsourced Services	9,959	10,302	84,301	87,209	2,051	2,121	5,093	5,269
Clinical Supplies	14,210	14,813	120,293	125,391	2,926	3,050	7,268	7,576
Infrastructure & Non-Clinical Supplies	12,744	7,320	107,879	61,967	2,624	1,507	6,518	3,744
Payments to Providers	342,990	382,338	317,567	344,201	24,137	26,730	301,184	336,212
Total Expenditure	**470,276**	**497,935**	**1,395,060**	**1,322,754**	**50,346**	**50,533**	**366,286**	**395,337**
Net Surplus/ (Deficit)	**(1,327)**	**(3,580)**	**(77,062)**	**(33,449)**	**(1,457)**	**(794)**	**2,523**	**(1,678)**

	Total Excluding COVID-19		COVID-19		Total	
	$000		$000		$000	
	Actual	Plan	Actual	Plan	Actual	Plan
Total Revenue	**2,204,647**	**2,227,058**	**162,794**	**0**	**2,367,441**	**2,227,058**
Expenditure						
Personnel	920,225	846,806	53,098	0	973,323	846,806
Outsourced Services	101,404	104,902	(3,054)	0	98,350	104,902
Clinical Supplies	144,697	150,830	4,768	0	149,465	150,830
Infrastructure & Non-Clinical Supplies	129,765	74,539	4,541	0	107,180	74,539
Payments to Providers	985,878	1,089,481	102,479	0	1,088,357	1,089,481
Total Expenditure	**2,281,969**	**2,266,558**	**161,832**	**0**	**2,443,801**	**2,266,558**
Net Surplus/(Deficit)	**(77,322)**	**(39,500)**	**962**	**0**	**(76,360)**	**(39,500)**

Net Deficit for the year totals to $76.3m against a planned deficit of $39.5m.

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

Health System Indicators

The baseline timeframe used by MoH for these indicators is the year ending December 2019. This differs to the baseline of 2019/20 as set in our 2021/22 Annual Plan and as shown in the Statement of Performance tables, which was set prior to the release of the Health System Indicators by MoH.

Health System Indicators	Time period	Māori	Pacific	Other	Total
Improving child wellbeing					
ASH rate in 0-4 years olds per 100,000 population, non-standardised	Baseline	7,391	11,866	4,749	5,905
	2021/22	5,256	9,023	3,339	4,233
Immunisation at 2 years of age	Baseline[47]	86.8%	96.6%	93.1%	92.5%
	2021/22	66.7%	81.0%	88.6%	84.7%
Improving mental health					
People aged 0-24 years old who access specialist mental health services within 3 weeks of referral	Baseline	75.5%	74.1%	69.2%	70.8%
	2021/22	63.1%	56.1%	79.0%	58.8%
Access to primary mental health and addiction services	Indicator currently under development by MoH				
Improving wellbeing through prevention					
ASH rate in 45-64 years olds per 100,000 population, standardised (SNZ)	Baseline	8,195	11,716	3,332	4,135
	2021/22	7,241	9,842	3,092	3,800
Participation in the bowel screening programme	Indicator currently under development by MoH				
Strong and equitable public health system					
Planned Care	Baseline	n/a	n/a	n/a	106.3%
	2021/22	n/a	n/a	n/a	100.1%
Acute hospital bed days per 1,000 population, standardised, by DHB of domicile	Baseline	585	815	386	424
	2021/22	563	753	373	405
Better primary care					
People who report they can get care when they need it, by DHB of domicile; weighted results	Baseline	78.6%	73.8%	84.3%	83.3%
	2021/22	77.7%	83.6%	83.0%	81.6%
People who report they feel involved in their care and treatment, by DHB of domicile; weighted results	Baseline	87.3%	84.7%	86.7%	86.6%
	2021/22	88.8%	88.2%	90.0%	88.3%
Financially sustainable health system					
Annual deficit	MoH data not available				
Actual deficit result	MoH data not available				

[47] 3 months ending Dec-2019

Health Quality and Safety Commission markers

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, open for better care, and determine whether the desired changes in practice and reductions in harm and cost have occurred.

Health Quality and Safety markers	2020/21	2021/22
Hand hygiene		
80% compliance with good hand hygiene practice	90.5%[48]	90.9%[48]
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	0.092	0.088
Falls		
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	10.0	11.5
Safe surgery		
Ratio of actual : expected number of deep vein thrombosis/pulmonary embolism cases	1.23[49]	1.12[49]
Patient deterioration		
% of early warning score calculated correctly	100%	100%
% of patients who triggered an escalation of care and received the appropriate response	85%	83%[48]
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1,000 admissions	0.9	1.6
Rate of rapid response escalations per 1,000 admissions	23	28
Pressure injuries		
% of patients with a documented and current pressure injury risk assessment	91%	90%
% of at-risk patients with a documented and current individualised care plan	63%	82%
% of patients with hospital-acquired pressure injury	0.7%	1.5%
% of patients with a non-hospital-acquired pressure injury	2.0%	3.7%
Safe use of opioids		
% of patients whose sedation levels are monitored and documented following local guidelines	80%	80%[48]
% of patients who have had bowel function activity recorded in relevant documentation	5%	5%[48]
% of patients prescribed an opioid who have uncontrolled pain	0.1%	0.2%[48]
% of surgical episodes of care with opioid-related harm	0.6%	0.6%

[48] Q1 to Q3 result.

[49] Result as at Q4.

COVID-19 vaccination

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, the Ministry of Health (MoH) provided additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy. The complete information provided by MoH can be found in Appendix One. The data below is a summary of our vaccination coverage as at the end of 2021/22 (using the 2021 HSU as the denominator), and the vaccinations administered by our DHB in 2021/22.

Waitematā DHB residents aged 12+ years vaccinated as at 30 June 2022, by ethnicity

Ethnicity	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	133,522	94%	132,115	93%	88,588	73%	92	3%
Māori	39,316	91%	38,108	88%	18,763	58%	117	7%
European/other	301,174	92%	297,785	91%	209,732	77%	2,276	14%
Pacific peoples	36,833	92%	36,002	90%	18,780	60%	59	5%
Unknown	3,436	114%	3,354	111%	1,927	60%	8	7%
Total	**514,281**	**93%**	**507,364**	**91%**	**337,790**	**73%**	**2,552**	**12%**

Note: Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021 and 30 June 2022.

COVID-19 vaccine doses administered by Waitematā DHB, by dose type and year

Year	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[50]
2020/21	86,109	48,093	0	0	134,202
2021/22	457,009	472,878	339,703	2,726	1,272,316
Total	**543,118**	**520,971**	**339,703**	**2,726**	**1,406,518**

See Appendix One for notes and additional information relating to COVID-19 vaccination.

[50] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

Ministerial Directions

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

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in Apr-14 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in Jul-08, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF
- The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID‑19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand. Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction

Statement of Waivers

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

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

The following waivers were given during the last year:

Meeting of the Waitematā DHB Board August 2021
Warren Flaunty noted his disclosed interest as a Trustee of the Waitakere Licencing Trust in relation to a discussion on item 3 ‘Chair’s Report’ related to the DHB positions statement on the sale and supply of Alcohol Act provided by Central TAS. The Board noted this declaration and was satisfied under Schedule 3, clause 36 (4) that Warren Flaunty could remain in the meeting for the discussion of the item.

Vote Health: Health and Disability Support Services Waitematā DHB Appropriation

An appropriation is a statutory authority from Parliament allowing the Crown or an Office of Parliament to incur expenses or capital expenditure. The Minster of Health is responsible for appropriations in the health sector. Each year, the Ministry of Health allocates the health sector appropriations through 'Vote Health' to DHBs, who use this funding to plan, purchase and provide health services, including public hospitals and the majority of public health services, within their areas. An assessment of what has been achieved with Waitematā DHB's 2021/22 appropriations is detailed below.

Appropriations allocated and scope

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

What is intended to be achieved with this appropriation?

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

How performance will be assessed and end of year reporting

Each DHB has a statutory responsibility to prepare:

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

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

Amount of appropriations

	2020/21		2021/22	
	Final Budgeted $000	Actual $000	Budget $000	Actual $000
Original appropriation	1,727,434	1,727,434	1,823,567	1,823,567
Supplementary estimates	-	7,163		51,723
Addition to the supplementary estimates	-	-		
Total appropriation revenue	1,727,434	1,734,507	1,823,567	1,875,290

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

Trusts

Waitematā DHB controls the Three Harbours Health Foundation.

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

Asset performance

Introduction

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

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

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

These reporting requirements include measurement of the following asset performance indicators:

A. condition
B. utilisation
C. functionality (fitness for purpose).

Waitematā DHB defines asset performance measures across the three asset portfolios either at the portfolio level or for critical assets within that portfolio. These are set out in the tables below. The DHB's Asset Management Leadership Group leads the development of asset management maturity for the organisation. This group undertakes a formal review of all asset performance measures on a quarterly basis to review results and adjust targets as required to drive continual improvement of the DHB's asset management practice.

The commentary section below the following tables of figures provides explanation where a significant adverse variance to target was recorded.

Facilities asset portfolio

The asset performance measures for the facilities portfolio reflect the need to ensure that the facilities are in acceptable condition, are well utilised without being at or over capacity, and meet compliance requirements. Building condition is maintained above poor and very poor condition by targeted refurbishment works. Targeted criticality assessments are underway and the condition of building stock is surveyed on a rolling 5-year basis to help inform future building and plant works.

Measure		Indicator	2021/22 Target	2021/22 Actual	2020/21 Target	2020/21 Actual
1.1	**Facility condition** Percentage of occupied buildings rated as 'poor' or 'very poor' condition *Assessment of facility condition based on visual inspection, reported as % of overall buildings value in 'poor' or 'very poor' condition (condition grading levels: very poor, poor, average, good, very good).*	Condition	<5%	2.56%	<5%	2.69%
1.2	**Facility utilisation based on bed occupancy** Average Medical/Surgical Bed occupancy *Average occupation of inpatient beds throughout the year. (Excluding short stay and ICU beds). The occupation of beds provides an indication of total utilisation across wards and surgical theatres. The target reflects the variation between peak winter and low summer demand.*	Utilisation	≥85%	88.8%	≥85%	92.1%

Measure		Indicator	2021/22 Target	2021/22 Actual	2020/21 Target	2020/21 Actual
1.3	**Theatre utilisation** Elective Theatre Utilisation *Performance against annual production plan for elective theatre utilisation. This measures how well the theatre spaces are utilised (across all surgeries) based on the number of 4 hour lists completed.*	Utilisation	≥95%	85.2%[51]	≥95%	96.3%
1.4	**Seismic compliance** Number of owned occupied buildings classed as 'potentially earthquake prone' *Number of owned occupied buildings with seismic state based on NBS of <34%. The target reflects the importance of having facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	0	1[51]	0	1
1.5	**Seismic compliance** Number of owned occupied buildings classed as "Potentially Earthquake Risk" *Number of owned occupied buildings with seismic state based on NBS of between 34% and 67%. The target reflects the importance of having patient and staff facilities that do not have a high risk of failure in a seismic event.*	Functionality (Fitness for Purpose)	≤10	10	≤10	10
1.6	**Seismic status of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is known *The current seismic status of some leased buildings is unknown as assessments have either not been carried out by landlords, or the information has not been provided by landlords.*	Functionality (Fitness for Purpose)	>85%	94.9%	>85%	88.6%
1.7	**Seismic compliance of leased buildings** Percentage of leased occupied buildings where seismic status (% NBS) is >67% NBS. *This is to assess the current state of leased buildings and indicate where further work is required or alternative accommodation options should be considered (where possible). Actions are in progress with landlords to bring buildings up to >67%.*	Functionality (Fitness for Purpose)	>70%	82.1%	>70%	70.5%
1.8	**Car parking compliance** Mobility car park spaces as a percentage of total car park spaces to be greater than New Zealand Guideline 4121 *Percentage of mobility spaces at Waitakere and North Shore Hospitals as percentage of total spaces. The target is based on the New Zealand Standards 4121 and was approved by the Waitematā DHB Disability Advisory Committee as part of delivering the New Zealand Disability Strategy.*	Functionality (Fitness for Purpose)	100%	140%	100%	133%

[51] See explanation 1.3 in commentary section

Clinical equipment asset portfolio

The asset performance measures for the clinical equipment portfolio reflect the need to ensure that the clinical equipment meets compliance/testing requirements, and that equipment is available to meet the service delivery needs of the clinical services.

Measure		Indicator	2021/22 Target	2021/22 Actual	2020/21 Target	2020/21 Actual
2.1	**CT Scanners Condition** Compliance with six monthly physics testing *Assessment of CT integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%	100%	100%
2.2	**MRI Condition** Compliance with annual physics testing *Assessment of MRI integrity and condition to ensure it meets health and safety requirements for radiological equipment. 100% compliance ensures assets operate safely and do not adversely impact health and safety of staff and patients.*	Condition	100%	100%	100%	100%
2.3	**CT Scanners Utilisation** Annual CT screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available and staffing resources within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	100%	≥100%	115%
2.4	**MRI Utilisation** Annual MRI screening productivity *Percentage of available scanning slots completed within operational business hours. (This takes account of the booking slots available within operational hours). This target was set by the service management and is intended to ensure the asset is fully utilised during operational hours.*	Utilisation	≥100%	150%	≥100%	141%
2.5	**Clinical Equipment Functionality** Critical clinical equipment passing monthly 'functionality test' *Percentage of critical clinical equipment that is inspected and passes functionality test against schedule. The target reflects the importance of having high criticality equipment fit for purpose and available when required. Critical clinical equipment are those that are classed as having high consequences associated with failure.*	Functionality (Fitness for Purpose)	100%	93%[52]	100%	97%
2.6	**Clinical Equipment Condition (Age Based)** Critical clinical equipment less than 3 years past End-of-Life *Percentage of critical clinical equipment that has not reached the end of its useful life, or is up to 3 years past the end of its useful life, where useful life is an assumed typical working life for each type of equipment. This is a new measure introduced on 1 July 2018. The target reflects current performance and is being actively increased over time.*	Condition	>80%	82%	>80%	83%
2.7	**Clinical Equipment Condition** Critical clinical equipment in above average or average condition *Percentage of critical clinical equipment in above average or average condition based on the methodology for measuring asset condition against AS/New Zealand 3551 as developed by the Clinical Engineering New Zealand Managers Forum (March 2017).*	Condition	>85%	99%	>85%	100%
2.8	**Clinical Equipment Maintenance** Number of non-scheduled maintenance visits/total number of maintenance visits (critical clinical equipment) *Based on the number of assets that are subject to non-scheduled corrective maintenance, or risk/incident management as a percentage of total maintenance visits (annual preventative maintenance plus non-scheduled maintenance). This is a new measure introduced on 1 July 2018.*	Functionality (Fitness for Purpose)	<35%	23%	<35%	21%

[52] See explanation 2.5 in commentary section

ICT asset portfolio

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

Measure		Indicator	2021/22 Target	2021/22 Actual	2020/21 Target	2020/21 Actual
3.1	**ICT Tier 1 Applications Functionality** Availability of IT Services (Tier 1 Apps) *Measures the operational integrity, performance and stability of Tier 1 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.996%	99.8%	100%
3.2	**ICT Tier 2 Applications Functionality** Availability of IT Services (Tier 2 Apps) *Measures the operational integrity, performance and stability of Tier 2 applications serving the DHB. Based on the number of minutes each system is available in month (during its hours of service)/Number of minutes each system is potentially available in month. Excluding planned outages. Target is in the 2012 SLA between health Alliance and the DHB.*	Functionality (Fitness for Purpose)	99.8%	99.996%	99.8%	100%
3.3	**End User Devices – Asset Age** Percentage of devices compliant with asset age replacement policy *The percentage of end user devices (excl. mobile and tablet) that comply with the asset age specified in the DHB replacement policy.*	Condition	>75%	91%	>75%	87%
3.4	**End User Devices - Security** Percentage of devices compliant with security update policy *Measures the date of the last security patch of end user devices (excl. mobile and tablet), then determines how many devices expressed as a percentage comply with the DHB security update policy.*	Condition	>80%	73%[53]	>80%	94%
3.5	**Software (Applications) - Condition** Percentage of applications with installed version number older than n-1 *Shows which applications are either at the current version or are one version behind the current version.*	Condition	>55%	92%	>55%	77%
3.6	**Software (Applications) – Service Interruptions** % of applications not experiencing Service Level Agreement (SLA) breaches (service interruptions) *Measures the percentage of applications that do not show as 'SLA breached' (service interruptions) on a per monthly count over a 12-month period.*	Functionality (Fitness for Purpose)	>80%	82%[54]	>80%	100%
3.7	**Software (Applications) – Redundancy or Resiliency** Percentage of applications architected for redundancy or resiliency *Percentage of Top 55 Tier 1 applications that are deployed on corresponding Tier 1 architecture at the end of the reporting period. Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).*	Functionality (Fitness for Purpose)	>30%	69%	>30%	67%
3.8	**Software (Applications) – Supportability** Percentage of assets supportable under Tier 1 Service Level Agreement (SLA) guidelines *Percentage of Top 55 Tier 1 applications that are labelled 'supportable to Tier 1' at the end of the reporting period.*	Functionality (Fitness for Purpose)	>30%	81%	>30%	78%

[53] See explanation 3.4 in commentary section

[54] See explanation 3.6 in commentary section

	Measure	Indicator	2021/22 Target	2021/22 Actual	2020/21 Target	2020/21 Actual
	Note that "Top 55" = Top 10 important apps for DHB, plus 15 additional "Apps of importance" (regional).					
3.9	**Technology Platforms (Physical and Virtual) – Condition** Percentage of windows systems that have been checked and patched, across all production and non-production environments. *Measures the percentage of systems that are captured and updated under the recently implemented rolling 13 week programme for server patching.*	Condition	>75%	92%	>75%	92%
3.10	**Technology (Tier 1 and Tier 2 systems) – Service Interruptions** Number of Service Level Agreement (SLA) breaches (service interruptions) recorded against application asset over a 12-month period. *Measures the count of unplanned service interruptions.*	Condition	<20	3.93	<20	3.08
3.11	**Technology (Remote Platform) Utilisation** Percentage of staff able to access clinical/non-clinical system platforms remotely. *Measures the percentage of unique user's activity against the total users.*	Utilisation	>35%	61%	>35%	58%

Commentary

This section provides explanation where a significant adverse variation to target was recorded in the asset portfolio tables.

1.3 Theatre utilisation	Q1: COVID-19 lockdown on 17 August saw the closure/suspension of elective surgery. As a result, only 75.4% of scheduled elective lists were held in Q1; and only 84.1% (1,265 of 1,504 planned) were held in Q2. The Elective Surgery Centre (ESC) was only open 7 weeks out of 32 weeks during this time. Q3: ESC only open 27% (124 of 454 scheduled lists), but NSH 98.5% (928 of 942 lists) and WTH 129% (165 of 128 planned). Q4: a result of 101.5% for the final quarter (1,576 cf. 1,552 planned) was aided by a large number of additional theatre lists being held in weekends and as extra weekday sessions. The full year 85.2% average was predominantly impacted by the ESC closure (being used as a COVID-19 ward), which finished the year having held only 48.8% of its scheduled 1,912 annual lists - as compared to a normal year at around 98%.
1.4 Seismic compliance	One building (B15N) has been identified as non-compliant. As per the Board's request, the Facilities Services Group has completed a Detailed Seismic Assessment (DSA) of this building. The DSA has identified some structural weakness with this building and we are engaging a Structural consultant to complete a remedial design and estimated cost to repair to back up a business case to PIC.
2.5 Clinical Equipment Functionality	Clinical Engineering prioritises repairs and Planned Maintenance routines on ECRI Risk 1 equipment (Life preserving equipment) & Risk 2 (High Criticality). In 2018 Waitematā undertook an exercise to include an additional "self-assessed" Service Assessed Criticality for clinical equipment, to take into account local risk considerations. Waitematā were the only DHB to introduce this additional measure, which has been included within the Waitematā asset performance measures since 2018. However, it has proved increasingly difficult to update the "self-assessed" Service Assessed Criticality rating to reflect changing local circumstances for each item of clinical equipment in every department. During FY 21/22 the Waitematā Asset Management Leadership Group agreed to remove this additional self-assessed criticality rating from the asset performance measures (reporting just on ECRI risk assessment) in order to align with the approach followed by other Te Whatu Ora Districts. Waitematā will retain the self-assessed Service Assessed Criticality scores within the clinical equipment database as an internal reference field for ongoing asset replacement.

3.4 End User Devices – Security	Q3: healthAlliance could not patch PCs due to printer software issues across Waitematā DHB. This was addressed and roll out resumed. Q4 : No updates available as Windows 7 at end of life. Windows 10 deployments long term approach in progress.
3.6 Software (Applications) - Service Interruptions	Q4 : SLA14 breached in June 2022 due to a Trend Micro Anti-Virus update that impacted the bulk of the Windows 7 fleet over 6 days

Financial statements

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Waitematā DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Waitematā District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Waitematā DHB group under section 19A of the Public Finance Act.

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waitematā District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

Naomi Ferguson

Acting Chair

Dated: 12 April 2023

Hon Amy Adams

Board member

Dated: 12 April 2023

Statement of comprehensive revenue and expense for the year ended 30 June 2022

	Notes	Group Actual 2022 $000	Group Actual 2021 $000	Parent Actual 2022 $000	Group and Parent Budget 2022 $000	Parent Actual 2021 $000
Revenue						
Patient care revenue	2	2,323,791	2,020,028	2,323,791	2,189,981	2,020,028
Interest revenue		1,701	1,276	1,325	352	905
Other revenue	3	41,949	48,341	41,902	36,725	49,826
Total revenue	31	2,367,441	2,069,645	2,367,018	2,227,058	2,070,759
Expenditure						
Personnel costs	4	973,323	831,433	973,323	846,806	831,433
Depreciation and amortisation expense	13,14	34,008	30,838	34,008	31,853	30,838
Outsourced services		98,350	100,152	98,350	104,901	100,152
Clinical supplies		149,465	130,095	149,465	150,830	130,095
Infrastructure and non-clinical expenses		55,271	40,924	55,271	11,579	44,588
Other district health boards		378,634	351,705	378,634	380,671	351,705
Non-health board provider expenses		709,723	598,467	709,723	708,810	598,467
Capital charge	5	27,126	21,347	27,126	20,004	21,347
Other expenses	6	17,901	25,702	17,901	11,104	25,702
Total expenditure	31	2,443,801	2,130,663	2,443,801	2,266,558	2,134,327
Surplus/(deficit)		**(76,360)**	**(61,018)**	**(76,783)**	**(39,500)**	**(63,568)**
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations	19	110,102	149,424	110,102	0	149,424
Total other comprehensive revenue and expense		110,102	149,424	110,102	0	149,424
Total comprehensive revenue and expense		**33,742**	**88,406**	**33,319**	**(39,500)**	**85,856**

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

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2022

	Notes	Group Actual 2022 $000	Group Actual 2021 $000	Parent Actual 2022 $000	Group and Parent Budget 2022 $000	Parent Actual 2021 $000
Balance at 1 July		572,955	460,149	553,378	432,824	443,122
Equity injections		32,461	24,400	32,461	57,660	24,400
		605,416	484,549	585,839	490,484	467,522
Comprehensive Income						
Surplus/(Deficit)		(76,360)	(61,018)	(76,783)	(39,500)	(63,568)
Other comprehensive revenue and expense						
Gain/(Loss) on property revaluations		110,102	149,424	110,102	0	149,424
Total comprehensive revenue and expense for the year		**33,742**	**88,406**	**33,319**	**(39,500)**	**85,856**
Balance at 30 June	19	**639,158**	**572,955**	**619,158**	**450,984**	**553,378**

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

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2022

	Notes	Group		Parent	Group and Parent	Parent
		Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Budget 2022 $000	Actual 2021 $000
Assets						
Current assets						
Cash and cash equivalents	7	47,882	81,691	41,973	345	77,468
Receivables	8	147,740	70,165	147,115	65,483	71,025
Investments	9	1,538	962	0	500	0
Inventories	10	11,209	9,729	11,209	11,000	9,729
Prepayments		7,696	4,898	7,696	4,840	4,898
Assets held for sale	11	0	0	0	0	0
Total current assets		216,065	167,445	207,993	82,168	163,120
Non-current assets						
Investments	9	13,919	15,407	0	15,000	0
Investments in associates and joint ventures	12	48,364	48,553	48,364	47,590	48,553
Property, plant and equipment	13	1,116,948	933,382	1,116,948	896,241	933,382
Intangible assets	14	9,202	11,147	9,202	3,367	11,147
Total non-current assets		1,188,433	1,008,489	1,174,514	962,198	993,082
Total assets		**1,404,498**	**1,175,934**	**1,382,507**	**1,044,366**	**1,156,202**
Liabilities						
Current liabilities						
Payables	15	227,144	173,772	225,153	169,808	173,617
Borrowings	16	0	0	0	0	0
Employee entitlements	17	468,577	361,885	468,577	371,174	361,885
Provisions	18	13,296	11,129	13,296	1,900	11,129
Total current liabilities		709,017	546,786	706,026	542,882	546,631
Non-current liabilities						
Borrowings	16	0	0	0	0	0
Employee entitlements	17	56,323	56,193	56,323	50,500	56,193
Total non-current liabilities		56,323	56,193	56,323	50,500	56,193
Total liabilities		**765,340**	**602,979**	**763,349**	**593,382**	**602,824**
Net assets		**639,158**	**572,955**	**619,158**	**450,984**	**553,378**
Equity						
Contributed Capital	19	464,832	432,371	464,832	490,031	432,371
Accumulated surpluses/(deficits)	19	(394,650)	(317,867)	(394,650)	(347,808)	(317,867)
Property Revaluation Reserves	19	548,976	438,874	548,976	289,451	438,874
Trust funds	19	20,000	19,577	0	19,310	0
Total equity		**639,158**	**572,955**	**619,158**	**450,984**	**553,378**

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

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2022

	Notes	Group Actual 2022 $000	Group Actual 2021 $000	Parent Actual 2022 $000	Group and Parent Budget 2022 $000	Parent Actual 2021 $000
Cash flows from operating activities						
Receipts from patient care:						
MoH		2,245,929	1,997,835	2,245,929	2,194,621	1,997,835
Other		42,218	54,425	53,858	26,735	54,725
Interest received		1,273	1,003	1,273	352	672
Payments to suppliers		(1,380,678)	(1,222,540)	(1,394,004)	(1365,495)	(1,222,540)
Payments to employees		(866,102)	(768,514)	(866,102)	(806,472)	(768,514)
Payments for capital charge		(13,758)	(21,397)	(13,758)	(20,004)	(21,397)
GST (net)		(154)	(1,184)	(154)	0	(1,184)
Net cash flow from operating activities	20	28,728	39,628	27,042	29,737	39,597
Cash flows from investing activities						
Sale of fixed assets		0	38,832	0	0	38,832
Purchase of property, plant and equipment		(95,211)	(76,418)	(95,211)	(163,486)	(76,418)
Acquisition of investments		212	(1,316)	212	0	(1,316)
Net cash flow from investing activities		(94,999)	(38,902)	(94,999)	(163,486)	(38,902)
Cash flows from financing activities						
Capital contributions from the Crown		32,462	24,400	32,462	57,660	24,400
Net cash flow from financing activities		32,462	24,400	32,462	57,660	24,400
Net (decrease)/increase in cash and cash equivalents		**(33,809)**	**25,126**	**(35,495)**	**(76,089)**	**25,095**
Cash and cash equivalents at the start of the year		81,691	56,565	77,468	76,434	52,373
Cash and cash equivalents at the end of the year	7	**47,882**	**81,691**	**41,973**	**345**	**77,468**

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

The accompanying notes form part of these financial statements.

Notes to the financial statements

1 Statement of accounting policies for the year ended 30 June 2022

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 2022 comprise Waitematā DHB and its subsidiaries (together referred to as the "Group"). The Group consists of the controlling entity, Waitematā District Health Board and the Three Harbours Health Foundation.

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

The DHB's subsidiaries, associates and joint arrangements are incorporated and domiciled in New Zealand.

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

The financial statements for the DHB and the Group are for the year ended 30 June 2022 and were approved for issue by the Board on 12 April 2023.

Basis of preparation

Health Sector Reforms
On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the DHB's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

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's).

Changes in accounting policies and disclosures – New and amended standards and interpretations
Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. The disclosure about the amendment to PBE IPSAS 2 is no longer relevant because this is effective for the 30 June 2022 financial statements.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

Standards issued and not yet effective, and not early adopted

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

PBE IPSAS 41 Financial Instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. The group has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. The group does not intend to early adopt the standard.

Subsidiaries

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

Joint Arrangements

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

Joint Venture

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

Joint Operation

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

Associates

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

Revenue

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

Revenue from exchange transactions

MoH population-based revenue

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

MoH contract revenue

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

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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

ACC contracted revenue

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

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

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

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

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

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

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

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

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

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

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

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

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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

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

Financial assets at amortised cost are subsequently measured using the effective interest rate (EIR) method and are subject to impairment. Gains and losses are recognised in surplus or deficit when the asset is derecognised, modified or impaired. The DHB and Group measure the following financial assets at amortised cost, Cash and cash equivalents, Short Term Deposits, Trade and Other Receivables, Prepayments and Trusts and Special Purpose Funds not recognised at a market value. Cash and cash equivalents include cash on hand, deposits held at call with banks and with NZ Health Partnerships Limited, other short-term highly liquid investments with original maturities of three months or less.

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

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

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

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

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

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

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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

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

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

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

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

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

Inventories
Inventories held for distribution at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge are measured at cost (using the Weighted Average Cost 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 Weighted Average Cost 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.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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) 1 to 80 years (1.25%-50%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 4 to 20 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 is recognised as an expense when incurred.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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

- Acquired software 3 to 10 years (20%-33%)
- Internally developed software 3 to 10 years (20%-33%).

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

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

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

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

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

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

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

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

Presentation of employee entitlements
Sick Leave, continuing medical education, annual leave, vested long service and sabbatical leave that are 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.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

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

Provisions

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

Make Good Lease Provision

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

ACC Accredited Employers Programme

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

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

Equity

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

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

Contributions from/ (repayment to) the Crown

Contributions from the Crown for DHB Crown approved projects.

Property Revaluation reserve

The revaluation reserve movement relates to the independent valuation of land and buildings carried out by CBRE.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

Trust/special funds
Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds. All trust funds are held in bank accounts that are separate from the DHB's normal banking facilities. Refer to Note 31 for details.

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

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

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

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

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:

Estimating the fair value of Land and building
The most recent valuation of land and buildings was performed by an independent registered valuer, Evan Gamby – M Prop Stud (Distn); Dip UV; FNZIV (Life); LPINZ; FRICS; Registered Valuer of CBRE. The valuation is effective as at 30 June 2022. Note 13 provides more details.

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.

1 Statement of accounting policies for the year ended 30 June 2022 (continued)

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

Estimating the liabilities for retirement gratuities, sabbatical leave and continuing medical education leave
Note 17 provides an analysis of the exposure in relation to estimates and uncertainties surrounding these leave liabilities.

Measuring the liabilities for Holidays Act 2003 remediation
Refer to Note 17 for details on the exposure in relation to the estimates and uncertainties surrounding provisions for Holidays Act 2003 remediation.

Provision for expected credit losses
The Group uses a provision matrix to calculate ECLs for trade and other receivables and contract assets. The provision rates are based on days past due. The ECL calculation is initially based on the Group's historical observed default rates. The Group will adjust the historical credit loss experience with forward-looking information. For instance, if forecast economic conditions are expected to deteriorate over the next year, the historical default rates are adjusted. At every reporting date, the historical observed default rates are updated and changes in the forward-looking estimates are analysed. The assessment of the correlation between historical observed default rates, forecast economic conditions and ECLs is a significant estimate. The amount of ECLs is sensitive to changes in circumstances and of forecast economic conditions. The

Group's historical credit loss experience and forecast of economic conditions may also not be representative of customer's actual default in the future. The information about the ECLs on the Group's trade receivables and contract assets is disclosed in Note 8.

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

Leases classification
Determining whether a lease agreement is a finance, or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The DHB has exercised its judgement on the appropriate classification of leases.

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

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

2 Patient care revenue

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Health and disability services (MOH contracted revenue)	2,138,662	1,885,270	2,138,662	1,885,270
ACC contract revenue	18,650	12,651	18,650	12,651
Inter district patient inflows	97,326	88,797	97,326	88,797
Revenue from other district health boards	51,910	15,396	51,910	15,396
Other patient sourced revenue	17,243	17,914	17,243	17,914
Total patient care revenue	**2,323,791**	**2,020,028**	**2,323,791**	**2,020,028**

3 Other revenue

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Clinical Training Agency	10,141	9,886	10,141	9,886
Donations and bequests received	1,961	1,735	1,961	1,735
Rental revenue	783	883	783	883
Professional, training and research	5,672	3,072	5,672	6,736
Dividend income	0	0	0	0
Gain on sale of assets held for sale	9	10,496	9	10,496
Other revenue	23,383	22,269	23,336	20,090
Total other revenue	**41,949**	**48,341**	**41,902**	**49,826**

4 Personnel costs

	Group		Parent	
Notes	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Salaries and wages	838,934	746,869	838,934	746,869
Contributions to defined contribution schemes	27,567	21,172	27,567	21,172
Increase/(decrease) in liability for employee entitlements	106,821	63,392	106,821	63,392
Total personnel costs	**973,322**	**831,433**	**973,322**	**831,433**

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

5 Capital charge

The DHB pays a capital charge to the Crown twice a year on 30 June and 31 December. The charge is based on the previous six-month actual closing equity balance. The capital charge rate for the year ended 30 June 2022 was 5% (2021: 5%).

6 Other expenses

	Notes	Group Actual 2022 $000	Group Actual 2021 $000	Parent Actual 2022 $000	Parent Actual 2021 $000
Audit fees for Waitematā DHB financial statement audit		310	266	310	266
Audit fees (for subsidiary financial statements)		0	0	0	0
Operating lease expense		15,939	11,427	15,939	11,427
Impairment of debtors	8	1,210	1,794	1,210	1,794
Impairment of Work in Progress		0	10,530	0	10,530
Disposal of Work in Progress		0	1,091	0	1,091
Board members fees	24	483	357	483	357
Other expenses		(41)	236	(41)	237
Total other expenses		**17,901**	**25,702**	**17,901**	**25,702**

No audit fees have been incurred for the subsidiary financial statements for the current or prior financial year as these audits are still outstanding. The DHB is working with their external auditors to complete the work required to obtain an appropriate level of assurance.

7 Cash and cash equivalents

The carrying value of cash at bank and term deposits with maturities less than three months approximates their fair value. Cash and cash equivalents include funds of $5.912m (2021: $4.230m) generated for specific purposes such as research. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is recognised in the surplus or deficit and is transferred from/to trust funds in equity.

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

	Group Actual 2022 $000	Group Actual 2021 $000	Parent Actual 2022 $000	Parent Actual 2021 $000
Cash at bank and on hand	5,912	4,230	3	7
Call deposits	0	0	0	0
NZ Health Partnerships Limited	41,970	77,461	41,970	77,461
Total cash and cash equivalents for the purposes of the statement of cash flows	**47,882**	**81,691**	**41,973**	**77,468**

8 Receivables

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Ministry of Health	38,213	43,644	38,213	43,644
Other receivables	30,372	15,723	29,747	15,051
Other accrued revenue	81,361	13,886	81,361	15,418
Less: Provision for impairment	(2,206)	(3,088)	(2,206)	(3,088)
Total receivables	**147,740**	**70,165**	**147,115**	**71,025**

Fair value
The carrying value of debtors and other receivables approximates their fair value.

Impairment
The ageing profile of trade receivables at year end is detailed below.

	Group 2022			Group 2021		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	140,140	(31)	140,190	66,329	(29)	66,300
Past due 1-30 days	3,861	(212)	3,649	1,805	(130)	1,675
Past due 31-60 days	863	(122)	741	1,391	(147)	1,244
Past due 61-90 days	367	(120)	247	868	(173)	695
Past due >90 days	4,715	(1,721)	2,994	4,392	(2,609)	1,783
Total	**149,946**	**(2,206)**	**147,740**	**74,785**	**(3,088)**	**71,697**

	Parent 2022			Parent 2021		
	Gross $000	Impairment $000	Net $000	Gross $000	Impairment $000	Net $000
Not past due	142,361	(31)	142,330	67,153	(29)	67,124
Past due 1-30 days	1,067	(212)	855	1,067	(130)	937
Past due 31-60 days	1,361	(122)	1,239	1,361	(147)	1,214
Past due 61-90 days	362	(120)	242	362	(173)	189
Past due >90 days	4,170	(1,721)	2,449	4,170	(2,609)	1,561
Total	**149,321**	**(2,206)**	**147,115**	**74,113**	**(3,088)**	**71,025**

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

The average expected credit loss rates are detailed below.

	Group		Parent	
	2022 Rate	2021 Rate	2022 Rate	2021 Rate
Not past due	0%	0%	0%	0%
Past due 1-30 days	5%	7%	20%	12%
Past due 31-60 days	14%	11%	9%	11%
Past due 61-90 days	33%	20%	33%	48%
Past due >90 days	37%	59%	41%	63%

Provision for impairment is calculated based on a review of significant debtor balances and an assessment of impairment using an “expected credit loss” model. The impairment assessment is based on an analysis of the likelihood to pay based on current circumstances and past collection history and write-offs. The expected credit loss rate is variable depending on the debtor category, therefore average rates across all categories have been included above.

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

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Balance at 1 July	3,088	(3,192)	3,088	(3,192)
Additional provisions made	1,210	(1,794)	1,210	(1,794)
Receivables written off	(2,092)	1,898	(2,092)	1,898
Balance at 30 June	**(2,206)**	**(3,088)**	**(2,206)**	**(3,088)**

9 Investments

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

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
Current portion				
Term deposits with maturities greater than 3 months and remaining duration less than 12 months	1,538	962	0	0
Total current portion	1,538	962	0	0
Non-current portion				
Portfolio investments	13,919	15,407	0	0
Total non-current portion	13,919	15,407	0	0
Total investments	**15,457**	**16,369**	**0**	**0**

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

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

The fair value of portfolio investment with a remaining duration greater than 12 months is $13.919m (2021: $15.407m). The fair value has been calculated based on quoted market prices at the balance sheet date without deduction for transaction costs.

10 Inventories

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Pharmaceuticals	765	764	765	764
Surgical and medical supplies	10,444	8,965	10,444	8,965
Total inventories	**11,209**	**9,729**	**11,209**	**9,729**

The write-down of inventories held for distribution amounted to $nil (2021: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities (2021: $nil). However, some inventories are subject to retention of title clauses.

11 Assets held for sale

There are no assets held for sale as at 30 June 2022 (2021: nil).

12 Investments in associates and joint ventures

	Principal activity	Interest held 30 Jun 2022	Balance date
Investments in joint ventures			
healthAlliance N.Z. Limited – Class A shares	Provider of shared services	25%	30 Jun
Healthsource New Zealand Limited	Provider of shared services	25%	30 Jun
Investments in associates			
Northern Regional Alliance Ltd (formerly Northern DHB Support Agency)	Provision of health support services	33.3%	30 Jun

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

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

12 Investments in associates and joint ventures (continued)

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

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

Value of investments in associates, joint ventures and partnerships

	Group		Parent	
	2022 $000	2021 $000	2022 $000	2021 $000
healthAlliance N.Z. Limited	47,394	47,783	47,394	47,783
HealthSource New Zealand Limited	170	170	170	170
McCrae Research	800	600	800	600
Total investments	**48,364**	**48,553**	**48,364**	**48,553**

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.

There were no impairment losses in the value of associates and joint ventures assessed for 2022 (2021: $nil). The fair value of the group's investment in healthAlliance N.Z. Limited is the same as the book value $47.394m (2021: $47.783m).

Summary of financial information of associates

	Assets $000	Liabilities $000	Equity $000	Revenue $000	Surplus/(deficit) $000
2022					
Northern Regional Alliance Ltd	24,904	20,689	4,214	20,751	(549)
Total	**24,904**	**20,689**	**4,214**	**20,751**	**(549)**
2021					
Northern Regional Alliance Ltd	26,653	21,890	4,764	18,576	1,207
Total	**26,653**	**21,890**	**4,764**	**18,576**	**1,207**

Summary of financial information of joint ventures

healthAlliance N.Z. Limited	2022 $000	2021 $000
Current assets	33,591	42,384
Non-current assets	201,202	197,263
Current Liabilities	35,875	32,058
Non-current liabilities	7,235	9,639
Included in the above amounts are:		
Cash and cash equivalents	8,939	25,731
Current financial liabilities (excluding trade payables)	13,279	10,286
Non-current financial liabilities (excluding trade payables)	7,235	9,639
Net assets (100%)	**191,683**	**197,951**
Revenue	177,500	152,357
Other comprehensive income	0	0
Total comprehensive income (100%)	(5,804)	(80)
Included in the above amounts are:		
Depreciation and amortisation	50,363	47,363
Interest income	82	68
Interest expense	429	507

12 Investments in associates and joint ventures (continued)

HealthSource New Zealand Limited	2022 $000	2021 $000
Current assets	9,684	8,876
Non-current assets	288	206
Current Liabilities	7,535	6,706
Non-current liabilities	1,655	1,663
Included in the above amounts are:		
Cash and cash equivalents	7,339	7,553
Current financial liabilities (excluding trade payables)	5,015	4,378
Non-current financial liabilities (excluding trade payables)	1,655	1,663
Net assets (100%)	**782**	**711**
Revenue	43,542	42,265
Other comprehensive income	0	0
Total comprehensive income (100%)	71	76
Included in the above amounts are:		
Depreciation and amortisation	48	95
Interest income	78	49
Interest expense	0	0

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

	2022 $000	2021 $000
Share of surplus/(deficit) before tax:	(1,651)	401
Less: Tax expense	0	0
Share of surplus/(deficit)	**(1,651)**	**401**

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

13 Property, plant and equipment

Parent and Group	Land $000	Buildings $000	Clinical Equipment $000	Other Equipment $000	IT Equipment $000	Work in Progress $000	Total $000
Cost or valuation							
Balance at 1 July 2020	266,838	424,887	144,111	37,821	6,107	47,225	926,989
Additions from WIP	0	33,324	8,890	1,289	626	(44,129)	0
Revaluation increase/(decrease)	77,433	13,899	0	0	0	0	91,333
Additions to WIP	0	0	0	0	0	82,074	82,074
Disposals	0	0	0	(362)	(855)	(1,091)	(2,308)
Transfer to intangible assets	0	0	0	0	0	0	0
Transfer to assets held for sale	0	0	0	0	0	0	0
Balance at 30 June 2021	**344,271**	**472,110**	**153,001**	**38,748**	**5,878**	**84,079**	**1,098,088**
Balance at 1 July 2021	344,271	472,110	153,001	38,748	5,878	84,079	1,098,087
Additions from WIP	11	21,065	8,817	1,254	1,223	(32,370)	0
Revaluation increase/(decrease)	0	96,533	0	0	0	0	96,533
Additions to WIP	0	0	0	0	0	107,066	107,066
Disposals	0	(2,425)	(58,929)	(12,908)	(3,140)	0	(77,402)
Transfer to intangible assets	0	0	0	0	0	0	0
Transfer to assets held for sale	(881)	881	0	0	0	0	0
Balance at 30 June 2022	**343,401**	**588,164**	**102,889**	**27,094**	**3,961**	**158,775**	**1,224,284**
Accumulated depreciation and impairment losses							
Balance at 1 July 2020	0	40,758	110,494	29,122	4,966	0	185,340
Depreciation expense	0	17,335	7,625	2,167	163	0	27,290
Impairment losses	0	0	0	0	0	10,531	10,531
Elimination on disposal/transfer	0	0	0	(362)	0	0	(362)
Elimination on revaluation	0	(58,093)	0	0	0	0	(58,093)
Balance at 30 June 2021	**0**	**0**	**118,119**	**30,927**	**5,129**	**10,531**	**164,707**
Balance at 1 July 2021	0	0	118,119	30,927	5,129	10,531	164,706
Depreciation expense	0	21,173	7,998	2,137	605	0	31,913
Impairment losses	0	0	0	0	0	1,674	1,674
Elimination on disposal/transfer	0	(2,407)	(58,929)	(12,884)	(3,140)	0	(77,360)
Elimination on revaluation	0	(13,597)	0	0	0	0	(13,597)
Balance at 30 June 2022	**0**	**5,169**	**67,188**	**20,180**	**2,594**	**12,205**	**107,336**
Carrying amounts							
At 1 July 2020	266,838	384,129	33,617	8,699	1,141	47,225	741,649
At 30 June and 1 July 2021	344,271	472,110	34,882	7,821	749	73,548	933,381
At 30 June 2022	**343,401**	**582,995**	**35,701**	**6,914**	**1,367**	**146,570**	**1,116,948**

The net carrying amounts of assets held under finance leases is nil (2021: nil) for clinical equipment. There are no IT assets in Work in Progress that need to be transferred to healthAlliance N.Z. Limited (2021: nil).

Impairment losses of $1.7m were recognised in the year (2021: $10.5m:) against work in progress projects. This has been recognised where there is risk that costs will not result in an asset due to uncertainty around the project's completion or the value that the completed project would provide the DHB. No work in progress costs were disposed of for projects that have been discontinued (2021: $1.1m).

Estimating the fair value of land and buildings
The most recent valuation of land and buildings was performed by an independent registered valuer, Evan Gamby – M Prop Stud (Distn); Dip UV; FNZIV(Life); LPINZ; FRICS; Registered Valuer of CBRE. The valuation is effective as at 30 June 2022.

Land
Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land, or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely. There is an on-going concerted effort from the Local and Central Government to manage land values and this may influence the fair value allocated at this point.

13 Property, plant and equipment (continued)

Land values were determined using a number of significant assumptions. Significant assumptions used in the 30 June 2022 valuation include:

- The land values that have been applied across the sites range from $435 to $3,000 (2021: $435 to $3,000) per square meter across all sites. The values of recent sales in this review varied from $398.77/m2 to $9,113.65/m2.
- Deductions have been applied to estimated land values to reflect impediments that prevent the land from being used at its highest and best use. These deductions range from 10% to 15% (2021: 10% to 15%) of the highest and best use value.

Buildings

All DHB Assets that have been valued are specialised hospital buildings (with the exception of 3 Mary Poynton Crescent). They are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. There is has been added uncertainty to the estimate of replacement cost forecasts due to the impact that COVID-19 and other related events have had and may have on supply chain of materials and labour market shortages.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions used in the 30 June 2022 valuation include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity. There have been no optimisation adjustments for the most recent valuation
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information
- There are no significant asbestos issues associated with the buildings and therefore no allowance made for deferred maintenance in this regard
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, the DHB's future maintenance and replacement plans, and experience with similar buildings. Residual lives of buildings on average have been reduced by 2 years since the 2021 valuation. This is due to reassessment of planned future maintenance costs and this has impacted the expected residual lives.
- Future maintenance costs relating to the current state of buildings have been considered over a 5 year period from 1 July 2022. This cost is estimated to be $84.3m and has been factored into the valuation of the buildings
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset
- The valuation considered the current understanding of the seismic condition of the buildings. Buildings that are an earthquake risk have been accorded a low or nil value by an adjustment to their respective residual life and an allowance for deferred maintenance where known.

Depreciation replacement costs varied depending on the location and nature of the building space. The following depreciation replacements ranges have been applied to the valuation estimation:

2022 Valuation	Specialist Patient Care buildings ($/m2)	Non-Specialist Patient buildings ($/m2)
North Shore Hospital Site	$3,139 to $17,662	$1,558 to $11,376
Waitakere Hospital Site	$3,380 to $13,345	$757 to $3,852
Mason Clinic Site	$2,938 to $10,818	$664 to $3,487

2021 Valuation (excluding buildings sold during the 2022 financial year)	Specialist Patient Care buildings ($/m2)	Non-Specialist Patient buildings ($/m2)
North Shore Hospital Site	$3,042 to $18,674	$892 to $8,757
Waitakere Hospital Site	$3,601 to $11,682	$658 to $2,738
Mason Clinic Site	$1,262 to $7,937	$1,350 to $1,350

Specialist patient care buildings and spaces are those that are purpose built for caring for patients. Non specialist patient buildings include building areas such as car parking buildings, office spaces, workshops and cafeterias. Mason clinic replacement cost per square meter has increased significantly in the year. This is a result of market pressures as well as reassessments from engineers.

The only non-specialised buildings included in the valuation is 3 Mary Poynton Crescent which is valued at fair value using market-based evidence using the capitalisation method under the income approach. The fair valuation of 3 Mary Poynton Crescent building was estimated to be $230k as at 30 June 2022 (2021: $238k).

13 Property, plant and equipment (continued)

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

	2022 $000	2021 $000
Buildings	134,564	67,143
Clinical equipment	7,681	5,858
Other equipment	3,730	547
IT equipment	595	0
Total work in progress	**146,570**	**73,548**

Impairment
No impairment loss has been identified in property, plant and equipment in 2022 (2021: nil).

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

14 Intangible assets

Finance, Procurement and Information Management System (FPIM); previously known as the National Oracle Solution (NOS)
The FPIM rights were tested for impairment at 30 June 2022 by comparing the carrying amount of the intangible asset to its recoverable service amount. A review of the assets value in use has been performed by considering the progress of the FPIM rollout across the DHBs.

14 Intangible assets (continued)

Movements for each class of intangible assets are as follows.

Parent and Group	FPIM Rights $000	Acquired Software $000	Work in Progress $000	Total $000
Cost				
Balance at 30 June 2020	2,849	10,312	5,886	19,047
Additions to WIP*	0	0	2,503	2,503
Additions from WIP	0	2,549	(2549)	0
Transferred to healthAlliance N.Z. Limited	0	0	0	0
Disposals	0	0	(292)	(292)
Impairment	0	0	0	0
Balance at 30 June 2021	**2,849**	**12,861**	**5,548**	**21,258**
Additions to WIP*	0	0	144	144
Additions from WIP	0	505	(505)	0
Transferred to healthAlliance N.Z. Limited	0	0	0	0
Disposals	0	(813)	0	(813)
Impairment	0	0	0	0
Balance at 30 June 2022	2,849	12,553	5,187	20,589
Accumulated amortisation and impairment losses				
Balance at 30 June 2020	0	6,792	0	6,792
Amortisation expense	0	3,320	0	3,320
Transferred to healthAlliance N.Z. Limited	0	0	0	0
Balance at 30 June 2021	**0**	**10,112**	**0**	**10,112**
Amortisation expense	24	2,065	0	2,089
Transferred to healthAlliance N.Z. Limited	0	(814)	0	(814)
Balance at 30 June 2022	24	11,363	0	11,387
Carrying amounts				
At 1 July 2020	2,849	3,520	5,886	12,256
At 30 June 2021	2,825	2,749	5,548	11,122
At 30 June 2022	**2,825**	**1,190**	**5,187**	**9,202**

*This includes transfer from PPE WIP

15 Payables

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Creditors and accrued expenses	164,506	141,550	162,515	141,395
Revenue in advance	41,008	23,798	41,008	23,798
GST payable	7,832	7,994	7,832	7,994
Capital charge payable	13,798	430	13,798	430
Total payables	**227,144**	**173,772**	**225,153**	**173,617**

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

16 Borrowings

There are no current finance leases held by the DHB.

17 Employee entitlements

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Current portion				
Holidays Act 2003 remediation	242,032	192,494	242,032	192,494
Accrued salaries and wages	14,360	14,987	14,360	14,987
Annual leave	121,719	104,071	121,719	104,071
Sick leave	1,800	1,584	1,800	1,584
Sabbatical leave	515	416	515	416
Continuing medical education	11,941	9,844	11,941	9,844
Other employee entitlements	19,818	9,375	19,818	9,375
Unsettled CEAs	44,702	18,290	44,702	18,290
Long service leave	4,077	3,957	4,077	3,957
Retirement gratuities	7,613	6,867	7,613	6,867
Total current portion	468,577	361,885	468,577	361,885
Non-current portion				
Continuing medical education	15,198	12,528	15,198	12,528
Long service leave	8,760	8,873	8,760	8,873
Sabbatical leave	5,784	6,354	5,784	6,354
Retirement gratuities	22,864	24,809	22,864	24,809
Sick leave	3,717	3,629	3,717	3,629
Total non-current portion	56,323	56,193	56,323	56,193
Total employee entitlements	**524,900**	**418,078**	**524,900**	**418,078**

The present value of sick leave, long service leave, sabbatical leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate of 3.72% (2021: 1.06%) and the salary inflation factor 2.38% (2021: 1.85%). In addition, a risk margin of 8.9% (2021: 10%) was applied to the central estimate. Any changes in these assumptions will affect the carrying amount of the liability.

Holidays Act 2003 remediation

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all noncompliance progressed during the 2020/21 and current financial years. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result, the DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability was estimated by:

- selecting a sample of current and former employees;
- calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result.

This liability recognised is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

17 Employee entitlements (continued)

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

18 Provisions

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Current portion				
ACC Partnership Programme	1,608	1,539	1,608	1,539
Make good provision	3,668	2,690	3,668	2,690
Cost of settlement - 44 Taharoto Road and 9 Karaka Street	8,020	6,900	8,020	6,900
Total current portion	**13,296**	**11,129**	**13,296**	**11,129**
Total provisions	**13,296**	**11,129**	**13,296**	**11,129**

Movements for each class of provision	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Balance at 1 July	11,129	4,270	11,129	4,270
Movement in provisions	2,167	6,859	2,167	6,859
Amounts used	0	0	0	0
Balance at 30 June	**13,296**	**11,129**	**13,296**	**11,129**

ACC Partnership Programme

Liability valuation

An external independent actuarial valuer, AON, has calculated the liability as at 30 June 2022. The actuary has attested he is satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuary's report.

Risk margin

A risk margin of 8.9% (2021: 10%) has been assessed to allow for the inherent uncertainty in the central estimate of the claim's liability. The risk margin has been determined after consideration of past claims history, costs, and trends. The risk margin is intended to achieve a 75% probability of the liability being adequate to cover the cost of injuries and illnesses that have occurred up to balance date.

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

- an average assumed rate of inflation of 2.38% (2021: 1.85%)
- a weighted average discount factor of 3.72% (2021: 1.06%) was applied.

Insurance risk

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

19 Equity

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Crown equity				
Balance at 1 July	432,371	407,971	432,371	407,971
Capital contributions from the Crown	32,461	24,400	32,461	24,400
Repayment of capital to the Crown	0	0	0	0
Balance at 30 June	464,832	432,371	464,832	432,371
Accumulated surpluses/(deficits)				
Balance at 1 July	(317,867)	(254,299)	(317,867)	(254,299)
	(317,867)	(254,299)	(317,867)	(254,299)
Surplus/(deficit) for the year	(76,360)	(61,018)	(76,783)	(63,568)
Revaluation reserves transfer on disposal	0	0	0	0
Transfer from/(to) trust funds	(423)	(2,550)	0	0
Balance at 30 June	(394,650)	(317,867)	(394,650)	(317,867)
Revaluation reserves				
Balance at 1 July	438,874	289,450	438,874	289,450
Impairment loss	0		0	
Revaluations	110,102	149,424	110,102	149,424
Balance at 30 June	548,976	438,874	548,976	438,874
Revaluation reserves consist of:				
Land	324,788	324,788	324,788	324,788
Buildings	224,188	114,086	224,188	114,086
Total revaluation reserves	548,976	438,874	548,976	438,874
Trust Funds				
Balance at 1 July	19,577	17,027	0	0
Movement	423	2,550	0	0
Balance at 30 June	20,000	19,577	0	0
Total equity	**639,158**	**572,955**	**619,158**	**553,378**

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

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Net surplus/(deficit)	**(76,360)**	**(61,018)**	**(76,783)**	**(63,568)**
Add/(less) non-cash items				
Depreciation and amortisation expense	34,008	30,838	34,008	30,838
Total non-cash items	**34,008**	**30,838**	**34,008**	**30,838**
Add/(less) items classified as investing or financing activities				
Unrealised (gain)/loss investments	0	0	0	0
(Gains)/losses on disposal of property, plant and equipment	(30)	(10,559)	(30)	(10,559)
	(30)	**(10,559)**	**(30)**	**(10,559)**
Add/(less) movements in statement of financial position items				
Debtors and other receivables	(70,295)	(18,659)	(70,295)	(18,659)
Inventories	(1,481)	(707)	(1,481)	(707)
Creditors and other payables	33,689	29,955	32,426	32,474
Provisions	2,167	6,859	2,167	6,859
Employee entitlements	107,030	62,919	107,030	62,919
Net movements in working capital items	**71,110**	**80,367**	**71,110**	**82,886**
Net cash flow from operating activities	**28,728**	**39,628**	**27,042**	**39,597**

21 Capital commitments and operating leases

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Capital commitments				
Property	153,439	138,376	155,395	138,376
Equipment	4,561	3,730	4,561	3,730
Total capital commitments	**158,000**	**142,106**	**159,956**	**142,106**

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

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

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Not later than one year	8,969	9,417	8,969	9,417
Later than one year and not later than five years	25,136	24,843	25,136	24,843
Later than five years	20,275	16,475	20,275	16,475
Total non-cancellable operating leases as lessee	**54,380**	**50,735**	**54,380**	**50,735**

22 Contingencies

Contingent liabilities
Lawsuits against the DHB
Waitematā DHB and its associates were notified of potential legal claims at 30th June 2022 which creates a contingent liability totalling approximately $664k (2021: approximately $910k) which related to various disputed claims against the DHB.

23 Related party transactions

All related party transactions have been entered into on an arm's length basis. The DHB is a wholly owned entity of the Crown. Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions. No provision has been required, nor any expense recognised for impairment of receivables, for any loans or other receivables to related parties (2021: $nil).

Significant transactions with government-related entities
The DHB has received funding from the Crown and ACC of $2.157b (2021: $1.898b) to provide health services in the Waitematā area for the year ended 30 June 2022.

Transactions with key management personnel

Key management personnel compensation	Actual 2022 $000	Actual 2021 $000
Board members:		
Remuneration	414	357
Full-time equivalent members	9	9
Salaries and other employee benefits of Executive Leadership Team (ELT)	3,745	3,595
Average full-time equivalent ELT members during the year	10	10
Number of ELT members as at 30 June	11	11
Total key management personnel remuneration	**4,159**	**3,952**
Total full-time equivalent personnel	**19**	**19**

23 Related party transactions (continued)

Due to the difficulty in determining the full-time equivalent for Board Members, the full-time equivalent figure is taken as the number of Board members. As at 30 June 2022, the number of key management personnel included the Chief Executive Officer and 11 members of the management team (2021: eleven members). Salaries and other employee benefits of Executive Leadership Team exclude leave cash out payments either during the year or at the time of termination and any settlement costs of $571k (2021: $200k).

24 Board member remuneration

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

	Actual 2022 $000	Actual 2021 $000
Prof Judith McGregor (Chair)	67	67
Edward Benson-Cooper	35	37
Sandra Coney	33	35
Kylie Clegg	42	43
Warren Flaunty	35	37
John Bottomley	33	32
Allison Roe	33	35
Eru Lyndon	33	0
Christopher Carter	33	34
Renata Watene	35	37
David Lui	35	0
Total board member remuneration	**414**	**357**

Co-opted committee members
Payments made to committee members appointed by the Board who are not Board members during the financial year amounted to $26k (2021: $26k) – Norman Wong (Audit and Finance Committee).

The DHB provided a deed of indemnity to Board members for certain activities undertaken in the performance of DHB functions. The DHB affected Directors' and Officers' liability and professional indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees. No Board members received compensation or other benefits in relation to cessation (2021: $nil).

25 Employee remuneration

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

	Actual 2022	Actual 2021		Actual 2022	Actual 2021
$100,000 – 109,999	591	527	$440,000 – 449,999	3	6
$110,000 – 119,999	481	322	$450,000 – 459,999	7	10
$120,000 – 129,999	379	231	$460,000 – 469,999	13	4
$130,000 – 139,999	300	148	$470,000 – 479,999	8	2
$140,000 – 149,999	186	75	$480,000 – 489,999	0	2
$150,000 – 159,999	120	50	$490,000 – 499,999	2	3
$160,000 – 169,999	68	44	$500,000 – 509,999	4	7
$170,000 – 179,999	60	28	$510,000 – 519,999	3	3
$180,000 – 189,999	47	34	$520,000 – 529,999	2	1
$190,000 – 199,999	30	19	$530,000 – 539,999	1	3
$200,000 – 209,999	25	24	$540,000 – 549,999	1	2
$210,000 – 219,999	23	23	$550,000 – 559,999	2	1
$220,000 – 229,999	25	28	$560,000 – 569,999	1	0
$230,000 – 239,999	20	28	$570,000 – 579,999	1	1
$240,000 – 249,999	19	19	$580,000 – 589,999	0	0
$250,000 – 259,999	31	21	$590,000 – 599,999	1	0
$260,000 – 269,999	26	27	$600,000 – 609,999	2	0
$270,000 – 279,999	24	20	$610,000 – 619,999	0	0
$280,000 – 289,999	25	15	$620,000 – 629,999	2	0
$290,000 – 299,999	19	22	$630,000 – 639,999	1	0
$300,000 – 309,999	22	20	$640,000 – 649,999	2	0
$310,000 – 319,999	18	10	$650,000 – 659,999	0	0
$320,000 – 329,999	15	18	$660,000 – 669,999	1	0
$330,000 – 339,999	19	14	$670,000 – 679,999	0	1
$340,000 – 349,999	21	19	$680,000 – 689,999	2	1
$350,000 – 359,999	14	15	$710,000 – 719,999	0	1
$360,000 – 369,999	14	9	$720,000 – 729,999	1	0
$370,000 – 379,999	9	7	$730,000 – 739,999	0	0
$380,000 – 389,999	11	11	$740,000 – 749,999	2	0
$390,000 – 399,999	10	12	$780,000 – 789,999	1	0
$400,000 – 409,999	14	9	$850,000 – 859,999	1	0
$410,000 – 419,999	5	8	$880,000 – 889,999	1	0
$420,000 – 429,999	7	9	$1,060,000 – 1,069,999	0	0
$430,000 – 439,999	11	5	$1,210,000 – 1,219,999	1	0
			Grand Total	**2,755**	**1,919**

During the year ended 30 June 2022 there were 137 (2021: 135) employees who received compensation and other benefits in relation to cessation totalling $3.259m (2021: $2.084m). There was leave cash ups outside of termination as allowed under the Holidays Act paid during the year of $3.48m (2021: $1.58m). Although the leave cashed up would have been earn in previous financial years, the amounts cashed up have been included in the remuneration table and impacting the banding of some employees.

26 Events after the balance date

On 1 July 2022 Te Whatu Ora and Te Aka Whai Ora were established with all 20 DHBs being amalgamated into Te Whatu Ora. Te Whatu Ora is responsible for running hospitals and commissioning primary and community health services. As a result of the health reforms, responsibility for public health issues will rest with this new entity. Te Aka Whai Ora is responsible for monitoring the state of Māori health and can commission services directly.

There were no other significant events after the balance date.

27 Financial instruments

27a Financial instrument categories

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

	Group		Parent	
Financial assets measured at amortised cost	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Cash and cash equivalents	47,882	81,691	41,973	77,468
Debtors and other receivables	147,740	70,165	147,115	71,025
Term investments	1,538	962	0	0
Portfolio investments	13,919	15,407	0	0
Total financial assets	**211,079**	**168,225**	**189,088**	**148,493**
Financial liabilities measured at amortised cost				
Creditors and other payables (excluding revenue in advance and GST)	178,304	141,980	176,313	141,825
Total financial liabilities measured at amortised cost	**178,304**	**141,980**	**176,313**	**141,825**

27b Financial instrument risks

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

Market risk

Price risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

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

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. As at year end The Group had no direct exposure to foreign currency risk (2021: nil).

Sensitivity analysis

As at 30 June 2022, if the New Zealand dollar had weakened/strengthened by 5% against the US dollar with all other variables held constant, the surplus for the year would have seen an insignificant impact.

Credit risk

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

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

Concentrations of credit risk for debtors and other receivables are limited due to the large number and variety of customers. The Ministry of Health is the largest debtor and is assessed as a low-risk and high-quality entity due to being a government-funded purchaser of health and disability services. No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

27 Financial instruments (continued)

Credit quality of financial assets

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

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Counterparties with credit ratings				
Cash, cash equivalents and investments:				
AA	0	102	0	0
AA-	48,608	81,843	41,973	77,468
A	0	537	0	0
A-	397	351	0	0
BBB+	543	682	0	0
BBB	513	452	0	0
BB+	247	0	0	0
Total counterparties with credit ratings	**50,308**	**83,967**	**41,973**	**77,468**
Total counterparties without credit ratings				
Cash, cash equivalents	0	0	0	0
Investments	13,031	14,093	0	0
Total counterparties without credit ratings	**13,031**	**14,093**	**0**	**0**
Total cash, cash equivalents and investments	**63,339**	**98,060**	**41,973**	**77,468**
Debtors and other receivables				
Existing counterparty with no defaults in the past	147,740	71,697	147,115	71,025
Existing counterparty with defaults in the past	0	0	0	0
Total debtors and other receivables	**147,740**	**71,697**	**147,115**	**71,025**

Liquidity risk

Management of liquidity risk

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

27 Financial instruments (continued)

Contractual maturity analysis of financial assets

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
Group						
2021						
Cash on hand	81,691	81,691	81,691	0	0	0
Debtors and other receivables	70,165	70,165	70,165	0	0	0
Investments	16,369	16,369	5,345	9,281	1,688	55
Total	**168,225**	**168,225**	**157,201**	**9,281**	**1,688**	**55**
2022						
Cash on hand	47,882	47,882	47,882	0	0	0
Debtors and other receivables	147,740	147,740	147,740	0	0	0
Investments	15,457	15,457	1,538	12,278	828	813
Total	**211,079**	**211,079**	**197,160**	**12,778**	**828**	**813**
Parent						
2021						
Cash on hand	77,468	77,468	77,468	0	0	0
Debtors and other receivables	71,025	71,025	71,025	0	0	0
Total	**148,493**	**148,493**	**148,493**	**0**	**0**	**0**
2022						
Cash on hand	41,973	41,973	41,973	0	0	0
Debtors and other receivables	147,115	147,115	147,115	0	0	0
Total	**189,088**	**189,088**	**189,088**	**0**	**0**	**0**

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

Contractual maturity analysis of financial liabilities

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
Group						
2021						
Creditors and other payables	141,980	141,980	141,980	0	0	0
Total	**141,980**	**141,980**	**141,980**	**0**	**0**	**0**
2022						
Creditors and other payables	178,304	178,304	178,304	0	0	0
Total	**178,304**	**178,304**	**178,304**	**0**	**0**	**0**
Parent						
2021						
Creditors and other payables	141,825	141,825	141,825	0	0	0
Total	**141,825**	**141,825**	**141,825**	**0**	**0**	**0**
2022						
Creditors and other payables	176,313	176,313	176,313	0	0	0
Total	**176,313**	**176,313**	**176,313**	**0**	**0**	**0**

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

FINANCIAL PERFORMANCE

28 Capital management

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

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

29 Three Harbours Health Foundation

The DHB has consolidated its wholly-owned subsidiary – Three Harbours Health Foundation (THHF). The DHB does not hold an equity investment in its wholly owned subsidiary (2021: $nil).

Summary of financial information of Three Harbours Health Foundation

	Assets $000	Liabilities $000	Revenue $000	Surplus/(Deficit) $000
2022	20,000	1,991	6,481	423
2021	19,577	1,687	6,172	2,550

30 Patient trust monies and restricted funds

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

The amounts of patient trust monies are detailed below.

	Actual 2022 $000	Actual 2021 $000
Balance at 1 July 2021	156	162
Monies received	649	683
Payments made	(634)	(689)
Balance at 30 June 2022	**171**	**156**

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

The amounts of restricted cash and investments are detailed below.

	Group		Parent	
	Actual 2022 $000	Actual 2021 $000	Actual 2022 $000	Actual 2021 $000
Current assets				
Cash and cash equivalents	5,908	4,223	0	0
Receivables	626	672	0	0
Investments	1,538	962	0	0
	8,072	**5,857**	**0**	**0**
Non-current assets				
Investments	13,919	15,407	0	0
Total trust/special fund	**21,991**	**21,264**	**0**	**0**

31 Explanation of major variances against budget

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

- Patient Care revenue for the year was below budget by $29.6m mostly due to under delivery of planned care.
- Expenditure for the year was $14.8m over budget, which is mostly due to:
  - In addition, the liability was increased by $31.5m more than budget after a reassessment of the liability.
  - Provisions increases relating to settlement of Nursing pay equity of $26.2m.
  - Infrastructure and non-clinical expenses being $39.2m higher than budget. This is mostly due to $39.0m of the cost savings budget being included in the Infrastructure and non-clinical expenses line, however the actual savings that have resulted from the DHB's financial sustainability programme are reflected across all revenue and expenditure lines.
  - NGO expenses were $101.6m favourable to budget mainly due to a lower than planned spend in Funder NGO contracts.
- Other comprehensive revenue and expense was $110.1m for the period and is unbudgeted. This relates to the gain on property valuations of $0.0m for Land and $110.1m for Buildings.

COVID-19 impacts were $1.0m favourable and are broken down as follows:

- Net additional revenue associated with COVID-19 was $163.4m, which is due to:
  - Additional funding received from the Crown in response to COVID-19 of $167.7m
  - $4.3m revenue lost attributed to COVID-19.
- Total expenditure attributed to COVID-19 was $162.5m, which is mostly due to:
  - Payments to external NGO providers in response to COVID-19 were $102.5m mainly for testing and vaccination related costs.
  - Additional personnel costs of $53.1m
  - Additional Clinical supplies and outsourced service costs of $2.3m
  - Additional Infrastructure and non-clinical additional costs of $4.5m.

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

- Receivables being $82.3m greater than budget mostly due to additional COVID-19 related receivables at 30 June 2022.
- Plant, property and equipment being $220.8m greater than budget mostly due to:
  - An unbudgeted increase in fair valuation of $110.1m.
  - Actual capital expenditure being less than budget due to timing of key major infrastructure projects. This is evident in the reduction in net investing cashflows being $68.3m lower than budget.
  - The financial year 2022 budget did not include the financial year 2021 fair valuation uplift of $149.4m
- Payables being $57.4m greater than budget mostly due to:
  - Continuation of COVID leading to higher than expected accruals for COVID-19 related costs compared to budget.
  - Increase of $13.4m for deferred payment of capital charge
  - Increase of $17.2m for revenue received in advance across various contracts
- Employee entitlements being $97.4m greater than budget mostly due to:
  - The Holidays Act 2003 Remediation liability being increased by $49.5m to recognise the reassessment of the liability estimation
  - Provisions increases relating to settlement of Nursing pay equity of $26.2m
  - Annual Leave balances increased by $17.6m mainly due to travel restrictions relating to COVID-19 resulting in staff taking less annual leave than budgeted
- Provisions are higher than budget mainly due to a $8.0m provision to allow for the cost of settlement of 44 Taharoto Road and 9 Karaka.
- Contributed capital being $25.2m less than budget due to lower than planned equity injections as a result of major capital projects requiring less cash funding as at 30 June 2022.

The major variances in the Statement of Cash flow

- Cash and cash equivalents as at 30 June 2022 were $42.3m higher than budget. The major variances are due to:
  - Net operating cashflows were $1.0m lower than budget with the main reasons being:
    - Receipts from the Ministry of health were $51.3m higher than budget which is mainly driven by additional COVID revenue.
    - Payables being higher than budget as discussed above
    - Employee entitlements being greater than budget as discussed above
  - Net investing cashflows were $68.5m favourable to budget due to timing of spend on major infrastructure projects as discussed above
  - Net financing cashflows were $25.2m unfavourable to budget as Ministry of Health capital contributions were not required to support major infrastructure projects as discussed above.

FINANCIAL PERFORMANCE

32 Disestablishment Basis

These financial statements are prepared on a disestablishment basis (discussed in note 1) as a result of the Health Sector Reform and the disestablishment of the DHB on 1 July 2022. However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

33 Breach of statutory reporting deadline

The 2021/22 annual report of Waitematā District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021
People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020
People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30 June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course

Comparing HSU 2021 and HSU 2020
To determine the coverage of the COVID-19 vaccine across the population of Waitematā DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[55]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

[55] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[56] (HSU 2021 vs. HSU 2020)

Year[57]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	9.09%	9.59%
2021/2022	82.26%	86.85%
Total	91.35%	96.44%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 91%, compared with 96% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccines doses administered by Waitematā DHB

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Waitematā DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

COVID-19 vaccine doses administered by dose type and year

Year[58]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[59]
2020/21	86,109	48,093	0	0	134,202
2021/22	457,009	472,878	339,703	2,726	1,272,316
Total	543,118	520,971	339,703	2,726	1,406,518

By 30 June 2022, a total of 1,406,518 COVID-19 vaccinations had been administered, of which 90% were administered in 2021/22.

[56] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

[57] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

[58] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.

[59] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

APPENDIX ONE: COVID-19 VACCINATIONS AND MORTALITY

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[60] (1 July 2021 – 30 June 2022)

Age group (years)[61]	Primary course Dose 1	Dose 2	Booster 1	Booster 2	Total[62]
0 to 11	38,360	20,311	-	-	58,671
12 to 15	33,044	32,106	21	-	65,171
16 to 19	26,842	27,066	9,939	-	63,847
20 to 24	32,436	32,970	19,659	3	85,068
25 to 29	35,672	36,368	23,211	7	95,258
30 to 34	41,145	42,228	29,146	31	112,550
35 to 39	41,011	42,146	31,018	34	114,209
40 to 44	36,507	37,736	29,842	38	104,123
45 to 49	34,648	35,805	29,517	63	100,033
50 to 54	33,431	35,188	30,738	104	99,461
55 to 59	29,202	31,627	29,749	164	90,742
60 to 64	24,197	27,590	27,371	229	79,387
65 to 69	16,496	21,881	23,424	405	62,206
70 to 74	13,054	18,615	20,303	548	52,520
75 to 79	9,267	13,524	15,609	552	38,952
80 to 84	6,355	9,517	10,753	338	26,963
85 to 89	3,415	5,165	5,898	148	14,626
90+	1,927	3,035	3,505	62	8,529
Total	**457,009**	**472,878**	**339,703**	**2,726**	**1,272,316**

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[63] administered by ethnicity[64] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	123,419	125,759	88,740	129	338,047
European/other	261,945	276,136	211,276	2,395	751,752
Māori	36,343	35,413	18,894	125	90,775
Pacific peoples	32,910	33,129	18,888	66	84,993
Unknown	2,392	2,441	1,905	11	6,749
Total	**457,009**	**472,878**	**339,703**	**2,726**	**1,272,316**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

[60] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.

[61] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.

[62] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

[63] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

[64] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

Waitematā DHB resident population vaccinated against COVID-19

People vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

People vaccinated by age group during 2021/22[65]

Age group[66] (years)	Partial [67]		Primary course [68]			Booster course		
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	32,963	33%	17,716	18%	-	0%	-	0%
12 to 15	28,997	85%	26,038	77%	-	0%	-	0%
16 to 19	28,466	93%	28,358	93%	5,416	50%	-	0%
20 to 24	32,090	82%	32,698	84%	19,010	54%	-	0%
25 to 29	34,563	76%	35,475	79%	22,493	57%	-	0%
30 to 34	40,725	78%	42,006	81%	28,398	61%	-	0%
35 to 39	41,010	80%	42,279	82%	30,674	66%	-	0%
40 to 44	38,638	84%	39,998	87%	30,572	70%	-	0%
45 to 49	34,341	79%	35,547	82%	29,017	75%	-	0%
50 to 54	34,898	80%	36,436	83%	31,070	77%	98	4%
55 to 59	29,790	75%	32,058	80%	29,582	81%	159	5%
60 to 64	25,775	73%	28,844	81%	28,105	85%	215	6%
65 to 69	18,441	62%	23,271	79%	24,065	88%	388	12%
70 to 74	13,610	56%	19,054	79%	20,691	91%	522	16%
75 to 79	10,293	58%	14,903	83%	16,671	94%	565	19%
80 to 84	7,009	57%	10,445	86%	11,533	96%	365	20%
85 to 89	3,946	60%	5,911	89%	6,477	98%	164	19%
90+	2,395	60%	3,581	90%	4,006	104%	76	17%
Total	**457,950**	**70%**	**474,618**	**72%**	**337,780**	**73%**	**2,552**	**12%**

People vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

People vaccinated by ethnicity during 2021/22[69]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received FirstBooster (18+)	Received firstbooster (18+) (% eligible)	Received second booster (50+)	Received second booster (50+) (% eligible)
Asian	112,050	79%	119,830	85%	88,583	73%	92	3%
Māori	33,355	77%	34,182	79%	18,763	58%	117	7%
European/other	246,687	75%	267,755	82%	209,728	77%	2,276	14%
Pacific peoples	30,388	76%	32,378	81%	18,779	60%	59	5%
Unknown	2,507	83%	2,757	91%	1,927	60%	8	7%
Total	**424,987**	**77%**	**456,902**	**82%**	**337,780**	**73%**	**2,552**	**12%**

[65] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.

[66] Age groupings in this table reflect age of the persons at end of financial year.

[67] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).

[68] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

[69] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

People vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	133,522	94%	132,115	93%	88,588	73%	92	3%
Māori	39,316	91%	38,108	88%	18,763	58%	117	7%
European/other	301,174	92%	297,785	91%	209,732	77%	2,276	14%
Pacific peoples	36,833	92%	36,002	90%	18,780	60%	59	5%
Unknown	3,436	114%	3,354	111%	1,927	60%	8	7%
Total	**514,281**	**93%**	**507,364**	**91%**	**337,790**	**73%**	**2,552**	**12%**

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)
50+ age determined as at 30-Jun-2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30-Jun-2022.

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[70]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:

[70] https://www.stats.govt.nz/methods/population-statistics-user-guide.

a. Official national and subnational projections

b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[71]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender.

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2020, 2021 and the Stats NZ PRP for Waitematā DHB

As at 31 December 2021, there is an estimated 656,496 health service users in the HSU 2021. This is an increase of 27,343 people from the HSU 2020 (an approximate 4% increase), and 17,096 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.[72]

Ethnicity	HSU 2020	HSU 2021	Stats NZ PRP 2021	Difference HSU 2020 – 2021 (Note 1)	Difference HSU – Stats NZ 2021 (Note 1)
Māori	55,523	57,114	65,800	1,591	8,686
Pacific peoples	48,260	50,181	47,500	1,921	-2,681
Asian	154,917	172,567	175,500	17,650	2,933
European/other	368,959	373,401	350,600	4,442	-22,801
Unknown	1,494	3,233	-	1,739	-3,233
Total (Note 1)	**629,153**	**656,496**	**639,400**	**27,343**	**-17,096**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 656,496. This is 17,096 above the Stats NZ total projected population of 639,400 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021.

[71] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

[72] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[73] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 deaths by age group and ethnicity

The following outlines the total number of deaths associated to COVID-19 in Waitematā DHB by age group and ethnicity at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	1
20 to 29	0
30 to 39	1
40 to 49	0
50 to 59	8
60 to 69	12
70 to 79	23
80 to 89	41
90+	28
Total	**114**

Ethnicity	
Asian	13
European/other	80
Māori	8
Pacific peoples	13
Unknown[74]	0
Total	**114**

[73] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

[74] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Waitematā District Health Board and Group's financial statements and performance information for the year ended 30 June 2022

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

Opinion

We have audited:

- the financial statements of the Health Board and Group on pages 59 to 93, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 13 to 18, 20 to 22, 24 to 26, 37 to 45, 48, 50 and 94 to 100.

In our opinion:

- the financial statements of the Health Board and Group on pages 59 to 93, which have been prepared on a disestablishment basis:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2022; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 13 to 18, 20 to 22, 24 to 26, 37 to 45, 48, 50 and 94 to 100:
  - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2022, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
      - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 12 April 2023. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without modifying our opinion, we draw attention to the following matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on page 62 outlines that the Health Board and Group have prepared their financial statements on a disestablishment basis because the Health Board and Group were disestablished, and their functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board and Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

Note 17 on page 82 outlines that the Health Board and Group have been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The

matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board and Group have estimated a provision of $242 million, as at 30 June 2022 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results
Appendix 1 on pages 94 to 100 outlines the information used by the Health Board and Group to report on its Covid-19 vaccine coverage. The Health Board and Group used the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 94. The further notes to Appendix 1 on pages 98 to 100 outline that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board and Group have provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19
Note 31 on page 92 to the financial statements and pages 13 to 18, 20 to 22, 24 to 26, 37 to 45, 48, 50 and 94 to 100 of the performance information, outlines the ongoing impact of Covid-19 on the Health Board and Group.

Basis for our opinion

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

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

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

Responsibilities of the Board of Te Whatu Ora - Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board and Group is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board and Group were responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board of Te Whatu Ora.
- We evaluate the appropriateness of the reported performance information within the Health Board and Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the Group audit. We remain solely responsible for our audit opinion.

We communicate with the Board of Te Whatu Ora regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 1 to 12, 19, 23, 27 to 36, 46 to 47, 49 and 51 to 58, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than the audit, we have no relationship with, or interests in, the Health Board or any of its subsidiaries.

Wikus Jansen van Rensburg
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand


WASH
YOUR
HANDS
OR
USE
HAND
SANITISER
World Hand
Hygiene Day
05 May 2022
Wordle
Patsy

“best care for everyone

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

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

“everyone matters

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

“with compassion

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

“connected

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

“better, best, brilliant...

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

Waitematā
District Health Board

Best Care for Everyone

ISSN 1178-2307 (web) ISSN 1175-7604 (print)