Annual Report

for the year ended **30 June 2015**

Lynda Wilson - 10 years old

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Waikato District Health Board (DHB), established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD Act), is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services, and disability support services in respect of specified geographically defined populations. Each DHB is a Crown Entity, owned by the Crown for the purposes of section 7 of the Crown Entities Act 2004, and is accountable to the Minister of Health who is the responsible Minister in terms of that Act.

This Annual Report has been prepared to meet the requirements of the Crown Entities Act 2004 (see Section 150 of the Act) and the Public Finance Act 1989 (see Section 43 of the Act). This report presents information on our performance over the 2014/15 year with ratings on the outputs and impacts we intended to deliver in terms of national, regional and local priorities and as stated in the Waikato DHB's 2014/15 Annual Plan.

- Name of DHB: Waikato District Health Board
- Address: Private Bag 3200, Hamilton 3240
- Phone: 07 834 3646
- Website: www.waikatodhb.health.nz

Our accountability documents (Statement of Intent, Annual Plan and Annual Report) are available on our website at:

www.waikatodhb.health.nz/strategy

Statement of Responsibility for the Year Ended 30 June 2015

The Board and management of Waikato District Health Board accept responsibility for the preparation of the financial statements and Statement of Service Performance for the year ended 30 June 2015 and the judgements used in them.

The Board and management of Waikato District Health Board accept responsibility for establishing and maintaining systems of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.

In the opinion of the Board and management of Waikato District Health Board, the financial statements and the Statement of Service Performance for the year ended 30 June 2015 fairly reflect the financial position and operations of Waikato District Health Board.

Signed on behalf of the Board

Bob Simcock, Chair
28 October 2015

Sally Christie, Deputy Chair
28 October 2015

Contents

Waiora Waikato Hospital from Lake Rotoroa

Mihi

He hōnore, he korōria ki te Atua.
He maungarongo ki te whenua.
He whakaaro pai ki ngā tāngata katoa.

Kia tau, tonu, ngā manaakitanga o tō tātou Atua ki runga i a Kiingi Tuheitia me te Kahui Ariki; otira, ki runga i a tātou katoa.

E whai iho nei, te ripoata - a - tau o te Poari Hauora o Waikato, kua whakaritea, hei aata tirohanga ma te motu; kia ea, anō, te kōrero e kiia ana:

‘Tūturu whakamaua kia tina!’ ‘Tina!’

‘Haumi e; hui e!’ ‘Taiki e!’

A brief explanation of the mihi

Honours and glorifies God. Prays for peace to predominate across the length and breadth of our country and for goodwill between all people.

Asks for manifold care and blessings upon King Tuhietia and his Royal Household and, indeed, upon all and sundry.

Confirms that what follows is the Waikato DHB annual report for public scrutiny, thus confirming an old saying, which translates, in this case, as:

‘Pull it together [the report], so that is done properly!'

‘It shall be done!’

‘Gather it together; weave everything together!’

‘It is accomplished!’

Foreword

Chief Executive foreword

I would like to thank members of the Board, my Executive Group, all our staff, general practices, our primary care alliance partners and the Māori, Pacific and community providers in our district for their dedication and care over the past year. You have all made a valuable contribution and a real difference to the health and overall wellbeing of the Waikato community. I was privileged to be appointed as Chief Executive and to be part of the Waikato DHB team.

The 2014/15 year was characterised by repositioning. In the past year we started to implement changes to lay the foundations for the future. These foundations will have a profound impact on the way we manage the health of our population for many years to come.

One new direction is greater consideration of what technology can give us as healthcare providers in this digital age. With the prevalence of smart devices in everyday life, it only makes sense that we use this technology in a way to deliver healthcare interactions as well.

Technology is giving us new ways of bringing healthcare to people, and people to healthcare. This is important for service delivery particularly to those people who live in the rural communities of our district. The capabilities that technology offers will add direct value to the patient experience in terms of less travelling, reducing waiting times and further enhancing patient care.

As health care professionals we have an obligation to do our best to keep patients safe. This year we took a leap forward in terms of “owning” our responsibility to keep patients protected from influenza while in our care. Based on my own experience and best practice, we introduced the Vaccinations for Health Care Workers Policy (flu vaccination policy). This provides the strongest protection for patients, colleagues, and members of the public. The policy gives staff a choice to get vaccinated or if for personal reasons staff don’t want vaccination, to wear an appropriate mask when undertaking work in a patient care location. This provides the next-best protection to patients. We will assess and review the impact of the policy at the conclusion of the influenza season. Unions and other relevant parties will be invited to participate. My observation is that there was overwhelming public support for the policy, and also good acceptance of it by the staff.

I am pleased to report tangible progress towards meaningful engagement with our consumers, their families and the community. People play a very important role in their own healthcare and also in improving our services. The strengthening of our approach to consumer feedback continues with a variety of initiatives. I am an advocate for stronger community engagement online. We plan to use online tools to stimulate informed discussion with our communities and consumers on important health topics, the challenges we face and the future directions of health services.

The Executive restructure is nearly completed and the Executive members are now developing their teams to improve the organisation's ability to respond to the needs of our population. We continue to develop the partnership between management and clinicians to ensure that high standards of clinical care, leadership and accountability flourish. The emphasis will be on improving quality, patient safety, clinical outcomes and patient experience. The partnership will extend to joint decision-making between management and clinical staff without compromising individual accountability.

We have continued to work with our primary care alliance partners. We are committed to working together to improve the health of our population and reduce inequalities. This requires a re-orientation towards prevention, self-care and better co-ordination. It also requires effective relationships between key providers that are based on respecting each other's skills and actively seeking to work effectively together.

During the year our inpatient mental health services came under particular scrutiny. Various reviews and investigations are underway or have been completed as a consequence. I'd like to take this opportunity to advise our patients and their whānau that we are keen to provide the best services we can and will give careful consideration to all recommendations for improvement we receive. I'd also like to advise our staff that you have the complete and strong support of your Board, myself and the Executive Group as you loyally and capably go about your difficult jobs.

Dr Nigel Murray

Chief Executive Officer

Chair foreword

I am proud to be the Chair of Waikato DHB and proud also of the contribution the organisation has made to improving the health of the Waikato population and reducing health inequalities during 2014/15. Having successfully completed a ten year building programme, the Board in the past year particularly wanted to support the organisation in achieving our vision of Te Hanga Whaioranga Mō Te Iwi - Building Healthy Communities. The Board believes that the Waikato DHB can and should be a leader in the New Zealand health system

In July 2014, Dr Nigel Murray joined us as our new Chief Executive and I want to take this opportunity to thank Nigel for the way he has stepped into his new role, and for the energy and leadership he has provided to the organisation.

A priority job the Chief Executive faced this year was to ensure that he has the right leadership team focused on the right things to move the Waikato DHB forward. The leadership review process he initiated was very constructive and engaged the views of many people. While there are still a few roles to be filled I am impressed by the level of energy and focus displayed by our Executive Group.

The Board has asked our Executive Group to look further into the future about how we need to change to better meet our communities' needs. We know we need to:

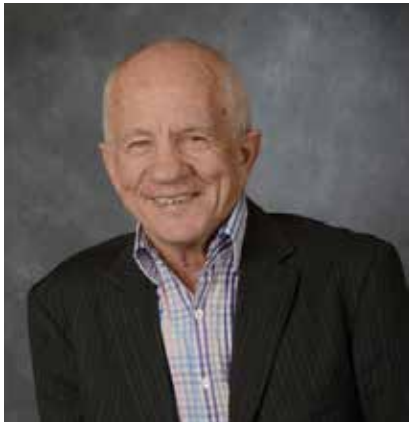
- Become much more 'outward' facing;
- Focus more on preventing illness;
- Get better at supporting people to manage their own health;
- Focus more on supporting primary care providers to do more in the community;
- Find new ways to support people living in rural communities;
- Strengthen the DHB's relationships with the communities we serve and the agencies that can help us to achieve our outcomes;
- Improve health outcomes for our Māori and Pacific communities.

In brief, we know that there are always ways to improve the services we provide.

The 2014/15 year was a year of significant achievement for Waikato DHB. This achievement depends on the willingly given, highly skilled contributions of thousands of individual people who work for and with this organisation. I want to thank everyone who has contributed to the progress during the year. Working in health is not an 'easy gig', but I never cease to be impressed by the talent and commitment of the people who choose to do it.

Bob Simcock

Chair



Bob Simcock

Waikato DHB Chair

Appointed: 9 December 2013

- Chairman, Hamilton Science Awards Trust
- Director, Rotoroa LLC
- Director, Simcock Industries Ltd
- Member, Waikato Regional Council
- Trustee, RM & AI Simcock Family Trust

Wife is the CEO of Child Matters, Trustee of Life Unlimited which holds contracts with the Waikato DHB, Member of Governance Group for the National Child Health Information Programme and Member of the Waikato Child and Youth Mortality Review Group.

Board Profiles

Top row L-R: Sally Christie, Martin Gallagher, Andrew Buckley, Ewan Wilson, Clyde Wade, Sharon Mariu
Front row L-R: Pippa Mahood, Gay Shirley, Bob Simcock, Crystal Beavis, Tania Hodges

Crystal Beavis

Elected: 9 December 2013

- Director, Bridger Beavis & Associates Ltd, Management Consultancy
- Director, Strategic Lighting Partnerships Ltd, Management Consultancy
- Life Member, Diabetes Youth New Zealand Inc
- Member, Lakes DHB Disability Support Advisory Committee
- Trustee of several Family Trusts

Husband is a part-time employee of Wintec which maintains close links with Waikato DHB in delivering health and social practice qualifications including nursing and midwifery.

Andrew Buckley

Re-elected: 9 December 2013

- Director, Crannog Ltd
- Director, Kyland Ltd
- Trustee, Golden 8 Family Trust
- Trustee, Alcohol and Drug Community Support Trust
- Primary Health Practice Principal, Osteopathic Medicine Clinic

Wife is an employee of Waikato DHB (nurse) and NZNO delegate / staff representative.

Sally Christie

Deputy Chair

Re-elected: 9 December 2013

Partner, Mr Michael O'Donnell, works for Workwise

Martin Gallagher

Re-elected: 9 December 2013

- Member, Hamilton City Council
- Vice President, Parent to Parent New Zealand (Inc)
- Trustee, Waikato Community Broadcasters Charitable Trust
- Trustee, He Puawai Trust
- Member, Lake Rotokauri Management Advisory Committee (Waikato District Council)
- Member, Lakes DHB Hospital Advisory Committee
- Alternate member of the Waikato Spatial Plan Joint Committee

Wife employed by the Selwyn Foundation which has contracts with the Waikato DHB.

Tania Hodges

Appointed: 9 December 2013

- Iwi, Ngati Pahauwera, Ngati Ranginui, Ngati Haua, Tuwharetoa, Maniapoto
- Director and Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)
- Director, Ngati Pahauwera Commercial Development Ltd
- Director, Ngati Pahauwera Development Trust Ltd
- Director, Ngati Pahauwera Tiaki Custodian Ltd
- Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)
- Trustee and Shareholder, Whānau.com Trust
- Justice of the Peace
- Member, Lakes DHB Community and Public Health Advisory Committee

Husband is a Ministry of Education employee. Son is medical trainee at Waikato Hospital.

Pippa Mahood

Re-elected: 9 December 2013

- Life Member, Hospice Waikato
- Member, Opus Trust Board
- Member, Institute of Healthy Aging Governance Group
- Board member, WaiBOP Football Association
- Member, Iwi Māori Council

Husband retired respiratory consultant from Waikato Hospital.

Sharon Mariu

Re-appointed: 9 December 2013

- Director and Shareholder, Register Specialists Ltd
- Director and Shareholder, THS & Associates Ltd
- Ministerial Appointee, National Health Committee
- Member, BOP DHB Community and Public Health/Disability Support Advisory Committee
- Director and shareholder, Asher Group Ltd
- Owner, Chartered Accountant in Public Practice

Daughter is an employee of Puna Chambers Law firm, Hamilton. Daughters are employees of Deloitte, Hamilton.

Ewan Wilson

Re-elected: 9 December 2013

- Hamilton City Councillor
- Director, Wilson Aviation Ltd
- Director, Grand Journey by Wilson Tours Ltd
- Director, Kiwi Regional Airlines Ltd

Daughter is an employee of Waikato DHB.

Gay Shirley

Re-appointed: 9 December 2013

- Owner, Chartered Accountant in Private Practice
- Trustee of a number of Family Trusts
- Chairman, Alandale Lifecare Ltd
- Chairman, Alandale Foundation Board

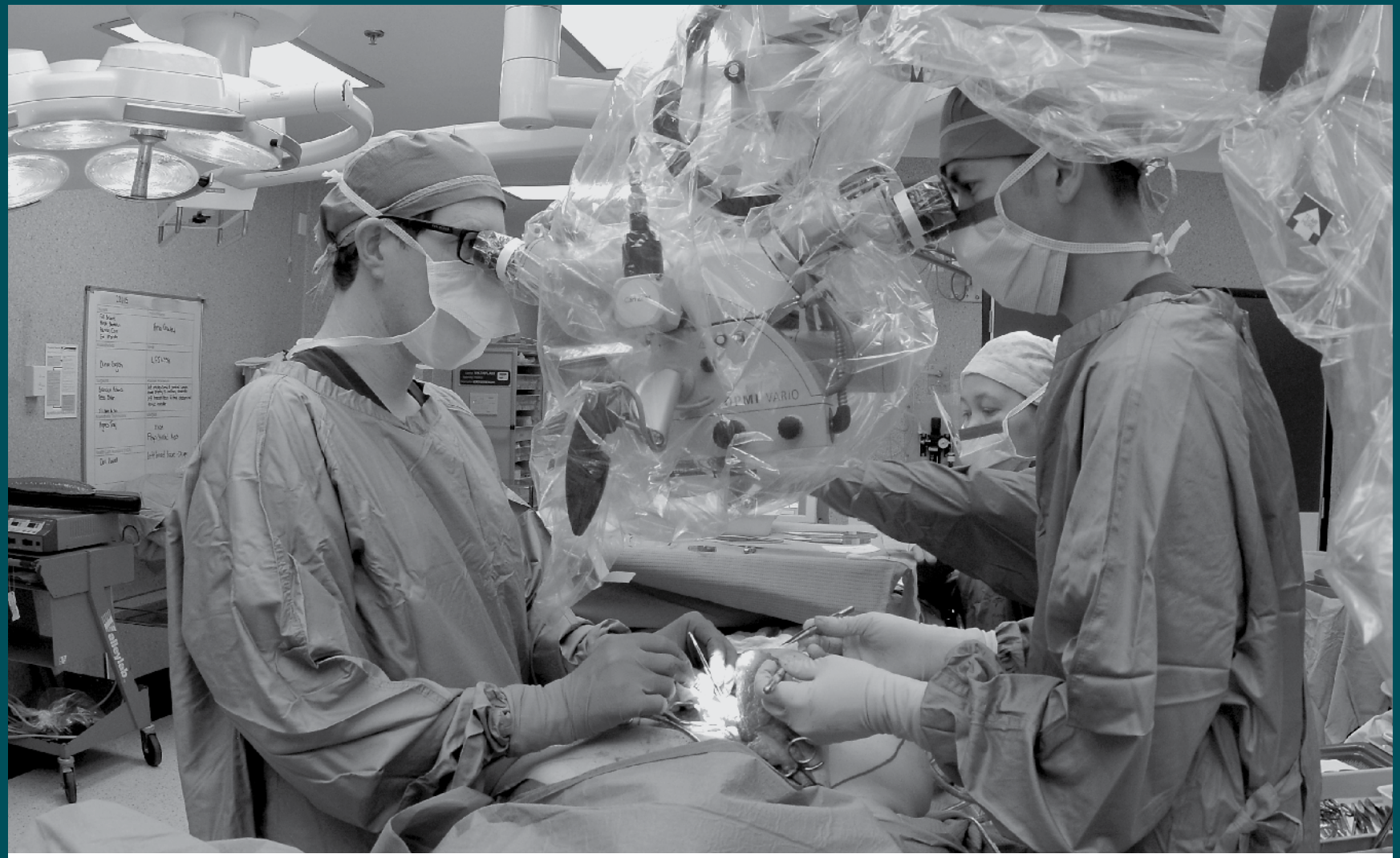
Husband trustee of Braemar Charitable Trust (the Trust owns all the shares in Braemar Hospital Ltd).

Clyde Wade

Re-elected: 9 December 2013

- Employee, Waikato District Health Board (Cardiologist)
- Shareholder, Midland Cardiovascular Services
- Director, Penrhyn Farms Ltd
- Trustee, Waikato Health Memorabilia Trust
- Trustee, Waikato Heart Trust
- Patron, Zipper Club of New Zealand
- Honorary Senior Lecturer in Medicine, University of Auckland
- Member, BOP DHB Hospital Advisory Committee

Part 1 Overview



Consultant plastic and reconstructive surgeon, Mr Brandon Adams, operating assisted by registrar, Arthur Yang and nurse

Introduction

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2015. In the Statement of Service Performance (part two), we present our actual performance results against the non-financial measures and targets contained in our Statement of Intent 2014/15.

Our focus is on providing services for our population that improve their health and reduce or eliminate health inequalities. We consider needs and services across all areas and how we can provide these services to best meet the needs of the population within the funding available. We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

We have both funded and provided health services this year. For the 2014/2015 year, we received approximately $1.232 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. The National Health Board also has a role in the planning and funding of some health services, for example, breast and cervical screening and the provision of disability support services for people aged less than 65 years; services are funded and contracted nationally.

During 2014/15 approximately 69 percent of funding received by Waikato DHB was used to directly provide hospital and health services. The remaining 31 percent was used to fund contracted services provided by non-government organisations (NGOs), primary health care organisations (Primary Health Organisations), Māori providers, Pacific providers, aged residential care, other DHBs, and pharmacies and laboratories. These services were monitored, audited, and evaluated for the level of service delivery.

As well as the strategic direction at a national, regional and local level, the following performance story diagram shows the links between what we do to enable and support our performance (stewardship), and our service performance (output classes, outputs and impacts).

Patient Shyarn Albert, with registered nurse, Yannie Lin on her discharge day as first patient leaving the new revamped ward E7 after being hospitalised for over 6 months

Diagram: Our Performance Story

National Performance Story

Health and disability system outcomes	New Zealanders lead longer, healthier and more independent lives	New Zealand's economic growth is supported
Overarching health sector goal	Better, sooner, more convenient health services for all New Zealanders	

Midland DHBs' Regional Performance Story

Midland vision	All residents of Midlands DHBs lead longer, healthier and more independent lives					
Regional Strategic Outcomes	To improve the health of the Midland population			To eliminate health inequalities		
Regional Strategic Objectives	To improve Māori health outcomes	Integration across the continuums of care	To improve quality across all regional services	To improve clinical information systems	To build the workforce	To efficiently allocate public health system resource
By focusing on these objectives, we will be able to drive change that enables us to live within our means						

Waikato DHB Performance Story

Our vision	Te Hanga Whaioranga Mo Te iwi Building Healthy Communities						
Our outcomes	To improve the health of our population			To reduce or eliminate health inequalities			
Our strategic priorities	Financials	Regional collaboration	Quality improvement	Addressing chronic conditions	Organisational and workforce development	Redevelopment	Rural

Service performance

Long-term impacts	People are supported to take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• Children and adolescents have better oral health • Long term conditions are detected early and managed well • Fewer people are admitted to hospital for avoidable conditions • More people maintain functional independence	• People are seen promptly for acute care • People have appropriate access to ambulatory, elective and arranged services • Improved health status for people with a severe mental illness • More people with end stage conditions are supported
Outputs*	• Percentage of eight month olds will have their primary course of immunisation on time	• Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	• Percentage of patients will be admitted, discharged or transferred from an Emergency Department (ED) within six hours

Stewardship

Stewardship	Workforce	Performance Management	Clinical Integration/ Collaboration/Partnerships	Information

* These are only an example of the outputs, full details in Part 2 of this report.

Our Organisational Profile

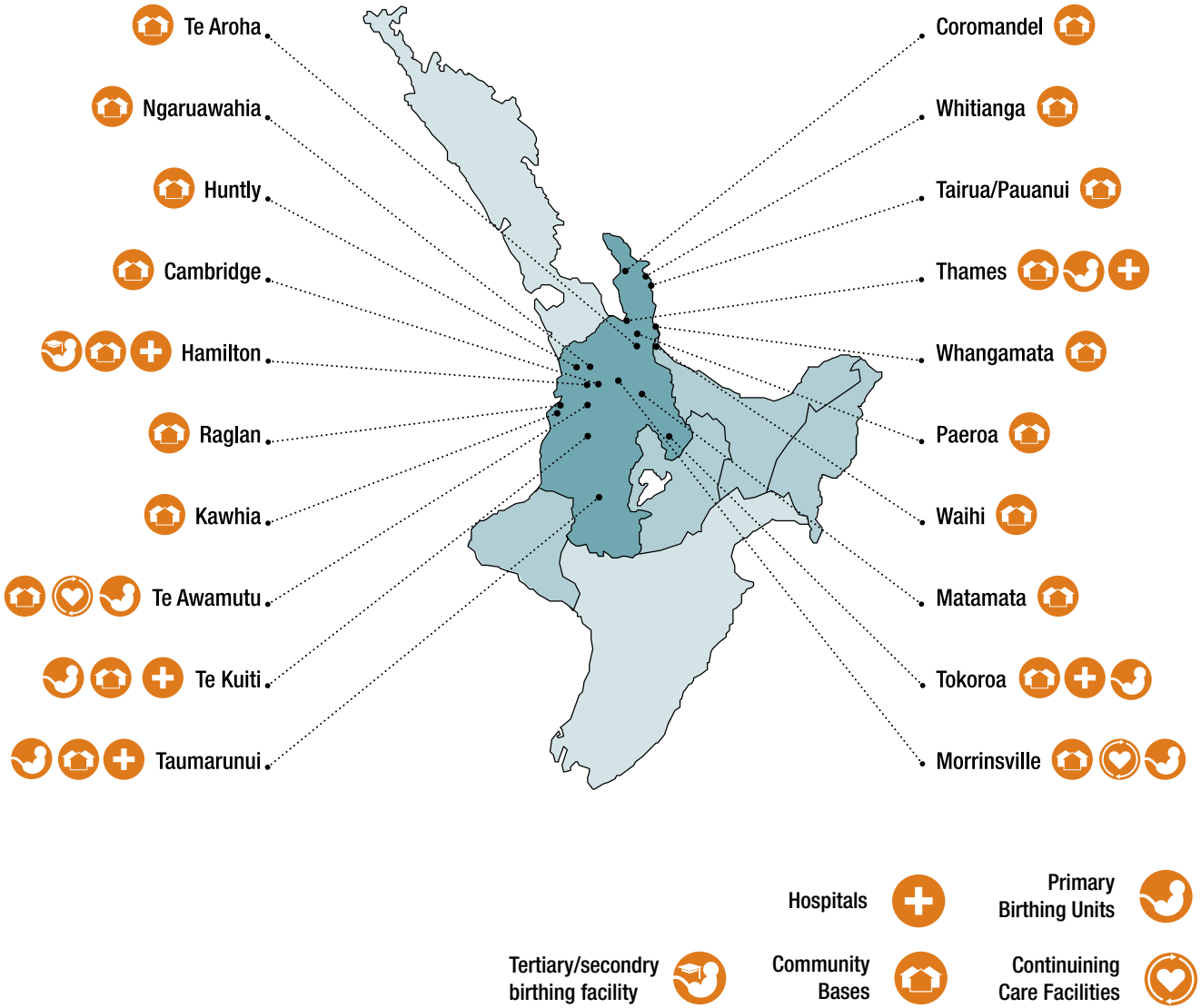
Waikato DHB
employs more than
6,000 people

Plans, funds and provides hospital and health services to around 375,910 people who live within the Waikato DHB boundaries

Provides tertiary services (such as highly complex surgery) to the Midland regional population of more than 853,725

Covers a widespread geographical area (21,220 square kilometres); almost 8 percent of New Zealand

Agendas and minutes of all Board meetings, as well as key planning and reporting documents, are on the Waikato DHB website
www.waikatodhb.health.nz



Location and population

Waikato DHB covers almost eight percent of New Zealand's population, from Northern Coromandel to close to Mt Ruapehu in the South, and from Raglan on the West Coast to Waihi on the East. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui.

For 2014/2015, our population was 375,910. There are 10 territorial local authorities within our boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames Coromandel, Waikato, Waipa, and Waitomo.

We have a larger proportion of people living in areas of high deprivation than in areas low deprivation. Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in high deprivation areas.

Our population is getting proportionately older (the 65-plus age group is projected to increase by 52 percent between 2011/2012 and 2025/2026). This, and the increase in chronic and complex health conditions, defines many of the strategies we are putting in place to meet future health needs.

The Māori population (estimated to be 22 percent of our population for 2014/2015) is growing at a slightly faster rate than other population groups and is estimated to be 23.3 percent by 2026. The Māori population is significantly impacted by many chronic conditions such as diabetes and smoking related diseases and show up disproportionately in adverse health statistics. These facts, plus the acknowledgement of the status of iwi in the Waikato, gives us a strong commitment to include and engage Māori in health service decision making; and to deliver health information and health services in a culturally appropriate way.

Pacific people represent an estimated 2.5 percent of our population and are a group that requires targeted health initiatives.

Approximately 60 percent of our population live outside the main urban areas. This represents diverse challenges in service delivery and additional barriers for people travelling from rural locations.

Overall population statistics hide significant variations within the large geographical area we cover. Documents such as Waikato DHB's Health Needs Analysis 2008 and Future Focus[1] provide an in-depth analysis of our populations, their health status and the significance for strategic health planning and for prioritisation of programmes at an operational level.

We retain strong links with neighbouring DHB's in the Midland region, which includes Bay of Plenty, Lakes, Tairawhiti and Taranaki. We are the tertiary provider for many services in the Midland region.

[1]See: http://www.waikatodhb.health.nz/about-us/waikato-health-needs/future-focus/

Governance and accountabilities

Waikato District Health Board (DHB) was formed in 2001 and is one of 20 district health boards established to plan, fund and provide health and disability services for their populations.

Our Board is responsible to the Minister of Health and comprises 11 members of which seven are elected and the Minister of Health appoints four. The aim is to ensure our Board is diverse, with two Māori members, representation for clinicians, a balance of male and female members, and members from rural communities to name a few.

Bob Simcock was appointed Chair of the Board on 19 December 2013. The chief executive is Dr Nigel Murray, who began 21 July 2014. Our Board and executive offices are located in Hamilton at the Waiora Waikato hospital campus.

Our Board has three statutory committees; Audit and Risk Management Committee, Community Public Health Advisory Committee, Health Waikato Advisory Committee, Disability Support Advisory Committee, which are made up of Board members and elected members from the community. To continue to maintain a high quality of clinical standards a Board of Clinical Governance supports the chief executive.

Te Tiriti o Waitangi is New Zealand's founding document and to ensure we, as a Crown entity, are adhering to te Tiriti we have a governance relationship with local iwi / Māori through Iwi Māori Council, which has representatives from Pare Hauraki, Ngati Maniapoto, Ngati Tuwharetoa, Te Runanga O Kirikiriroa representing urban Māori, Pare Waikato, Ruakawa, and Whanganui iwi.

Our workforce at a glance

As at 30 June 2015, the Waikato DHB had 6566 employees with 5480 full time equivalents.
These employees are central to the DHBs ability to plan, fund, and deliver health services to Waikato communities.

Employee diversity

	Count of ethnic	
International	2264	34%
Māori	607	9%
Not Identified	178	3%
NZ European	3464	53%
Pacific Islander	53	1%

The majority of the workforce are still NZ European and the total number of Māori has remained static from 2014.

Age range (years)

	Count of age range	
<26	462	7%
26-35	1341	20%
36-45	1393	21%
46-55	1742	27%
56-65	1368	21%
>65	260	4%

The average age of DHB employees continues to be 45.6 years.

Employment status

	Casual	Full-Time	Part-Time	Grand Total
Administration / Management	20	855	311	1186
Allied / technical	33	707	436	1176
Medical	8	601	142	751
Nursing / midwifery	150	1030	1866	3046
Support	6	229	172	407

The majority of staff are full time (52%) with approximately 44% being part time. The rest are casuals.

L-R Nurses, Tara Robbins and Sara Hablous, in ward M12 at Waikato Hospital, who were part of the Opioid collaborative project

Functions of a DHB

As a DHB we:

- Plan the strategic direction for health and disability services in partnership with key stakeholders
- Plan regional and national work in collaboration with the National Health Board and other DHBs
- Fund the provision of the majority of the public health and disability services in our district, through the agreements we have with providers
- Provide hospital and specialist services primarily for our population but also for people referred from other DHBs
- Promote, protect, and improve our population's health and wellbeing through health promotion, health protection and education, and the provision of evidence-based public health initiatives

We collaborate with other health and disability organisations, stakeholders and our communities to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation, and waste across the health system to achieve the best outcomes for our community.

Providing health and disability services

We are responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services. The services are provided through Health Waikato (our provider division), across five hospital sites, two continuing care facilities, a mental health inpatient facility and 20 community bases. Our hospitals provide a range of inpatient and outpatient services and are located across the district:

- Waikato Hospital (Hamilton) – secondary and tertiary teaching hospital and Henry Rongomau Centre (mental health facility)
- Thames Hospital – Rural Hospital
- Tokoroa Hospital – Rural Hospital
- Te Kuiti Hospital – Rural Hospital
- Taumarunui Hospital – Rural Hospital

Health Waikato, through Waikato Hospital, will maintain its preferred tertiary provider status to the Midland DHB region. Waikato Hospital is the base for nursing, midwifery and allied health clinical trainees as well as medical trainees at the Waikato Clinical School. This is an academic division of the Faculty of Medical and Health Sciences (Auckland University) and provides clinical teaching and research for undergraduate and postgraduate medical and allied health science students. The main purpose of the school is to provide an outstanding environment in which medical students can undergo their clinical training.

For further information about Health Waikato, including an overview of performance please see

www.waikatodhb.health.nz/health_waikato

House officer, Dr Sagun Banjade, in ward A3 Waikato Hospital

Planning and funding health and disability services

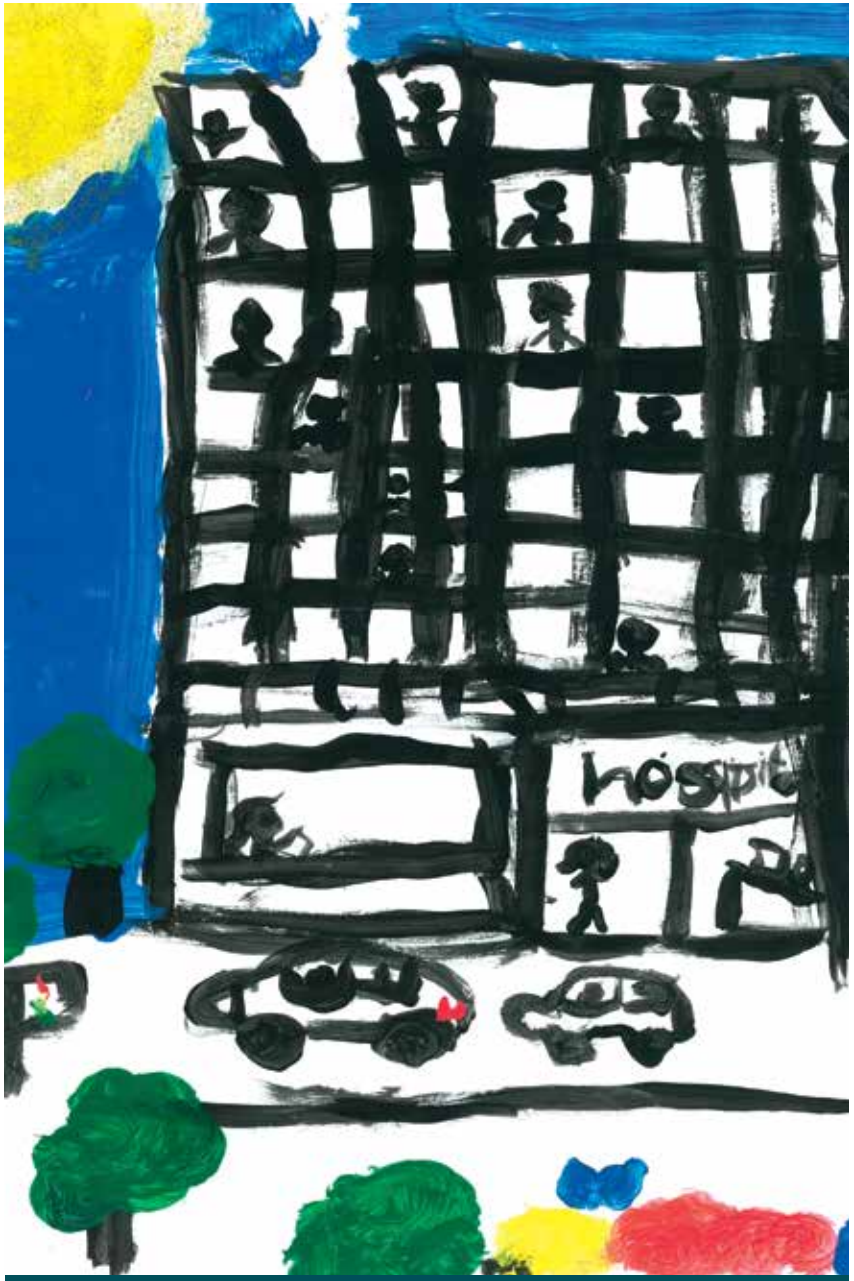
The Planning and Funding division of the DHB is responsible for planning and funding health and disability services across our district. The core responsibilities are:

- Assessing the population's current and future health needs
- Determining the best mix and range of services to be purchased
- Building partnerships with service providers, Government agencies and other DHBs
- Engaging with stakeholders and community through participatory consultation
- Leading the development of new service plans and strategies in health priority areas
- Prioritising and implementing national health and disability policies and strategies in relation to local need
- Undertaking and managing contractual agreements with service providers
- Monitoring, auditing, and evaluating service delivery

While the Planning and Funding division contracts services from Health Waikato, they also contract services from a wide range of non-government organisation (NGO) providers, as well as other DHBs who often provide more specialist services.

Planning and Funding is responsible for oversight of the total funding package for the DHB and linking this with the Ministry of Health. Planning and Funding's role incorporates ensuring equitable acceptable and effective spending of health funds and ensuring that all services funded are delivered in line with expectations. It acts for the DHB in local and national technical and strategic forums working on the development of funding and pricing as well as service and purchasing frameworks.

In order to live within the available funding whilst maintaining sustainable services it is essential to ensure that services are funded at appropriate levels and that value from health expenditure is maximised in terms of both health gain and the DHBs priorities. Additional focus in these areas have been required over the past few years and will continue to be, given the fiscal constraints and the need for DHBs to make decisions based on information and analysis.



Painting created by a Waikids patient at Waikato Hospital

National Performance Story

The following diagram is part of our wider performance story (see pages 14 and 15) and shows the national strategic direction.

Health and Disability System Outcomes	New Zealanders lead longer, healthier and more independent lives	New Zealand's economic growth is supported
Overarching Health Sector Goal	Better, sooner, more convenient health services for all New Zealanders	

Health and Disability System Outcomes

The outcomes provide a broad framework for the wider health and disability system. The outcomes are long-term and are influenced by a number of factors and key stakeholders. The system level outcomes include not only longer, healthier and more independent lives, but also support for sustainable economic growth. This latter outcome reflects the positive impact that better health will have on the ability of individuals to study, work and participate in their communities, as well as the direct contribution health sector organisations (like DHBs and Primary Health Organisations) make to local economies.

Overarching Health Sector Goal

A complex network of organisations and people delivers health and disability services in New Zealand. Each has their role in working with others across the system to achieve better, sooner, more convenient health services for all New Zealanders. The network of organisations is linked through a series of funding and accountability arrangements to ensure performance and service delivery across the health and disability system.

There are many mechanisms that DHBs can use to monitor their performance towards achieving the national goal; better, sooner, more convenient health services for all New Zealanders. The Health Targets provide a clear and specific focus for action to ensure that New Zealand's health care is of the highest quality and within the best possible time.

Health Target Results

DHBs report their progress in the Health Targets to the Ministry of Health four times a year, the Ministry then reports their findings to the Minister and the public. Health Target results can be found on websites, in newspapers, newsletters, e-newsletters, annual reports, and publications or reports.

We do not always meet the Health Targets, however we do ensure that we report on our results using a variety of mechanisms, including those listed above and in posters displayed throughout Waikato DHB hospitals and other facilities. Multi-methods for reporting our results is done so the public has various opportunities to see how we are performing. This helps us to work as hard as possible to excel at the targets and to show the public that we are accountable to them

Shorter stays in emergency department

Target: 95 percent of patients will be admitted, discharged, or transferred from an emergency department within six hours

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	86%	87%	91%	88%	94%	94%	89%	94%	93%	88%	93%	94%
All DHBs	92%	93%	93%	93%	94%	94%	94%	94%	95%	93%	94%	95%

More information about our results and performance is on page 59

Improved access to elective surgery

Target: The volume of elective surgery will be increased by at least 4,000 discharges per year (nationally)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	108%	116%	106%	111%	113%	115%	116%	113%	114%	115%	111%	116%
All DHBs	105%	105%	105%	105%	105%	107%	106%	105%	107%	107%	106%	107%

More information about our results and performance is on page 113

Increased immunisation

Target: 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	80%	87%	90%	82%	87%	91%	81%	86%	91%	83%	89%	91%
All DHBs	87%	91%	92%	89%	91%	94%	89%	91%	93%	90%	92%	93%

This age group for this target changed from two year olds in 2011/12 to eight month olds for the 2012/13 year. More information about our results and performance is on page 71

Shorter waits for cancer treatment

Target: Everyone needing radiation or chemotherapy treatment will have this within four weeks.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	100%	99.5%	100%	100%	100%	N/A	99.7%	100%	N/A	100%	100%	N/A
All DHBs	100%	99.9%	100%	100%	100%	N/A	99.9%	100%	N/A	100%	100%	N/A

More information about our results and performance is on page 109

Faster cancer treatment

Target: 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	N/A	N/A	N/A	N/A	N/A	68%	N/A	N/A	65%	N/A	N/A	56%
All DHBs	N/A	N/A	N/A	N/A	N/A	66%	N/A	N/A	67%	N/A	N/A	68%

Quarter two was the first time faster cancer treatment was reported as a health target.

More heart and diabetes checks

Target: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	60%	75%	86%	63%	77%	88%	67%	79%	89%	73%	85%	90%
All DHBs	52%	69%	86%	55%	73%	87%	59%	78%	88%	67%	84%	89%

The target for 2013/2014 was 75%. More information about our results and performance is on page 85

Better help for smokers to quit

Target: 95 percent of patients who smoke and are seen by a health practitioner in public hospitals.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	93%	96%	95%	94%	97%	96%	93%	96%	96%	96%	96%	94%
All DHBs	94%	96%	95%	95%	95%	95%	95%	95%	96%	96%	96%	96%

More information about our results and performance is on page 67

Better help for smokers to quit

Target: 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
Waikato DHB	42%	62%	84%	46%	68%	87%	51%	73%	88%	61%	84%	90%
All DHBs	40%	60%	88%	43%	66%	89%	51%	72%	89%	57%	86%	90%

More information about our results and performance against both parts of this target is on page 68

Regional Performance Story

Midland Vision	All residents of Midlands DHBs lead longer, healthier and more independent lives				
Regional Strategic Outcomes	**To improve the health of the Midland population**		**To reduce or eliminate health inequalities**		
Regional Strategic Objectives	To build the workforce	Systems integration across the continuum of care	To improve quality across agreed regional services	To improve clinical information systems	To improve Māori health outcomes
By focusing on these objectives, we will be able to drive change that enables us to live within our means					

Regional Services Plan Priorities

The Midland DHBs produced a Regional Service Plan (RSP) for the 2014/15 year. The strategic intent for the Midland region is described in our RSP and is presented as part of our performance story diagram.

The RSP describes a vision for the future of health services in our region and provides a framework for the Midland DHBs to continue to plan and work cooperatively. This approach builds on activities commenced in earlier years while focusing on tangible activities with increasing specificity. Although as a region we strive to advance the regional collaboration programme the RSP does not prescribe radical changes in current patient flows or existing configuration of hospital services. Rather, it focuses on how the region can work together to support vulnerable services, to develop a consistent standard with regard to quality, to improve equity of access and outcomes for regional services, national service priorities and to improve health outcomes across the region as a whole. HealthShare is tasked with co-ordinating the delivery of regional planning and implementation on behalf of the Midland DHB region.

The following identifies the priorities in the RSP.

1. Improve Māori health outcomes.
2. Integrate across continuums of care.
3. Improve quality across all regional services.
4. Build the workforce.
5. Improve clinical information systems.
6. Efficiently allocate public health system resources.

Waikato DHB is committed to being an active participant in our regional planning process. This is evidenced by both clinical and management representatives from our DHB being part of the various forums and networks that have been established to guide RSP implementation activities as well as directly funding regional work and positions. The RSP is a plan of action around specific areas that clinicians have identified as priorities as well as national priorities. Clinical networks are the primary vehicle through which change will be driven and delivered. Clinicians

noted the need for clinical networks to lead service improvement through the use of integrated patient pathways, common clinical policies, and shared clinical audit programmes. These networks help small services to develop sustainable services plans to ensure quality and safety, with vulnerable local services transferred in a planned way to regional locations or supported regionally.

Neurosurgical Multi-Disciplanary-Meeting (MDM) in session at Waikato Hospital

Regional Outcome Monitoring

The Midland DHBs identified some common outcome measures that we could monitor across the Midland region. A small set of health measures help demonstrate whether Midland DHBs are achieving their goals of making a positive difference in the health of our populations and in eliminating health inequalities.

1 **Life expectancy** – life expectancy is a calculation of life expectancy at birth based on the mortality rates of the population in each age in a given year.

2 **Premature death** – early death is the rate of deaths before the age of 75 years.

3 **Amenable mortality** – are deaths that could in theory be averted by good healthcare.

4 **Fewer people smoke** – the percentage of year 10 high school students who have indicated they have never smoked.

5 **Reduction in vaccine-preventable diseases** – the 3-year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds.

6 **Improving health behaviours** – the percentage of obese of New Zealand's 5-14 years population and the percentage of obese of New Zealand's 15+ years population. (Obesity is defined as a body mass index (BMI) of 30 or more – calculated by dividing a person's weight in kilograms by the square of their height in meters. Measure 6 is a national measure taken from the New Zealand Health Survey.)

Monitoring these measures over time will give us a picture of the health of the Midland DHB region. Looking at the life expectancy differences, early death rates, amenable mortality, and infant mortality between populations and geographical areas as well as comparing our results to other regions and national averages will enable us to target resources and activities where significant health gain can be made.

How we monitor performance against our outcomes is an ongoing issue, we hope the six measures chosen will be suitable for providing us with a picture of health for the region. We will continue to monitor the suitability of these measures.

Average life expectancy at birth in the Midland region 2007-09	Bay of Plenty DHB	Lakes DHB	Tairawhiti District Health	Taranaki DHB	Waikato DHB	NZ
Females	82.4	80.5	78.0	81.5	81.8	82.4
Males	77.5	76.4	73.8	77.2	76.9	78.4

The life expectancy table shows that babies born in the Midland region (with the exception of females in the Bay of Plenty) have a lower life expectancy than average for New Zealand. Tairawhiti in particular stands out as having a life expectancy 4.2 years lower than the national average for both females and males.

Local Performance Story

Waikato DHB continues to deliver improvements in health outcomes. During 2014/2015 we made significant progress, but there is still more to be done.

Our Vision	Te Hanga Whaioranga Mo Te iwi Building Healthy Communities					
Our Outcomes	**To improve the health of our population**			**To reduce or eliminate health inequalities**		
Our Strategic Priorities	Financials	Regional Collaboration	Quality Improvement	Addressing Chronic Conditions	Organisational and Workforce Development	Rural

Our outcomes:

Our outcomes are:

- To improve the health of the Waikato DHB population; and
- To reduce or eliminate health inequalities.

As is evidenced in our performance story, our outcomes for our population line up directly with the Midland region outcomes. While we will be monitoring outcome measures at a regional level, we will continue to monitor outcome measures at a local level.

As discussed in the section on regional outcomes, life expectancy is one measure we can monitor. We recognise that life expectancy cannot be completely attributable to or controlled by our activities or the activities of the health sector. It is not an indicator that changes quickly; external factors (e.g. the global financial situation) frequently drive changes and multiple agencies (such as the Ministry of Education, the Ministry of Social Development, Department of Internal Affairs and Te Puni Kokiri) also affect life expectancy. As sub national life expectancy information is available every five years from Statistics NZ, we have looked at other outcome measures, which may give a more regular indication of whether the health of our population is improving, and health inequalities are being reduced. The information in the following table was sourced from the most recent New Zealand Health Survey.

Measure	Previous Result	Latest Result	New Zealand Comparison
Life expectancy – Male (Waikato DHB)	77.2 years (2005-07)	78.3 years (2009-11)	78.6 years
Life expectancy – Female (Waikato DHB)	81.8 years (2005-07)	82.9 years (2009-11)	82.6 years
Excellent, very good or good self-rated health – 15 years and over (Waikato DHB)	88% (2006/07)	88.1% (2011/14)	89.5% (2011/14)
Excellent, very good or good parent-rated health – 0–14 years (Waikato DHB)	97.6% (2006/07)	97.2% (2011/14)	98.2% (2011/14)

The life expectancy measure results are sourced from Statistics NZ and the remaining measures and results are sourced from the NZ Health Survey.

The most recently available data from Statistics NZ demonstrates the comparison in the life expectancy between our Waikato DHB population and New Zealand as a whole. It was expected the next release of the life expectancy data would be in mid-2015 due to the cancellation of 2011 Census, however at the time of developing this report more recent data was still not available.

Our Strategic Priorities

Our strategic priorities are a continuation from previous years, as they are not short-term issues easily resolved within a 12-month period. Our local strategic outcomes align directly to the regional strategic outcomes. Strides have been taken and performance has improved, however more can be achieved.

Our local priorities areas and a short description are outlined in the following table.

Strategic Priority	Description
Financials	Ensuring delivery on agreed financial forecasts and the ability to live within our means
Regional collaboration	Improving clinical services quality and viability across the Midland region and reducing duplication of effort and bureaucracy
Quality improvement	Constantly seeking opportunities to get better at how we function and improve effectiveness
Addressing chronic conditions	These conditions are the leading cause of ill health and premature death in New Zealand. They disproportionately affect low income earners, Māori and Pacific people.
Organisational and workforce development	Building a sustainable health workforce to serve future generations
Rural	A significant number of our people live in areas we consider as rural. We are planning for clinical sustainability in rural health services and exploring opportunities to get the workforce better joined up.
Redevelopment	Ensuring that the right things are being built as part of our building programmes. Buildings designed for the way in which services should be delivered in the future.

The local priorities have been included in our overall performance story to ensure items important to us that are not explicitly covered in the regional strategic intent are included in the Waikato DHB Annual Plan. An example of such a priority is Redevelopment. The redevelopment strategic priority is not listed in our performance story table; however, it is a priority, which requires monitoring.

Whanganui river, Taumarunui

Financials

Our parent financial result for 2014/2015 was a $2.940 million deficit, against a planned break even budget.

Cost of Service Statement by Group for the year ended 30 June 2015	Parent 2015 Actual	Parent 2015 Budget
Income	**$000**	**$000**
Funder	1,166,909	1,161,375
Governance and Planning	5,289	5,289
Provider	762,134	751,822
Eliminations	(678,459)	(682,184)
	1,255,873	1,236,302
Expenditure		
Funder	1,110,163	1,116,560
Governance and Planning	4,937	5,182
Provider	822,234	796,739
Eliminations	(678,459)	(682,184)
	1,258,875	1,256,297
Share of associate surplus/(deficit)	(5)	-
Share of joint venture surplus/(deficit)	67	-
Surplus/(deficit)	(2,940)	5

Financially it was another tough year and we will continue to face the challenge of improving performance in an environment of constrained revenue growth.

Regional Collaboration

Regional Collaboration has been an increasing focus over the past few years. Continual effort is evident in the development and implementation of the Midland Regional Services Plan, which is reported on in detail on a quarterly basis. Regional collaboration is important for strengthening existing relationships and networks for continued development and working on projects and initiatives to avoid duplication and enhance consistency across the Midland Region. Key highlights and progress at a regional level include:

- The Midland Iwi Relationship Board (MIRB) continues to participate in planning processes at a regional level and supports as appropriate regional activities, which align to work undertaken by the Midland General Manager's Māori, and work relating to Māori Health Plan targets and actions.
- Work has commenced on a number of initiatives, some of these include:
  - retention and recruitment for rural primary care workforces
  - promoting health as a career (Kia Ora Hauora Midland Region Programme)
  - focus on vulnerable, hard to recruit, new and emerging workforces
  - ageing workforce strategies
  - workforce intelligence and modelling
- Midland Maternity and the Rural Health Advisory Group are continuing to work together to look at rural maternity services
- After five years of scoping, planning and delivery Waikato Hospital Pharmacy joined the Midland Regional ePharmacy solution in early May. ePharmacy will allow pharmacists to see the dispensing history of patients from around the region while streamlining workflows and inventory management within Waikato Hospital Pharmacy itself. It will also make it easier to identify possible interactions and allergy alerts for medicines.

Quality improvement

The National Patient Safety Campaign continues and three new areas of focus were included; medication safety, Venous Thromboembolism (blood clots), and reducing pressure injuries.

Quality improvement has been a significant focus over the past eight years with a variety of improvements being made each year. We are continuing to implement the Quality Strategy that sets the direction for the way we want to work, puts our patients at the heart of everything we do and aims to give our patients / clients and our staff a better experience of our healthcare services. We are also committed to implementing the initiatives specified by the national Quality Improvement Committee. All staff, clinical leaders, and managers are responsible for improving quality and participating in quality improvement initiatives and projects.

The Quality Strategy is the framework to guide key priorities for us to focus on. In developing the strategy, three domains are used to focus our priorities and report in a consistent matter. These domains are:

- Patient safety
- Patient outcomes
- Patient experience

The reporting framework for these domains include:

- Patient safety
  - Reduce medication errors and improve prescribing practice
  - Reduce the incidence of hospital acquired infection
  - Reduce the incidence and impact of patient falls
  - Improve access to acute theatres
  - Consistent access to appropriate health professionals available for patient care 24/7
- Patient outcomes
  - Reduce hospital mortality rates
  - Reduce failure to rescue rates
  - Reduce the hospital re-admission rates following discharge home
  - Improve maternity care
  - Reduce hospital acquired ulcers
- Patient experience
  - Improve timely access to all service users
  - Improve discharge planning and reduce delay on date of discharge
  - Improve hospital cleanliness
  - Improve customer service and responsiveness

Our reporting templates will record progress against the key domains and be reported annually in a Quality Account. This account will form part of the Annual Report process as an adjunct report. A standard quality performance dashboard is provided monthly for Board meetings, to assure Board members that the services provided across the DHB are safe and effective.

Aileen Derby with the new scanner at Waikato Hospitals Sterile Services Unit

Addressing chronic conditions

Early intervention for healthy eating and activity (Project Energize)

Project Energize turned ten years old in 2015. The programme is delivered to primary and intermediate schools in the Waikato with the aim to teach healthy eating and physical activity to children between 5 and 12 years old.

Funding for the programme comes from the Waikato DHB in partnership with Sport Waikato and is delivered by Sport Waikato. The Relationships are well established with Health Waikato, Alliance Primary Health Organisations as well as the Auckland University of Technology and Waikato University.

Results for Project Energize continue to be outstanding with the international Cochrane Collaboration review of the World Health Organisations Health Promoting School framework, demonstrating there is evidence the Project Energize is improving the health and wellbeing of children.

More smokers make more attempts to quit

We recognise that actions we take at a regional and local level will link with the actions driven at a national level to contribute to the achievement of the goal of a Smokefree New Zealand by 2025. Key work for 2014/15 includes:

- Success in reaching and maintaining the Ministry of Health target. This is due to the diligent work of front line staff as they identify and offer help to people who smoke every day
- A greater focus on maternity and child health services with all Lead Maternity Carers and hospital Midwives being offered training in nicotine addiction and stop smoking support. A Call to Action was launched in December 2014 and has lead into maternity services in the Elizabeth Rothwell Building supporting a smokefree culture where patients, staff and visitors can expect to be in a smokefree environment
- Greater engagement with mental health services and contribution to the development of national guidelines for smokefree mental health services.

L-R Specialty Clinical Nurses for Cardiac Rehabilitation exercise programme, Pauline Honey and Tracy Butler- Holdaway with Sport Waikato's Stephanie McLennan

- Mandatory fields on discharge summary
- Bulk supply of nicotine replacement products available for non-inpatient areas such as Women's Outpatient, Non Government Organisations, community and primary care services

Wrap around services for older people

Our population is ageing, which will have significant impacts on our health system. The increase in the number of older people will drive an increase in demand for acute personal health and long-term disability support services. DHB services for older people are working in partnership with primary care and non-government organisation providers to achieve a continuum of care that can be easily accessed by the older person and provide positive outcomes. We have continued to work with our primary care partners and regional DHBs to develop and refine integrated services that address the needs of older people. Some of the work carried out in 2014/2015 includes:

- Implementing the findings from the review of the Supported Transfer and Accelerated Rehabilitation Teams (START)
- Waikato DHB is participating in a national process to determine core quality measures Results Based Accountability processes will also guide development of population and client outcome indicators
- All aged residential facilities in DHB area using, or training their nurses to use, the InterRAI assessment tool
- Work with key regional and local stakeholders to implement regional dementia clinical pathway initiatives
- Proactive use of DHB specialist Health of Older People Services (geriatricians, gerontology nurse specialists) to advise and train health professionals in primary care and aged residential care.

Organisational and workforce development

Waikato DHB is committed to being a good employer and actively demonstrates adherence to good employer principles. The DHB is aware of the legal and moral obligations, and values its staff as being key to excellence in service provision. The Waikato DHB continues to build on its reputation as a sought after place to work.

Our policies make it clear that this DHB will continue to:

- Provide an Equal Employment Opportunities environment
- Provide an environment which is healthy and safe
- Appropriately accommodate employees with known disabilities
- Impartially select suitably qualified people
- Recognise aspirations, cultural differences of Māori and non-Māori
- Support teaching and learning
- Review and update policies and procedures that support good employer aims
- Proactively address claims of harassment and bullying
- Enable flexibility of work where ever feasible that progresses the organisations aims
- Review post entry and exiting data
- Proactively influence organisational culture

The DHB has a significant training and development programme, which is available to all DHB employees on the basis of their qualifications and developmental needs.

Leadership, accountability and culture

Royal Australasian College of Medical Administrators (RACMA)
The aim of the college is to improve leadership and management capability for medical professionals so that they can use their medical and clinical knowledge, skill and judgement to administer or manage a hospital or other health service.

Three clinicians within the Waikato DHB have completed the programme. The programme is structured to give insights into issues that are not covered by medical training including medico legal, contracts, budgets, resource management, and leadership.

Harassment and bullying prevention
Since establishing the policy, the DHB has continued to refine the training element, which is mandatory for all managers. The review comprised:

- External review of the DHB harassment and bullying prevention programme

- Review of the alignment with the Worksafe Best Practice Guidelines
- Participant feedback

The result was that the training programme material was amended to include greater emphasis on management behaviours.

Recruitment, selection and induction

Manager orientation

The purpose of this initiative is to ensure that new managers have a standard orientation plan, which is customised to the individual and their induction needs.

The approach creates links for new managers with their relevant Human Resource Consultant, Health and Safety Advisor, Recruitment Coordinator, Accountant and other relevant DHB staff. At the completion of the plan, performance objectives should be agreed together with a career and development plan.

Benefits for managers who have completed the process are that the plan kept them focused and on track with their orientation, and set clear expectations about what is required.

Registrar orientation

The DHB has listened to feedback from new registrars (PGY1) and has updated its orientation programme. Most compliance modules such as quality and risk, fire training, venepuncture, adult deterioration detection system, and smoking cessation are available on line and can be accessed before they start, and many other topics are covered during the three-day orientation programme using an interactive case study to reinforce learning. Material is accessible on line at www.waikatodhb.health.nz/rmo. The benefits are that PGY1s begin orientation before they start, information is available when they want it, and learning is experiential which makes the session relevant and interesting.

Pre-employment health screening

The DHB continues to health screen all new employees to ensure that they are fit for work and establish if any reasonable accommodations are required for people with disabilities.

Children's worker checks

The Waikato DHB has been establishing systems and processes to support children's worker checking for its staff who are in children's worker and core children's worker roles, and for those involved with children's teams.

Prior to 1 July 2015 the DHB has established which roles require checking, provided educational material for managers including face to face presentations, an escalation process around urgent police vetting, and data capture in the DHBs human resource information system.

The Waikato DHB is ready to implement children's worker checking.

Employee development, promotion and exit

Resident Medical Officer health careers event

Each year the DHB hosts the Resident Medical Officer Careers Evening for junior medical staff and medical students at Waikato DHB to support them to make decisions about their career intention and vocational training pathways.

The event brings DHB and primary health sector senior doctors and the junior medical staff and students in a fair like atmosphere, where they can have informal discussions. This year the event attracted 58 participants.

Attracting secondary school students to health careers

The Waikato DHB annual health careers day was held in 2014 with 150 attendees from 17 high schools from across the Waikato. The aim of the event is to give secondary school students the opportunity to become informed about the various health occupations available in DHBs.

L-R Dr Nurhidayah Mohammad Khir and Dr Illina Mohd Rothi with Mr Simon Lou, Maxillfacial consultant, at the 2015 RMO health careers evening

The evaluation indicated that the event was successful and was repeated in 2015.

The Waikato DHB remains committed to supporting the Kia Ora Hauora programme which aims to increase the numbers of Māori in health careers.

The DHB continues to provide Gateway placements. The DHB's Māori Health Unit takes additional students into their unit who are Māori, and provides them with a broader introduction to a career in health. This is to increase the numbers of Māori in health careers. This is a long run strategy.

Exiting information

The DHB has an exiting policy and process so more information about why people are leaving is captured. This process allows us to capture exiting data from people who have more than one reason for leaving. The top ten reasons for why people left over 2014/2015 are similar to the reasons stated for 2013/2014.

The top ten reasons people left the Waikato DHB for 2014/2015 are:

Total number of staff who left the DHB for 2014/2015. N=984

Reason for leaving	Number
Relocation	170
Overseas	148
HR transfer	141
End employment agreement	119
More time with family	108
Better career prospects	102
Ceasing work	97
Out of health	92
New job higher salary	84
Retirement	80
Other	1040

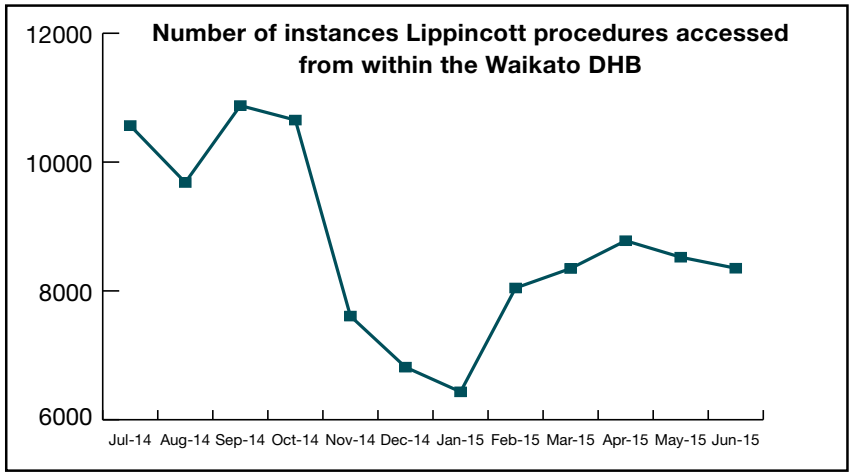
Please note, people can tick however many reasons for leaving that they wish

Lippincott procedures

This is an online evidence based point of care procedure guide for nurses and is available to all nurses who have access in the midland region. This means that nurses in primary care, aged care, or in hospitals have access to research based nursing protocols, which are regularly updated. The vendor links with DHB's prior to making changes so they are highlighted. There is also an app available, which allows users to download the material and work off line.

There are a growing number of people who use the app for iPad. In addition, another group use Lippincott via the Midland e4 Learning site when doing training. Neither of these groups use is counted. Anecdotal evidence suggests that people are making greater use of these procedures.

The following graph shows the pattern of use of online material at the DHB.



Flexibility and work design

Roster review for resident doctors

The DHB is continuing to work with resident doctors to review the rosters to address the fatigue risk. Benefits of this approach include, people directly affected by rostering decisions now have input into developing the roster and rosters are as user friendly as possible.

Reviews of two rosters have been completed and others are underway. In some cases, additional full-time equivalents will be required; in others, additional full-time equivalents would be offset by

run category changes and reduced call back. Strategies are in place to mitigate risk factors around weekend patterns.

Dedicated education units
The dedicated education units have been implemented in three wards in Older Persons and Rehabilitation Service, two in Orthopaedics, and one in Internal Medicine. The aim of the dedicated education units is to shift students from observing and following to becoming part of the nursing model of care. The nurses in these wards benefit from having additional nursing support from the dedicated educators and the students benefit because the placement is a more realistic experience of nursing.

The research that goes along side this has shown a significant positive shift in the culture of learning and in the experience of the students. Alongside this, some areas have noted the reduction in falls and reduced length of time to answer call bells. Students have integrated as team members and their presence is missed during the semester breaks.

Remuneration, recognition and conditions

Staff Service Recognition Programme 2015
Staff Service Recognition Programme is designed to formally recognise the loyal service contributions of our staff members who have reached continuous service milestones. In this programme, service is recognised at five yearly intervals commencing with 10-years of service.

For 2015, there were 564 staff celebrating 10 years or more continuous service and 86 staff celebrating 30 years of continuous service or over.

The Chief Executive, members of the Waikato District Health Board, members of the executive groups, supporting managers and colleagues, attend the presentations. Family and friends are also welcome.

Salary and conditions
The Waikato DHB applies remuneration and rewards fairly and equitably within the boundaries of the Multi-Employer Collective Agreements.

The DHB has regular meetings with unions at which views are exchanged and information shared. The DHB supports the bipartite action group. The DHB continues to support its employees to participate in DHB health and safety systems. There are currently 424 employees who have completed the DHBs own comprehensive health and safety training from across the DHB representing 6% of the organisation.

Safe and healthy environment

Safety culture
Waikato DHB formed a Safety Culture Working Group in 2014 to provide staff, union and management input into safety culture activities. Safety culture is defined as being “about our health and safety behaviours that exist as underlying norms of the organisation – i.e. what we do when no one is watching.”

Safety culture work in 2015 has included an internal survey; a series of questions posed one at a time each month. Questions have established:

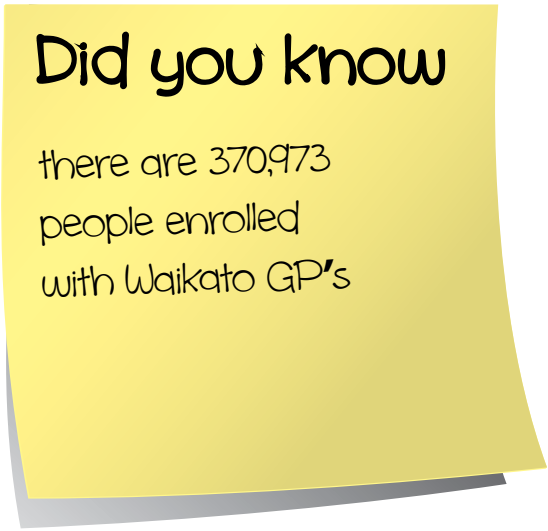
a) the level of team leader/ manager support

b) the perceived level of bullying

c) if performance issues are identified and resolved

Two more questions will be released in 2015. An action plan will be implemented to address findings from the survey questions.

ACC partnership programme
The annual ACC workplace safety management audit was undertaken by an external auditor in September 2014. The primary work site chosen for the audit was the Henry Bennett Centre. The audit also covers policy and practices across the organisation, including contractor management. This is a significant area given the DHB has recently completed its $200 million building programme. The DHB has retained its tertiary status.



Rural

Telehealth

Telehealth is at the forefront of hospital services in Thames, telehealth (or video conferencing) is being used to improve access and equity for patients living remotely. All four types of the technology are being used throughout the hospital to link patients with specialists throughout the Waikato; tele-acute support, tele-ambulatory care, tele-ward support, and tele-workplace support.

The tool helps to improve professional collaboration by allowing video conferencing with other specialists. There is also a videoconference set up for education days and general meetings. In the future, telehealth may be able to facilitate the management of acute patients and potentially be used to augment specialist services in the community both by tele-monitoring and increased primary care support.

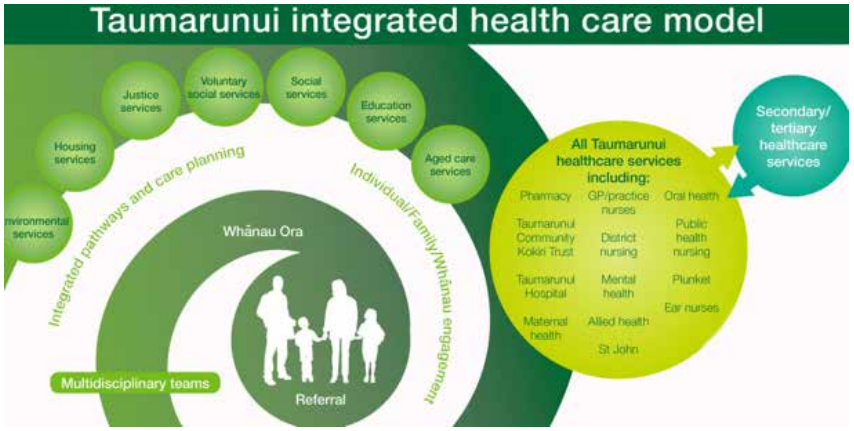
Thames trialled a mobile cart unit, which it hopes will be used increasingly for virtual ward rounds and the development of a virtual stroke unit.

Coromandel and Taumarunui residents now have access to more specialist services without having to travel to Waikato Hospital; a health practitioner will always physically see the patients and the service will only be used for services and consultations where it is deemed safe.

Taumarunui integrated health care model

Patients' access to quality health care in rural parts of Waikato DHB has long been a concern for the DHB, but the roll out of a new 'model of care' (which is linking community and hospital services in Taumarunui), looks to be the new benchmark.

The asthma referral pathway identifies children that present at the hospital or General Practitioner with asthma and refers them on for assessment and treatment. They are then asked if they would like to enrol with the Whānau Ora programme delivered by Taumarunui Community Kokiri Trust, which involves a Whānau Ora assessment and holistic approach to improving social, physical and spiritual wellbeing. For the asthma pathway, this includes being referred to a public health nurse for a home visiting programme.



Social Sector Trials

The Social Sector Trials involve the Ministries of Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered.
The Trials test what happens when a local organisation or individual directs cross-agency resources, as well as local organisations and government agencies to deliver collaborative social services.

There are four Social Sector Trials operating in the Waikato:

Area	Trial started	Focus of trial
Waikato District	1 July 2013	Youth-focused outcomes - 12-18 years old
Taumarunui	1 March 2011	Child and youth-focused outcomes - 5-18 years old
Waitomo District	1 March 2011	Child and youth-focused outcomes - 5-18 years old
South Waikato District	1 March 2011	Child and youth-focused outcomes - 5-18 years old

Waikato DHB has increased its involvement and participation in the Social Sector Trials with the commitment of a dedicated staff member, which has improved communication between the Waikato Social Sector Trial Leads and the Waikato DHB.

Redevelopment

From 2005, Waikato District Health Board started on a major $500 million service and facility redevelopment project. The biggest projects were at its Waiora Waikato Hospital Campus, where the total rebuild has provided more than 800 jobs and more than $100 million flowing into the community.

Significant building and refurbishment projects also occurred at Thames Hospital and in some rural facilities. Many of them involved service development as well as physical transformation or new buildings, with the aim of providing more modern, accessible and patient-focused health care for the future. The redevelopment (which included some major new buildings) was an opportunity to modernise and upgrade facilities for the future.

Waikato DHB provided oversight of the projects via a Programme Management Office and a Building Project Office set up for the task.

The last major project was completed mid-2014.

Arial view of Waikato Hospital showing the completd 10 year bulding project

Part 2 Statement of Service Performance

L-R Miriam Smits, Kitchen assistant, Julia Keepa, Food Supervisor and Raewyn Moody, Kitchen assistant at Taumarunui Hospital

Our service performance

In order to assess information on how well we have delivered our outputs, and if we have made the impact we intended to, we have identified a set of performance measures against which we could evaluate our performance for the 2014/2015 year. The measures chosen are a mixture of indicators of quality, quantity and timeliness. This section is structured around our performance story and provides detail on our performance against firstly our Impact measures and then our Output measures. Detail on our contribution to achieving our outcomes is presented in part one.

The targets we have set for the various measures in this report were determined by factors including national direction, population demographics, health inequalities, previous year's performance, an assumption of little or no additional investment compared with 2013/2014 and the specific actions we planned to undertake. The national health targets and a number of other national reporting requirements have been integrated in the set of measures we have chosen for 2014/2015.

The information presented in this section demonstrates that we have a responsibility across the whole of the continuum of health and disability, from keeping people well, to services for people with an advanced progressive disease which is no longer responsive to curative treatment. The following table shows our long-term and intermediate goals. The measures reported on in this section of the report will all align to an intermediate impact and a long-term impact.

Against each result we show whether or not we have achieved the target by using the following symbols:

✓ Achieved

✗ Not achieved

Long-term impacts	People are supported to take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• An improvement in childhood oral health • Long term conditions are detected early and managed well • Fewer people are admitted to hospital for avoidable conditions • More people maintain their functional independence	• People receive prompt and appropriate acute and arranged care • People have appropriate access to elective services • Improved health status for those with severe mental illness and / or addictions • More people with end stage conditions are supported appropriately • Support Services

Our service performance – funding

The table shows the income and expenditure information for the prevention services, early detection and management services, intensive assessment and treatment services, and rehabilitation support output classes. These output classes are consistent across all DHBs.

The budget figures are based on the Ministry of Health data dictionary definitions that were used to calculate the budget as presented in the Waikato DHB Annual Plan for 2014/15. Output class allocations are based on specific costing system rules to separate and assign costs resulting in total revenue and total expenses that will be different to the statement of comprehensive income.

Output class reporting is a different way of slicing our information. We do not yet have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2014/15 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code. The outer years are based on the same cost and revenue ratios being applied to total cost and revenue.

Cost of service statement by output class for the year ended 30 June 2015

	Parent 2015 Actual	Parent 2015 Budget	Parent 2014 Actual
Income	**$000**	**$000**	**$000**
Intensive assessment and treatment services	829,186	817,580	751,916
Early detection and management	259,008	259,702	270,229
Prevention	27,829	24,379	29,044
Rehabilitation and support	139,850	133,978	139,681
	1,255,873	1,235,639	1,190,870
Expenditure			
Intensive assessment and treatment services	853,088	841,999	780,378
Early detection and management	243,124	246,156	237,856
Prevention	25,500	23,377	30,389
Rehabilitation and support	137,163	124,107	138,431
	1,258,875	1,235,639	1,187,054
Share of associate surplus/(deficit)	(5)	-	5
Share of joint venture surplus/(deficit)	67	-	26
Surplus/(deficit)	(2,940)	-	3,847

Output class reporting is a different way of slicing our information. We do not yet have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2014/15 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code. The outer years are based on the same cost and revenue ratios being applied to total cost and revenue.

Our Impacts

In this context, an impact is defined as “the contribution made to an outcome by a specified set of goods and services (outputs), or actions or both”. While we expect that our outputs will have a positive effect on the Impact measures, it must be recognised that there are outputs from other organisations and groups that will also have an effect.

Chantelle Hill ACNM with smoking cessation patches offered to new mothers in the newborn intensive care unit (baby MANGI)

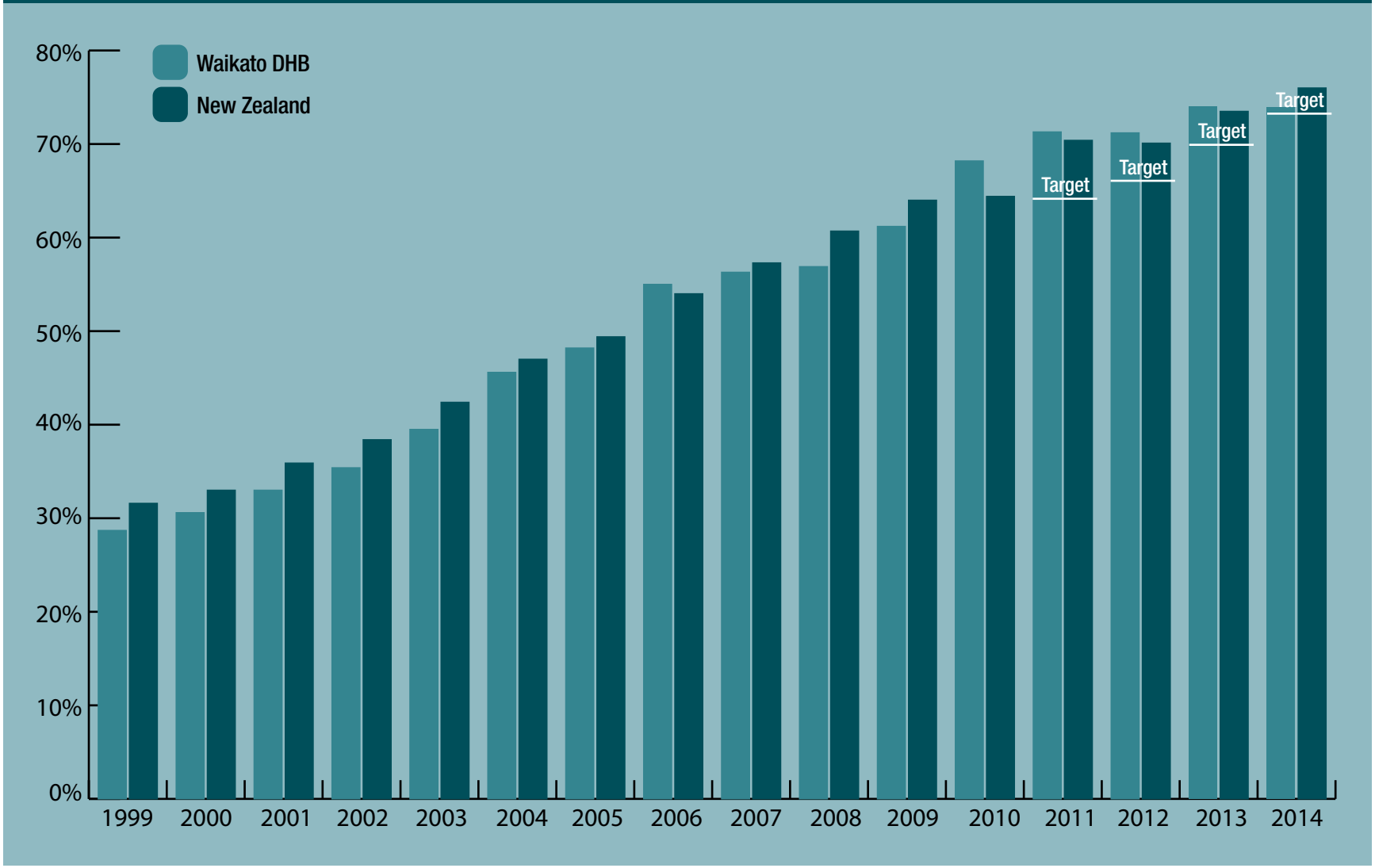
Long-term impact	**People are supported to take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Impact measures	• An increase in the percentage of Year 10 students who have never smoked	• Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	• Percentage of New Zealand population aged 15 years plus considered obese

Impact measure

People are supported to take greater responsibility for their health

Fewer people smoke

An increase in the percentage of Year 10 students who have never smoked



People are supported to take greater responsibility for their health

Fewer people smoke

Impact measure

Measure	Baseline 2009	Previous year 2013/14	Target 2014/15	Result 2014/15
An increase in the percentage of Year 10 students who have never smoked	60.5%	74.0%	>73.3%	✓ 73.9%

Significance of measure

Smoking is the single biggest cause of morbidity and early death. Reducing the prevalence of smoking is one of the greatest ways to influence 'better health' in the population in the short, medium and long-term. Supporting our population to say "no" to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

Increasing the percentage of Year 10 students who have never smoked will mean they are significantly less likely to be regular life-long smokers. The survey used to report on this measure is undertaken by Action on Smoking and Health (an external organisation) and is based on a sample of students within our district. This impact is linked to output measures in the prevention, early detection and management and intensive assessment output classes.

Waikato DHB performance

The result is sourced from a survey of school students and covers a calendar year. The result is very close to the 2013 result, which was a three percent increase on the result from the two previous years. The results of this survey show the national average for District Health Boards is 76 percent.

We will continue to monitor this measure as we work towards the goal of New Zealand becoming smokefree by 2025. Our local tobacco control working group will be reviewing this information as well as other relevant information to inform their planning to determine what can be done to improve performance to enable a smokefree New Zealand by 2025.

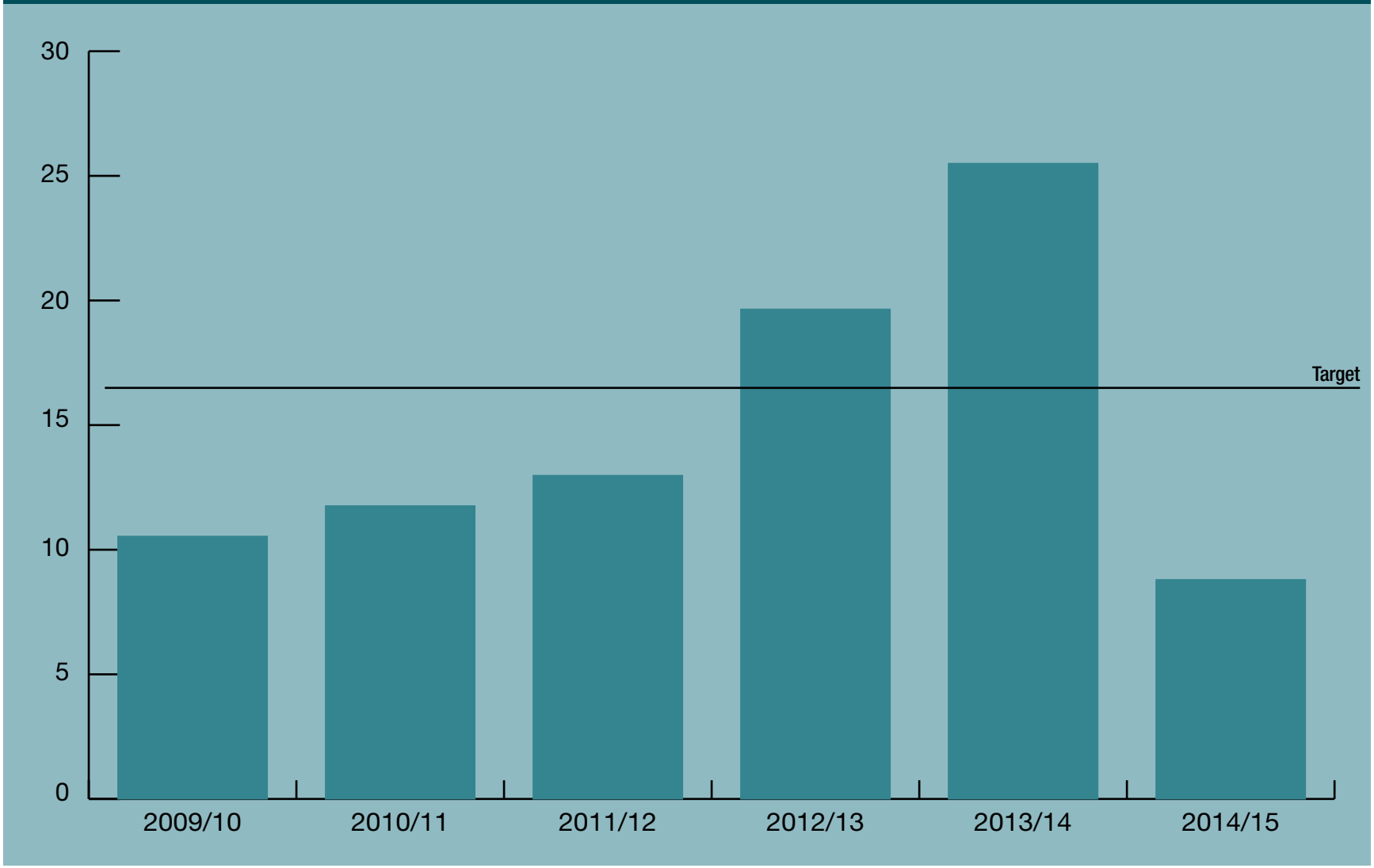
Please note: the 2014/2015 Annual Plan uses the 'less than' symbol <. This was an error, the 'more than' symbol was meant to be in front of the target: >73.3 percent.

Impact measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure

Measure	Baseline 2009/2010	Previous year 2013/14	Target 2014/15	Result 2014/15
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	12.98	25.5	< 22.95	✓ 8.8

Significance of measure

Immunisation can prevent a number of diseases and is a very cost effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine.

New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). These diseases are entirely preventable.

Waikato DHB performance

Ambulatory Sensitive Hospitalisations (ASH) rates for immunisation start at age 6 months for general immunisation, and age 15 months for Measles Mumps and Rubella (MMR)-sensitive conditions.

Analysis of the information in this area has identified a quality improvement initiative that has been implemented for this set of results. The reporting methodology used previously over stated the number of hospitalisation for this measure. The methodology has been updated to reflect that vaccine preventable diseases are scored from six months.

The result for this measure is an improvement on the previous period's results. The results for 2014/15 show only three hospitalisations for vaccine preventable diseases. This is a significant improvement from the 12 hospitalisations in 2013/14.

Some 67 percent of the hospitalisations in 2014/15 were for sepsis due to streptococcus pneumonia, with the remainder being for whooping cough. There were no measles related hospitalisations in 2014/15 compared to six in 2013/14. This improvement follows a comprehensive response to a measles outbreak in our district in 2013/14.

There have been a number of strategies put in place to reduce the incidence of whooping cough. Over the period 2013/14 to 2014/15 hospitalisation for whooping cough has moved from six to one.

Impact measure

People are supported to take greater responsibility for their health

Improving health behaviours

Measures	Baseline 2006/2007	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of New Zealand population (aged 15 years plus) considered obese	28.3%	36.1%	<27.8%	✗ 36.1%

Significance of measure

Good nutrition is fundamental to health and to the prevention of disease and disability.

Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year. Research shows that regular physical activity can help reduce risk for several diseases and health conditions and improve overall quality of life.

Regular physical activity can help protect from heart disease and stroke, high blood pressure, noninsulin-dependent diabetes, obesity, back pain, osteoporosis, self-esteem and stress management, development of disability in older adults.

Waikato DHB performance

The results for this impact measure are sourced from the New Zealand Health Survey.

The New Zealand Health Survey is a national population-based health survey carried out annually by the Ministry of Health. The results are based on data collected from the 2011/12 and 2012/13 survey (July 2011 to June 2013).

It continues to be a challenge to identify an appropriate impact measure for this portion of our performance story. This measure is routinely monitored on generally a four year cycle via the New Zealand Health Survey.

We will continue to look locally and regionally to endeavour to identify a meaningful, affordable and relevant measure. There are a number of initiatives Waikato DHB has been involved in to decrease the percentage of people considered obese; such as Project Energize, which focuses on increasing positive food and exercise behaviours in children.

Long-term impact	**People stay well in their homes and communities**			
Intermediate impacts	Children and Adolescents have better oral health	Long term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	People maintain their functional independence
Impact measures	• Mean decayed missing and filled teeth score of year 8 children	• A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable	• Ambulatory sensitive hospitalisations per 100,000 for congestive heart failure	• Increase in the average age of entry to age related residential care (years)

Impact measure

Dr Margurite Paterson house office in the maxillofacial and dental department with patient Ioka Joliffe

People stay well in their homes and communities

Children and Adolescents have better oral health

Impact measure

Measure	Baseline 2010	Previous year 2013/14	Target 2014/15	Result 2014/15
Mean decayed missing and filled teeth score of Year 8 children	1.60%	New measure	< 1.38%	✓ 1.08%

Significance of measure

Good oral health in children indicates early contact with health promotion and prevention services, which will hopefully be lifelong good oral health behaviours.

Oral health is an integral component to many health and wellbeing benefits, including preventing decay of teeth and disease in the mouth and gums, comfort in eating (especially ability to maintain good nutrition in old age), quality of life, and self-esteem.

By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's decayed missing and filled teeth score, the more likely that their teeth will last a life time.

This measure also provides information that allows DHBs, and the Ministry, to evaluate how health promotion programmes, and services such as the DHB Community Oral Health Service (COHS) and other child oral health providers, are influencing the oral health status of children.

Decreasing the mean score of decayed, missing, and filled teeth will show that Waikato DHB has made an impact on the Ministry of Health intermediate outcome of protecting and promoting good health and independence through providing effective publicly funded child oral health programmes (health promotion, prevention and treatments) that reduce the prevalence of oral disease in children.

The data breakdown by ethnicity enables the DHB to identify and target the pockets of deprivation in their district where children's oral health status is poorest.

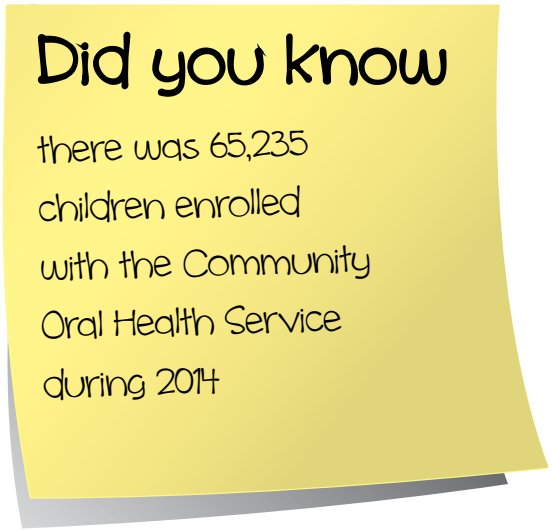
Waikato DHB performance

This measure covers a calendar year period to line up with the school year.

The target for the year has been met.

Community Oral Health plans to continue to build upon the concepts and tools for a preventive approach to dentistry that includes continuing professional development for staff, the regular use of digital radiography to diagnose and monitor the progress of decay, fissure sealants and fluoride varnish applications.

Caution needs to be exercised as the report is based on manually collected data.

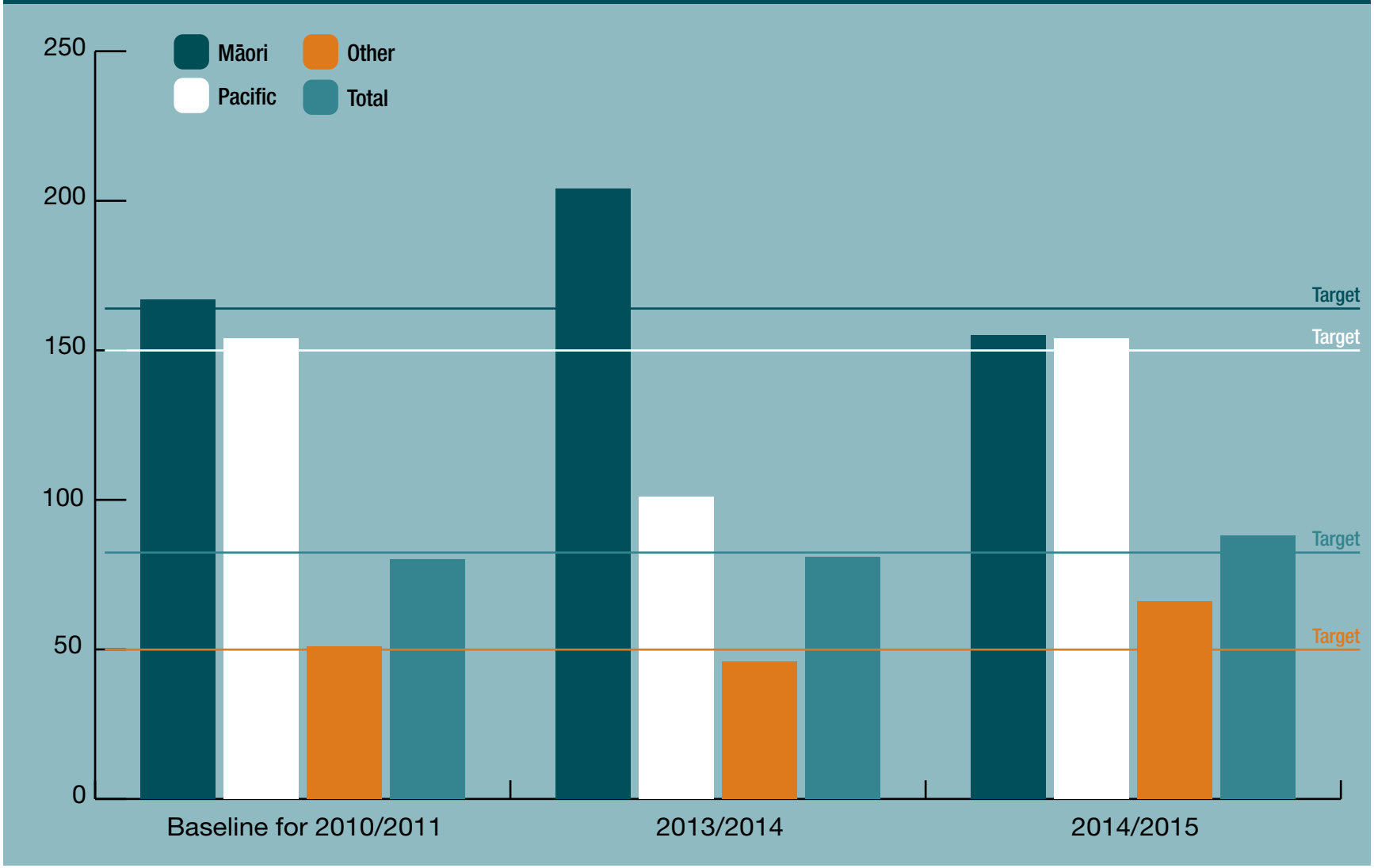


Impact measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Ambulatory sensitive hospitalisations per 100,000 for congestive heart failure (0 – 74 age group)



People stay well in their homes and communities

Long term conditions are detected early and managed well

Impact measure

Measure	Baseline Sept 2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Ambulatory sensitive hospitalisations per 100,000 for congestive heart failure (0 – 74 age group)	Māori 167 Pacific 154 Other 51 Total 80	Māori 204 Pacific 101 Other 46 Total 81	Māori <165 Pacific <150 Other <50 Total <80	✓ Māori 155 ✗ Pacific 154 ✗ Other 66 ✗ Total 88

Significance of measure

Early detection will lead to successful treatment, or a delay / reduction in the need for secondary and specialist care. This is expected to enable more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage cardiovascular disease. It is one of the largest causes of death in New Zealand, and disproportionately affects Māori. Often by the time heart problems are detected, the underlying cause is usually well advanced.

Research shows that cardiovascular disease is a significant cause of avoidable hospitalisations. Reducing the number of avoidable hospital admissions will free up hospital staff and resources for more acute and urgent cases while also ensuring the services being funded in the community, including primary care, are being used optimally

Waikato DHB performance

The Integrated Performance and Incentive Framework, which is being developed nationally, was still in a transition process in 2014/15. We have therefore chosen to report on the same measure we did last year around avoidable hospitalisations for congestive heart failure. Our performance has improved against this measure for Māori compared to the previous year however for the rest of the population groups it has declined.

During 2015/16 we are planning to undertake a piece of work in this area which we anticipate will have a positive impact on performance. The first focus of this work will be direct primary care access to echocardiography as part of a community integrated heart failure service. This is expected to lead to fewer first specialist assessments being needed and timelier access to specialist advice. It will provide general practice with clinical best practice steps to better diagnosis and manage heart failure.

We will continue to monitor and participate in the national Integrated Performance and Incentive Framework. We expect this work will impact on our local performance measurement framework.

L-R Patient, Charlie Ryland in kids emergency department being accessed by registered nurse Courtney White.

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Impact measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
The number of ambulatory sensitive hospital admissions per 100,000 population **0-4 years**	3932	New Measure	< 4105	✗ 5612
The number of ambulatory sensitive hospital admissions per 100,000 population **45-64 years**	2055	New Measure	< 2273	✓ 2200
The number of ambulatory sensitive hospital admissions per 100,000 population **0-70 years**	1747	New Measure	< 1918	✗ 2138

Significance of measure

Reducing the number of avoidable hospital admissions (admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors) ensures that patients who need services that can be provided in community settings receive them there rather than in hospitals. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases, ensure the services being funded in the community, including primary care, are being used optimally, and deliver better, sooner, more convenient healthcare for all New Zealanders.

The results are expressed as a standardised rate with the national level being 100, with results under that level being positive.

Waikato DHB performance

Population aged between 0 and 4 years
Not achieved

Ambulatory sensitive admissions for this age group increased significantly over this period. The key drivers for this increase appear to be Gastroenteritis/ dehydration, Asthma and respiratory illness also increased in the July-Sept period compared to prior years.

Further work will occur to identify if this fluctuation is a trend or reflects unusually high seasonal illness.

Population aged between 45 and 64 years
Achieved

The target for this group was achieved with a result of 2200, which is less than the target of 2273.

Population aged between 0 and 74 years
Not Achieved

This target was not met with a result of 2138 when the target was less than 1918. The areas with significant growth included respiratory, asthma and constipation.

Impact measure

People stay well in their homes and communities

People maintain Functional Independence

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Average age of entry to age related residential care (years) - **Rest home**	84.1	84	≥ 84.1	✓ 85
Average age of entry to age related residential care (years) - **Dementia**	83.6	83	≥ 83.6	✗ 83
Average age of entry to age related residential care (years) - **Hospital**	80.6	85	≥ 80.6	✓ 86

Significance of measure

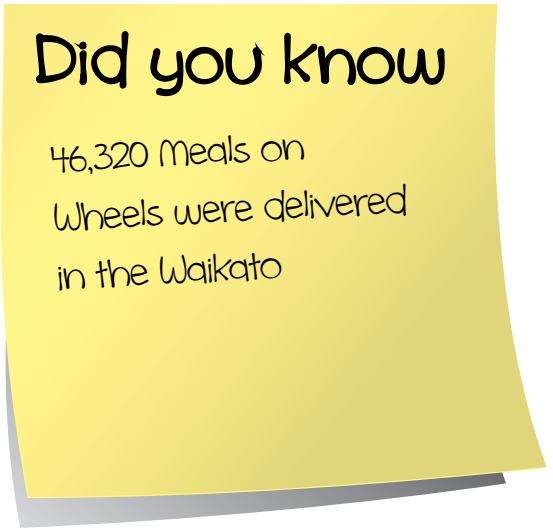
This measure provides an indication of the effectiveness of increasing home and community support options for older people who remain in their home rather than enter institutional care.

With a population that is ageing, there tends to be an increased demand on our constrained resources. We are looking to manage the expected growth in demand by improved models of care that support people to remain independent for as long as possible.

The expected growth in the proportion of older people with complex care needs means there will be a corresponding growth in the rate of expenditure to meet those needs. Rest home care is funded at a higher level compared with home and community support services. Reducing the demand for rest home care will assist the DHB in managing the rate of growth in expenditure on Health of Older People Services, whilst ensuring the appropriate level of care is committed to older people.

Waikato DHB performance

Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires Aged Residential Care. As we do not currently capture this information, our best proxy indicator is to increase the average age at which an older person enters Aged Residential Care.



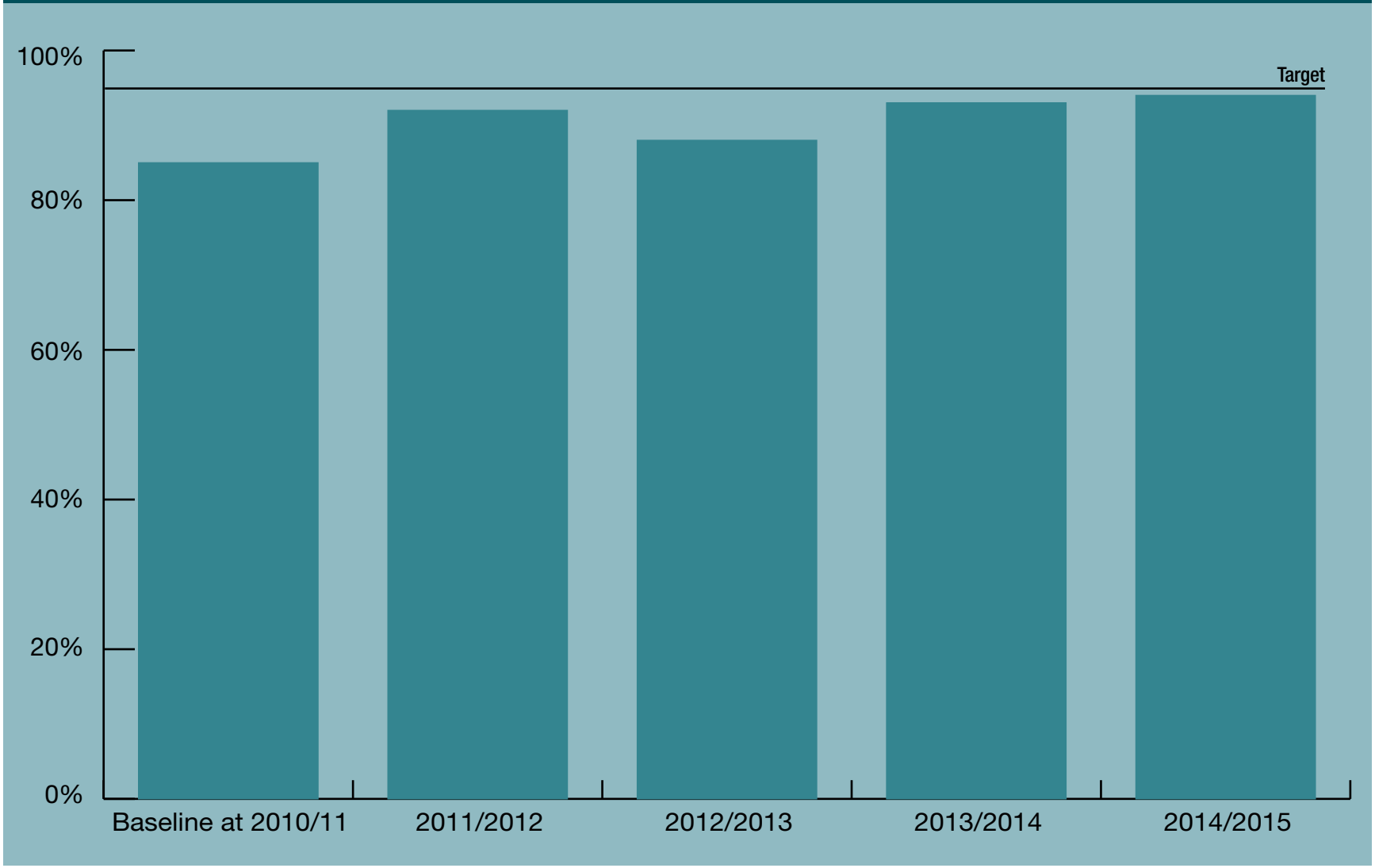
Long-term impact	**People receive timely and appropriate specialist care**			
Intermediate impacts	People receive prompt and appropriate acute care	People have appropriate access to elective services	Improved health status for people with severe mental illness	More people with end stage conditions are appropriately supported
Impact measures	• Percentage of patients admitted, discharged, or transferred from an emergency department within six hours	• Elective service standardised intervention rates (per 10,000): - Major joint replacement procedures - Cataract procedures - Cardiac surgery - Percutaneous revascularization - Coronary angiography services	• Decrease in 28 day acute readmission rates	

Impact measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Percentage of patients admitted, discharged, or transferred from an emergency department within six hours



People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Impact measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours	85%	93%	95%	✗ 94%

Significance of measure

Emergency departments are a vital service to a community due to the unforeseen and unplanned nature of many health related emergencies or events. It is important to ensure those presenting at an emergency department with severe and life-threatening conditions receive immediate attention. Emergency department's must have an effective triage system to ensure those requiring immediate attention receive this as fast as possible. Long stays in emergency departments are linked to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients.

The duration of stay in Emergency Department is influenced by services provided in the community to reduce inappropriate Emergency Department presentations, the effectiveness of services provided in Emergency Departments and the hospital and community services provided following exit from an Emergency Department. Reduced waiting time in Emergency Departments is indicative of a coordinated 'whole of system' response to the urgent needs of the population. Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to.

This measure covers emergency department facilities for Waikato DHB this includes Waikato, Thames, Tokoroa, and Taumarunui hospital emergency departments.

This is one of the National Health Targets.

Waikato DHB performance

Waikato DHB has not met the target for the 2014/2015 year. Further work is required in order to consistently meet this target.

A lot of focus has gone into reducing the Emergency Department wait times and this will continue throughout the 2015/2016 year. The work has a focus on:

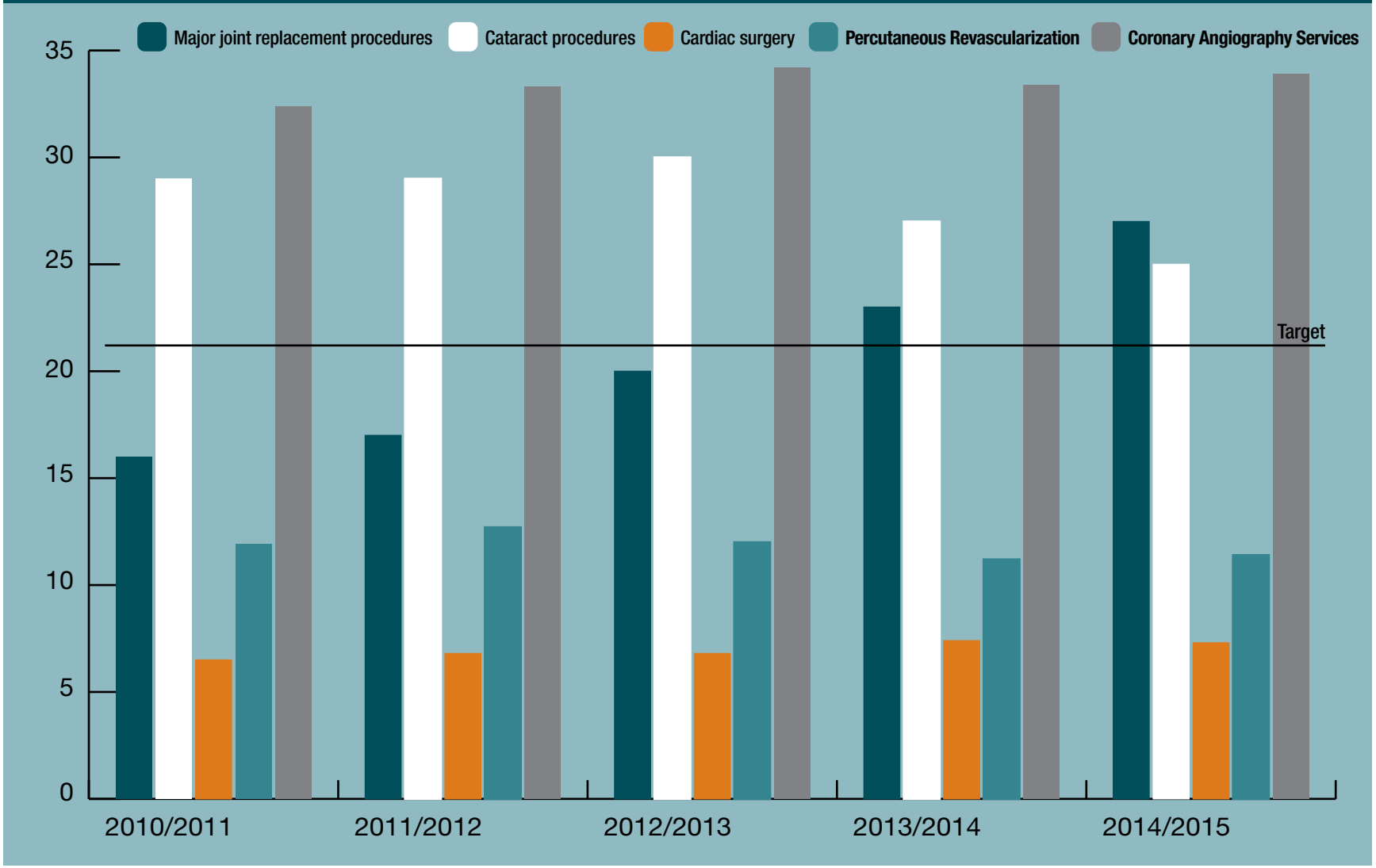
- reducing demand – weekend management
- addressing delays in transfer from Emergency Department to specialities
- reducing delays for specialities to see patients
- improving the hand over and transfer for admitted patients

Impact measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

Elective service standardised intervention rates (per 10,000)



People receive timely and appropriate specialist care

People have appropriate access to elective services

Impact measure

Measures	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Elective service standardised intervention rates (per 10,000) — **Major joint replacement procedures**	21	23	21	✓ 27
Elective service standardised intervention rates (per 10,000) — **Cataract procedures**	27	27	27	✗ 25
Elective service standardised intervention rates (per 10,000) — **Cardiac surgery**	6.23	7.4	6.5	✓ 7.3
Elective service standardised intervention rates (per 10,000) — **Percutaneous Revascularization**	11.8	New measure	12.5	✗ 11.4
Elective service standardised intervention rates (per 10,000) — **Coronary Angiography Services**	32.4	New measure	34.7	✗ 33.9

Significance of Measure

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. Timely access to elective services is a measure of the effectiveness of the health system. Meeting standard intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives. Knowing that access to services is equitable will improve the public's trust and confidence in the public health system. Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

Waikato DHB performance

The DHB met two of the five procedural targets related to elective services. The primary focus for the 2014/15 year was on reducing wait lists from five to four months. The mix of procedures wait listed for surgery is determined by clinical prioritisation tools and reflects the needs of those patients referred for surgical assessment.

The overall conclusion that can be drawn from the health target (more surgery delivered overall than required) and the reduction in wait lists to four months is that the mix of actual demand differs from the preferred standardised intervention rate at a procedural level. More work is required to determine whether that reflects the characteristics of the local population relative to the national average, whether it reflects disproportionality in the rates of referral for these conditions from primary care, or whether the rate of acute (rather than elective) treatment of these conditions is higher than the national norm.

Impact measure

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
28 day acute readmission rates (mental health and addictions)	13%	10%	≤ 15%	✓ 12%

Significance of measure

Hospitalisation/facility admission is an important means of stabilizing and establishing or re-establishing regimens for those with acute mental health and/or addiction issues. However, admissions are of high cost in terms of healthcare expenditure and a disruption to the personal and professional lives of the individual, their family and whānau.

It is hoped that the efforts made to keep readmission rates as low as possible (without compromising care), will show how the DHB is preventing individuals from experiencing a "revolving door" by following best practice during and post admission.

Waikato DHB performance

The readmission rate over this period was within the KPI target set nationally. There has, however been a 2 percent increase on rates for the 2013/14 year. This in part correlates with a general trend of higher occupancy and increasing acuity.

The Service has some additional options for home based treatment and crisis respite which means that the inpatient cohort of service users is generally at an even higher level of acuity. The service remains committed to understanding the clinical importance of this measure and will be working with a senior clinician to examine this measure in relation to acuity, and patient flow more fully.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Impact measure

Significance of Measure

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering.

Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process.

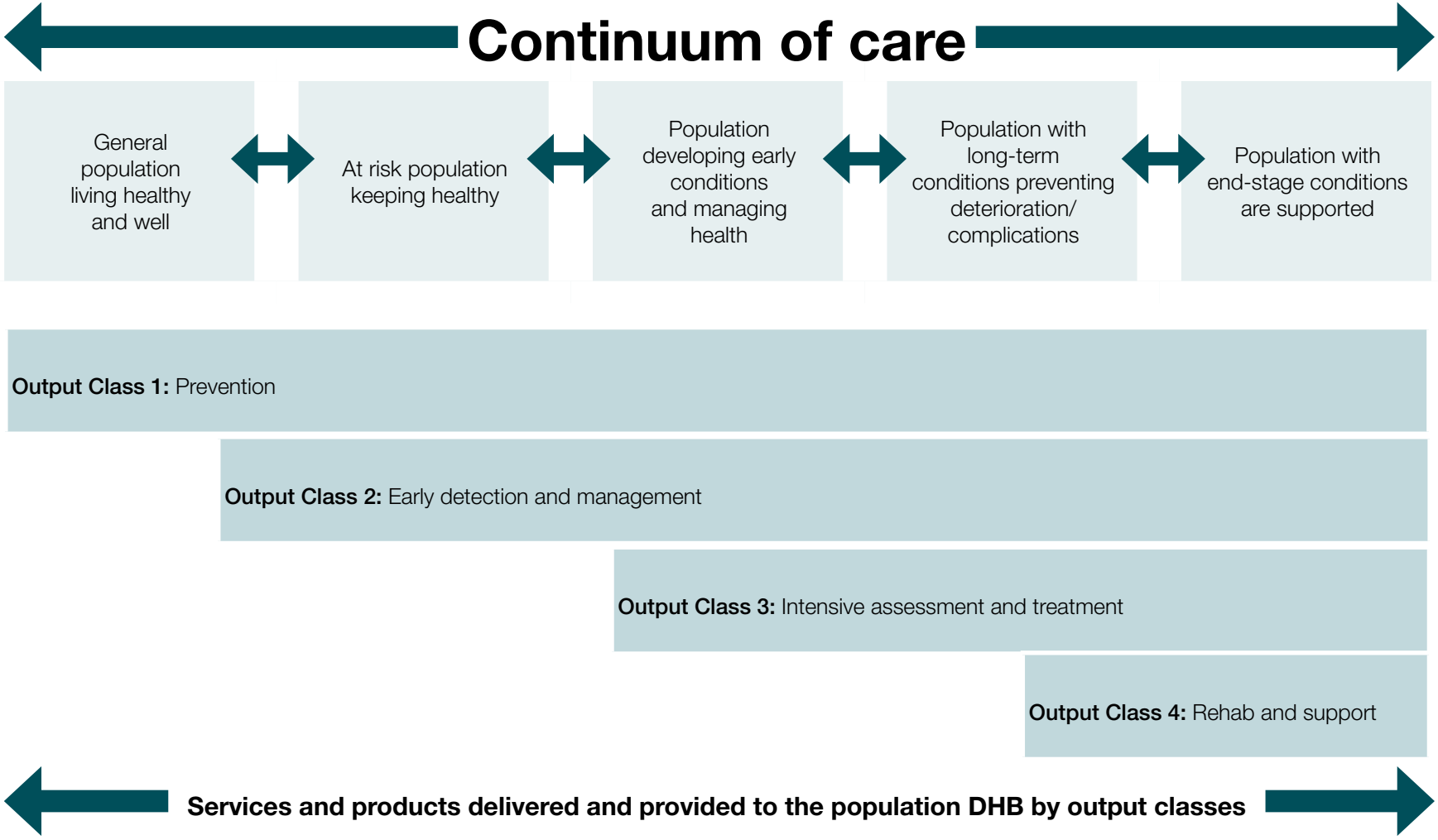
Waikato DHB performance

We have been unable to identify an appropriate impact measure during 2014/15. The development of Waikato Palliative Care Plan expected to occur commenced, however it is far from complete. Once agreed, the plan will detail a high level 'road map' for palliative care and end of life for the Waikato district. This plan will take into account a significant number of national, regional and local initiatives which include increased hospice funding, palliative care health needs analysis and updated service specifications.

Through the process to develop this plan, it is expected that the key measures for monitoring performance in this area will be identified. This will enable Waikato DHB to further refine our performance story for our intermediate impact of more people with end stage conditions are appropriately supported.

Our Outputs

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The four output classes that have been agreed nationally represent a continuum of care, as follows:



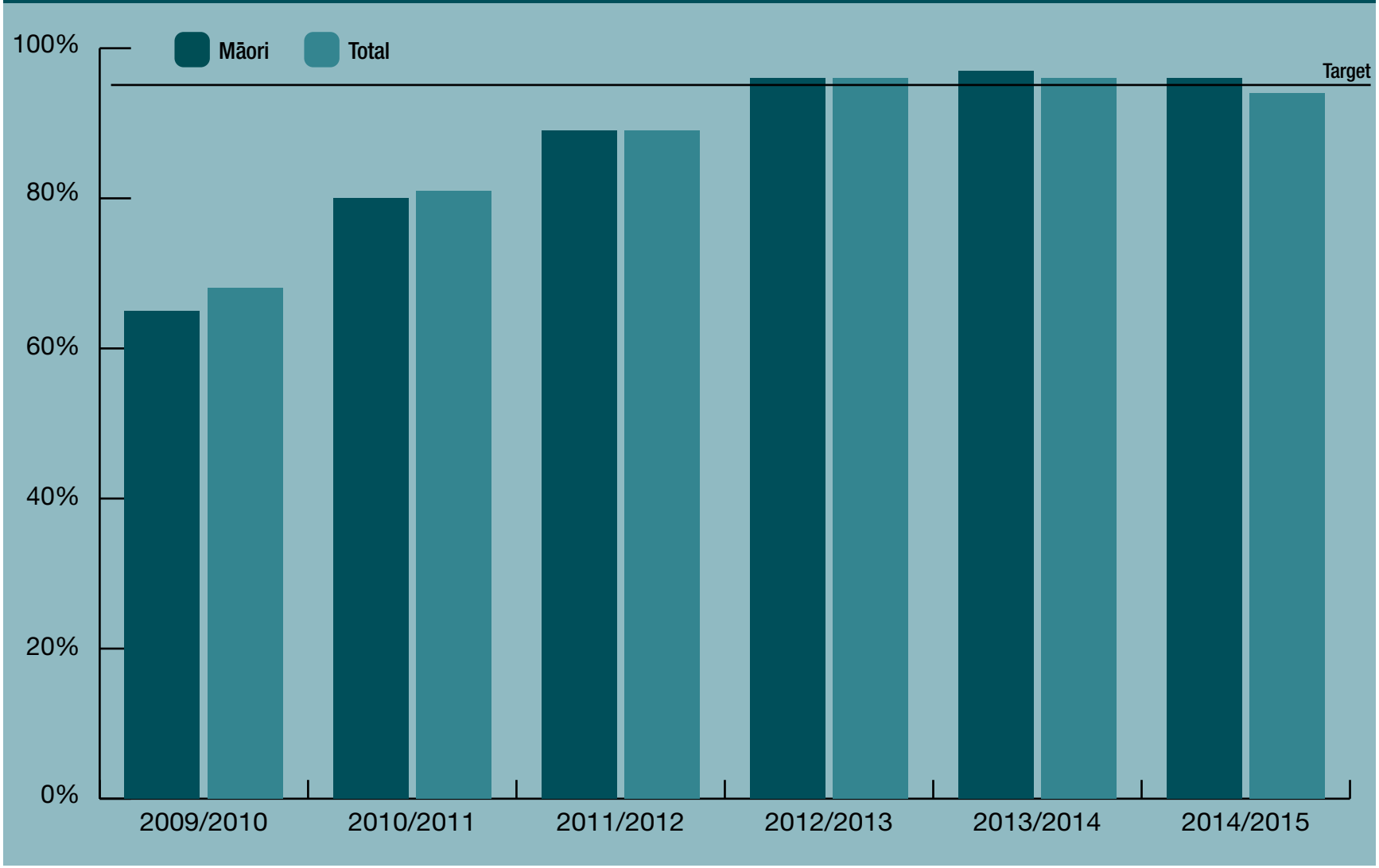
Long-term impact	**People are supported to take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Output Performance Measures	• Percentage of hospitalised smokers offered advice to quit • Percentage of Primary Health Organisations enrolled smokers offered advice to quit • Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	• Percentage of eight month olds fully immunised • Percentage of the population older than 65 years who have received the seasonal influenza immunisation	• Percentage of infants who are fully or exclusively breastfed at 6 weeks • Percentage of infants who are fully or exclusively breastfed at 3 months • Percentage of infants who are exclusive, fully and partially breastfed at 6 months • The number of people participating in Green Prescription programmes • Percentage of Kura Kaupapa Māori primary schools participating in Project Energize • Percentage of total primary schools participating in Project Energize

Output measure

People are supported to take greater responsibility for their health

Fewer people smoke

Percentage of hospitalised smokers offered advice to quit



People are supported to take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of hospitalised smokers offered advice to quit	81%	96%	95%	✗ 94%

Significance of measure

Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of a quit attempt. By encouraging and supporting more smokers to make quit attempts we expect there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of the individuals contracting smoking-related diseases.

By ensuring that health professionals at the hospital routinely address nicotine dependence, DHBs are helping to ensure that people receive better health and disability services, which take into account the implications that smoking can have on health and address patients' risk factors as well as their existing health issues.

This is one of the National Health Targets.

Waikato DHB performance

Waikato District Health Board (DHB) achieved the target in quarter 1 and exceeded the target in quarters two and three. In quarter four, Waikato DHB did not reach the target when the result was 93.5 percent. However this target was achieved for the 12 month period. Of the 13,113 smokers discharged from Waikato hospitals 5,276 were Māori (33 percent) and of these Māori 5061 (96 percent) were offered support. There were seven Waikato DHB hospitals reporting monthly against this target for inpatients and all areas have a Smokefree champion nurse or midwife in place who sustained local knowledge. The smoke status and intervention fields in discharge summary became mandatory in June 2015.

Over the last 12 months, there was been a drive to educate and upskill staff working in maternity services and thereby create a culture change and promotion of smokefree environments on hospital campus.

The new Mental Health National Guidelines will also increase staff support and knowledge of nicotine addiction. Waikato DHB also contributed to the Governments Smokefree Aotearoa 2025 goal by advocating for effective legislation and increased regulation on tobacco outlets, increased taxation on tobacco and increasing public support with expansion of Smokefree environments.

Output measure

People are supported to take greater responsibility for their health

Fewer people smoke

Measure	Baseline June 2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of Primary Health Organisation enrolled smokers offered advice to quit	28%	84%	90%	✓ 90%

Significance of measure

Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of that attempt.

By encouraging and supporting more smokers to try to quit there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of the individuals contracting smoking related diseases.

By ensuring that health professionals across all health care settings routinely address nicotine dependence, DHBs are helping to ensure that people receive better health and disability services which take into account the implications that smoking can have on health and address patients' risk factors as well as their existing health issues.

This is one of the National Health Targets.

Waikato DHB performance

All Primary Health Organisations within Waikato DHB area have systems in place to implement Ask, Brief Advice, Cessation Support (ABCs) in primary care which include workforce training, champions and electronic systems. Hauraki Primary Health Organisations have achieved the target of 92 percent, National Māori Coalition Primary Health Organisations have achieved 92 percent, and Midlands Health Network achieved 89 percent.

Please note: the 2014/2015 Annual Plan identifies the baseline result as being for 2010/2011. This was an error, the baseline is for March to June 2012.

People are supported to take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	New measure	New measure	90%	✓ 95%

Significance of measure

At present, tobacco smoking places a significant burden on the health of New Zealander's and on the New Zealand health system. Tobacco smoking is related to a number of life-threatening diseases, including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. It also increases pregnant smokers' risk of miscarriage, premature birth and low birth weight, as well as their children's risk of Asthma and Sudden Unexplained Death in Infants (SUDI).

By ensuring that all health professionals are routinely providing their patients with advice and support to quit, DHBs, Primary Health Organisations and midwives are helping to ensure that people receive better health and disability services, and live longer and healthier lives.

Waikato DHB performance

Waikato has met this target with 95% of women who identified as smokers offered brief advice and support by their lead maternity carer (LMC).

Waikato Maternity Quality and Safety Programme set up a "Call to Action" in response to the low numbers of women quitting smoking during pregnancy. The Call to Action was launched May in 2014 with the aim that "Every woman will get excellent high quality support for a smokefree pregnancy and motherhood". As part of the "Call to Action" and to achieve the National Target, Waikato is ensuring that all LMCs have been offered the locally developed "Hapu Mama Smoke Free Pregnancies" specialised training. Each quarter LMCs are the national target data to update them on their progress.

Through Maternity Quality and Safety Programme and in partnership with Te Puna Oranga (Waikato Māori Health Team) and population health, Waikato has developed Hapu Mama Smokefree Pregnancies Tupeka Kore framework, which is a step change management framework to improve smoking cessation services in maternity, the programme is being rolled out in Waikato Hospital maternity services and will be rolled out to primary birthing services in 2015/16.

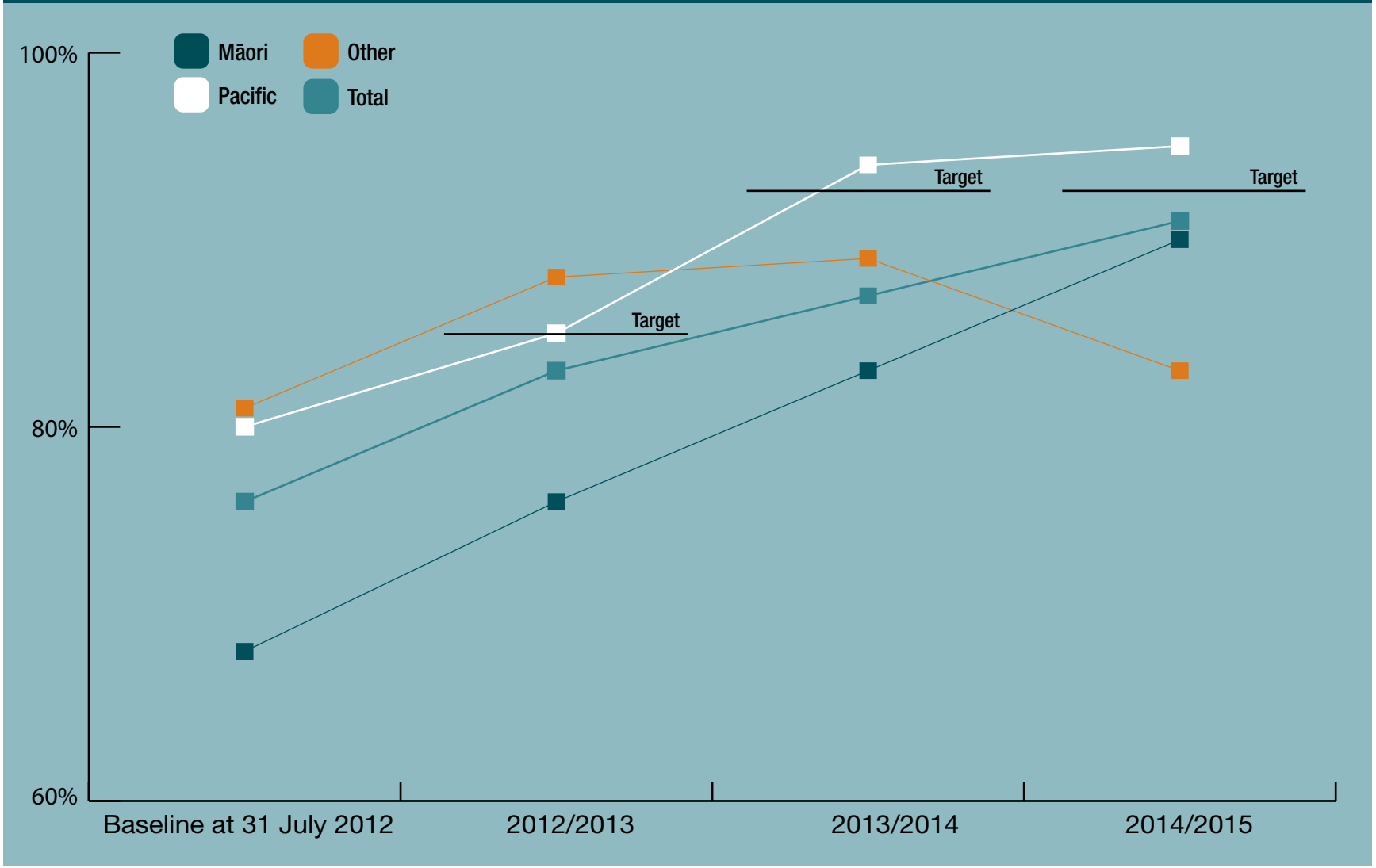
A Hapu Mama Smoke Free Pregnancy Incentives Scheme pilot was put in place by Te Puna Oranga aimed at women who smoke in the 1st/2nd trimester who are Māori or non-Māori with a Community Services Card. Women were offered support from Aukati Kai Paipa, community based stop smoking services, Nicotine Replacement Therapy, carbon monoxide monitoring and incentives. The results have demonstrated a 70 percent quit rate in the pilot group during the pilot programme.

Output measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Percentage of eight month olds fully immunised



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measures	Baseline July 2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of eight month olds fully immunised	Māori 68% Pacific 80% Other 81% Total 76%	Māori 83% Pacific 94% Other 89% Total 87%	Māori 95% Pacific 95% Other 95% Total 95%	✗ Māori 90% ✓ Pacific 95% ✗ Other 83% ✗ Total 91%

Significance of measure

Immunisation can prevent a number of diseases and is a very cost effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people.

The diseases protected against include diphtheria, tetanus, whooping cough, polio, hepatitis B, haemophilus influenzae type B, pneumococcal, measles, mumps, and rubella. Immunisation rates have increased remarkably since 2009, and the immunisation target of increasing eight month olds coverage will support early enrolment and on-going engagement with primary care and well child services.

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children. This equates to longer and healthier lives. The changes which are required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated. These actions are leading to improved implementation of the Primary Health Care Strategy, and the primary care workforce including maternity is better equipped to address the needs of children and families.

This is one of the National Health Targets.

Waikato DHB performance

Waikato DHB has had a consistent year achieving 91 percent coverage throughout the period. While the 95 percent target has not been attained, this result is still an achievement given back in 2010 coverage was around 75 percent. In late 2014, the National Child Health Information Platform was implemented and the DHB National Immunisation Register team is now co-located at Midlands Health Network to align activity.

The biggest barrier that now needs addressing is reducing the decline rate, which is currently greater than 5 percent. Waikato DHB has a number of strategies to lift performance that include:

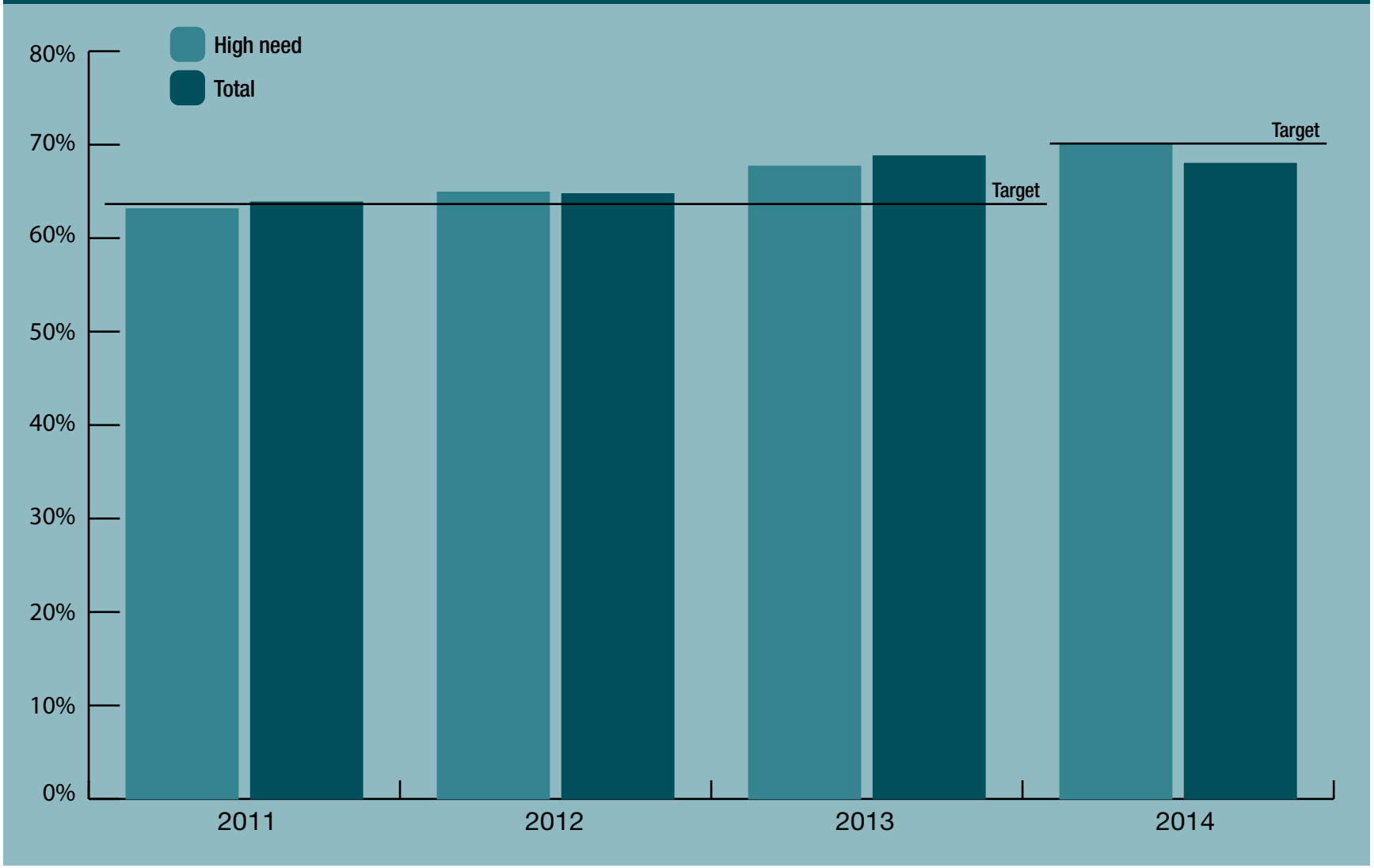
- A new governance group to provide leadership and performance oversight
- A project to identify how the declines are occurring and what can be done to reduce the number and proportion
- Increasing understanding about what is occurring at general practices to immunise by the time the baby is six weeks old with the aim to increase six month coverage
- Weekly meetings among the key stakeholders to discuss progress with the cohort coverage and resolve any operational issues
- An inaugural evening immunisation forum that any interested healthcare professional can attend at no cost

Output measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Percentage of the population older than 65 years who have received the seasonal influenza immunisation



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measures	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of the population older than 65 years who have received the seasonal influenza immunisation — **High Need**	63%	67.7%	70%	✓ 70%
Percentage of the population older than 65 years who have received the seasonal influenza immunisation — **Total**	63%	68.8%	70%	✗ 68%

Significance of measure

Influenza has a large impact on our community, with 10-20 percent of New Zealanders infected. Some of these people become so ill they need hospital care, and a small number die. Influenza also has a financial impact, particularly in workplaces, and can potentially overwhelm both primary care and hospital services during winter epidemics.

Having a 'flu shot' is the best way to protect against the unpleasant effects of influenza; headaches, fever, aches and pains. It will also greatly reduce your risk of serious complications that can develop from the flu.

The eligible population for this measure is New Zealanders at high risk of complications which are people aged 65 years and over, anyone less than 65 years of age with long-term health conditions, and pregnant women. In relation to the measure, the period over which the vaccination programme runs is mid-March to July each year.

Waikato DHB performance

Waikato DHB determined prior to the seasonal influenza season to improve access to people over 65 through a range of initiatives. These included comprehensive communication to the public through all local media outlets and by enabling immunisations to be provided free in pharmacies where the pharmacist was a trained vaccinator. However, communication messages were also clear that peoples usual general practice would be a good first point of call.

The approach to extend the influenza immunization programme to pharmacies has caused some concerns from general practice but given we had not in past years achieved our target and with the enthusiasm from pharmacists to provide this service this was seen to be the right thing to do for patients and has the potential to assist us to reach the target given there is no need to make an appointment with pharmacies. There are 24 pharmacies throughout Waikato offering this service.

Hisae Shiwa Mchale, with baby at the Hamilton Migrant Centre for the World Breast feeding Week Big Latch On

People are supported to take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of infants who are fully or exclusively breastfed — **6 weeks**	Māori 62% Pacific 56% Other 72% Total 68%	Māori 63% Pacific 70% Other 73% Total 70%	Māori 68% Pacific 68% Other 68% Total 68%	✗ Māori 60% ✓ Pacific 68% ✓ Other 73% ✓ Total 68%
Percentage of infants who are fully or exclusively breastfed — **3 months**	Māori 49% Pacific 53% Other 60% Total 56%	Māori 45% Pacific 47% Other 66% Total 54%	Māori 54% Pacific 54% Other 54% Total 54%	✗ Māori 43% ✗ Pacific 47% ✓ Other 60% ✓ Total 54%
Percentage of infants who are exclusive, fully or partially breastfed — **6 months**	New measure New measure New measure New measure	Māori 52% Pacific 67% Other 65% Total 62%	Māori 59% Pacific 59% Other 59% Total 59%	✗ Māori 54% ✗ Pacific 57% ✓ Other 64% ✓ Total 61%

Significance of measure

Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden.

Breastfeeding sustains the link between the mother's and baby's immune systems that was established during pregnancy.

- During pregnancy, the mother passes antibodies to her baby through the placenta, and these proteins circulate in the infant's blood for weeks to months after birth.
- Breast-fed infants gain extra protection from antibodies, other proteins and immune cells in human milk.
- At around four months of age babies will start to produce some of their own antibody protection but the developing immune system is not fully functional until a child is around two years of age.

The immune factors that come from a mother, via her breast milk, to her baby are amazing. Not only do they give a baby protection against a wide range of illnesses but they switch on protective effects in the baby.

Waikato DHB performance

It is important for breastfeeding mothers to feel comfortable about breastfeeding so that they continue to breastfeed.

This measure provides some indication for the percentage of mothers breastfeeding up to six months.

During 2014/15 we continued to incorporate breastfeeding messages and education into the following three key programmes:

- Waikato Pepi-Pod Programme
- Midland Safe Sleep Programme
- Waikato Wahakura / Waikawa Programme

The results are sourced from Plunket

Please note the change to the measure for 6 months, which now includes 'partially' breastfed data.

Output measure

People are supported to take greater responsibility for their health

Improving health behaviours

Measure	Baseline	Previous year 2013/14	Target 2014/15	Result 2014/15
The number of people participating in Green Prescription programmes	New Measure	New Measure	3274	✓ 5802

Significance of measure

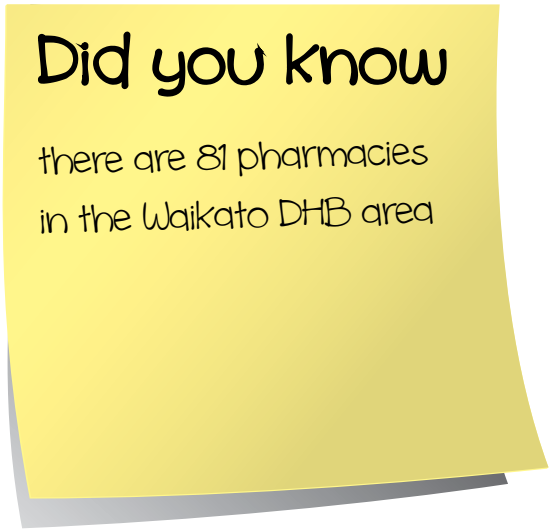
The Green Prescription programme is where general practitioners write prescriptions for exercise, rather than (or as well as) a prescription for medication. This initiative has been embedded within primary care and community-based sports trust systems with several randomized controlled trials showing there is high effectiveness and cost-effectiveness evidence.

Waikato DHB performance

Waikato DHB manages the contract for Green Prescriptions on behalf of the Ministry of Health with Sport Waikato providing the service.

The target for this year has been exceeded, this is because there was a lag in numbers last year and Sport Waikato worked to catch up on the previous year's target as well as successfully achieving this year's target.

Referrals for Green Prescriptions come from medical centres, hospitals, mental health providers, self-referrals, physiotherapists, midwives, and many others.



People are supported to take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2009	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	93.8%	100%	93.8%	✓ 100%
Percentage of total primary schools participating in Project Energize	98.8%	100%	98.8%	✓ 100%

Significance of measure

Project Energize is a school-based initiative funded by the Waikato DHB and delivered by Sports Waikato. The focus is on improving children's physical activity and nutrition through fun and interactive activities with the involvement of schools, parents, and community. Project Energize is successfully working to treat and prevent two key factors attributed to obesity, poor eating habits and poor physical activity.

Through Project Energize the DHB can positively influence health behaviours of Waikato's tamariki/children and reduce the risk factors associated with many chronic conditions.

Waikato DHB performance

100 percent of total primary schools and Kura Kaupapa Māori participate in Project Energize.

Project Energize has just celebrated its 10th birthday with key relationship developed as listed below:

- Health promoting schools
- National Heart Foundation and Foodsstuffs
- Cancer Society of NZ
- Eco store
- I love eggs
- Fitness locker

Beyond Waikato Sport Northland have entered into relationship with Sport Waikato for Project Energize, there are five Energize schools in Counties Manukau and initial discussions with Capital Coast DHB have commenced.

Project Energize continues to demonstrate that schools, teachers and students all participate in a variety of services offered such as fitness design, fundamental movements and healthy, breakfast sessions to name a few from the school toolkits.

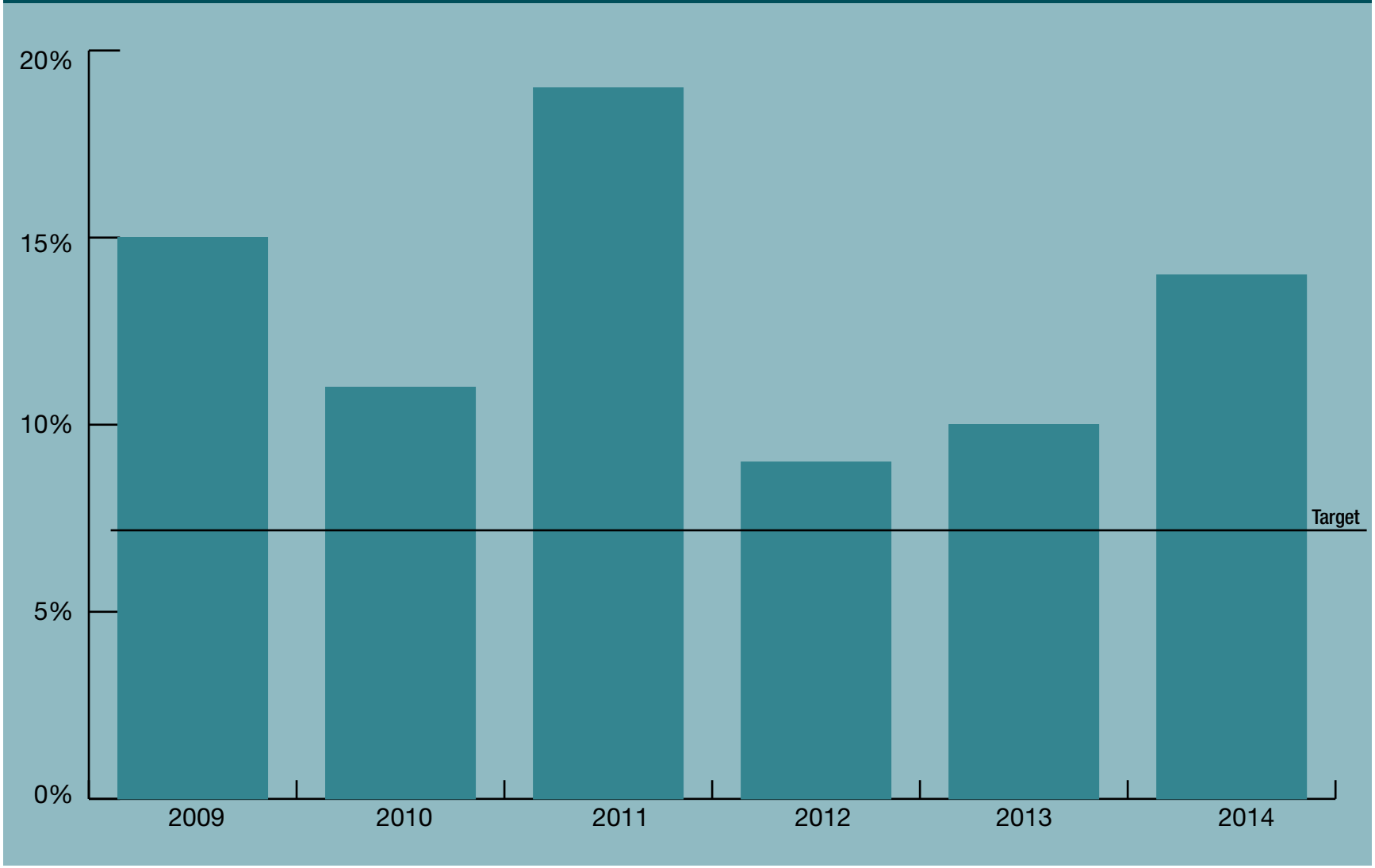
Long-term impact	**People stay well in their homes and communities**			
Intemediate impacts	An improvement in childhood oral health	Long term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence
Output Performance Measures	• Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination • Percentage of children (0-4) enrolled in DHB funded dental services • Percentage of adolescent utilisation of DHB funded dental services	• Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years • Percentage of eligible women (20-69) have a cervical cancer screen every three years • Percentage of eligible women (50-69) have a breast screen in the last two years	• Percentage of rest home residents receiving vitamin D supplement from their GP • Percentage of eligible population who have had their B4 school checks completed • Incidence rates per 100,000 and number for rheumatic fever	• Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months • Percentage of population enrolled with a Primary Health Organisation • Percentage of needs assessment and service co-ordination (NASC) waiting times for new assessment within 20 working days

Output measure

People stay well in their homes and communities

An improvement in childhood oral health

Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination



People stay well in their homes and communities

An improvement in childhood oral health

Output measure

Measure	Baseline 2009	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	11%	10%	< 7%	✗ 14%

Significance of measure

Oral health is an integral component to many health and wellbeing benefits, including preventing decay of teeth and disease in the mouth and gums, comfort in eating (especially ability to maintain good nutrition in old age), and self-esteem.

Research shows that improving oral health in childhood and adolescence has benefits over a lifetime. Good oral health in young people indicates early contact with health promotion and prevention services, which will hopefully be lifelong good oral health behaviours.

By monitoring the number of pre-school and primary school children (0 – 12), who are overdue for their scheduled examination, the DHB is able to determine how to quickly respond if the target is not met.

Waikato DHB performance

This measure covers a calendar year period to line up with the school year

This report is the Community oral health result at 30 June 2015. The arrears target was unfortunately not attained, however arrears have tracked favorably in the last quarter and the tail of arrears, which spanned 8 months at its peak, has reduced to 5 months. The availability of dental therapists and the working speed of graduates compared to experienced staff has impacted on service achievements. The service is continuing to focus on reducing the tail of arrears and ensure that low decile schools and disadvantaged group are prioritised. The service is planning to target end of year graduates to fill vacancies for 2016 onwards, and is working with the training institutions for undergraduate placements during 2015.

Output measure

People stay well in their homes and communities

An improvement in childhood oral health

Measure	Baseline 2009	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of children (0-4) enrolled in DHB funded dental services	43%	68%	73%	✗ 70%

Significance of measure

Oral health is an integral component to many health and wellbeing benefits, including preventing decay of teeth and disease in the mouth and gums, comfort in eating (especially ability to maintain good nutrition in old age), and self-esteem.

Research shows that improving oral health in childhood has benefits over a lifetime. Good oral health in children indicates early contact with health promotion and prevention services, which will hopefully be lifelong good oral health behaviours.

By increasing the number of pre-school children less than five years of age (0 – 4 year olds, inclusive), who have enrolled for DHB-funded oral health services, the DHB will show that it has made an impact on the outcome of protecting and promoting good health and independence.

The measure indicates the accessibility and availability of publicly-funded oral health programmes, which will in turn reduce the prevalence and severity of early childhood caries, and improve oral health of primary school children.

Waikato DHB performance

Oral health measures are reported annually (in quarter three) for the previous calendar year.

A two percent improvement in the number of children enrolled with Community Oral Health was evident at 30 June 2015, however the service acknowledges that it didn't achieve its target. In 2015/2016, the percentage of enrolled preschool children will significantly increase - children five years of age and younger have been automatically enrolled for oral health services in the national child health information programme (NCHIP) and the current priority is integrating this information with paper-based records prior to counting them in our enrolled numbers.

People stay well in their homes and communities

An improvement in childhood oral health

Output measure

Measure	Baseline 2009	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of adolescent utilisation of DHB funded dental services	66%	71.3%	85%	✗ 69.9%

Significance of measure

Oral health is an integral component to many health and wellbeing benefits, including preventing decay of teeth and disease in the mouth and gums, comfort in eating (especially ability to maintain good nutrition in old age), and self-esteem.

Research shows that improving oral health in childhood and adolescence has benefits over a lifetime. Good oral health in children indicates early contact with health promotion and prevention services, which will hopefully be lifelong good oral health behaviours.

Increasing the proportion of adolescents, in school (from 13 years up to and including 17 years of age), who have accessed DHB-funded oral health services will show that the DHB has made an impact on the outcome of protecting and promoting good health and independence by providing accessible and available publicly-funded adolescent oral health programmes. The programmes will help reduce the prevalence and severity of oral disease in adolescents.

Waikato DHB performance

This measure covers a calendar year period to line up with the school year. 17,355 adolescents were seen in 2014 compared to 16,995 in 2013 – this represents a 2 percent increase in uptake between years but does not compare to the 4 percent increase in total adolescent population (12 – 17 year-old).

The DHB continues to encourage private dentists to take up the service agreement, especially in its small and rural towns. In 2014 there were six new dentists holding the Combined Dental Agreement (CDA) for adolescents with one small rural town Waihi about to have its first contracting dentist (start date 01/07/15) for many years.

The Combined Dental Agreement claims dataset continues to be the DHBs source of information, enabling identification of areas where uptake of the service by young people is low and enables focussed solutions to localised situations. This has meant positive solutions agreed at times with the Preschool and School Oral health Services including use of that service during school holidays

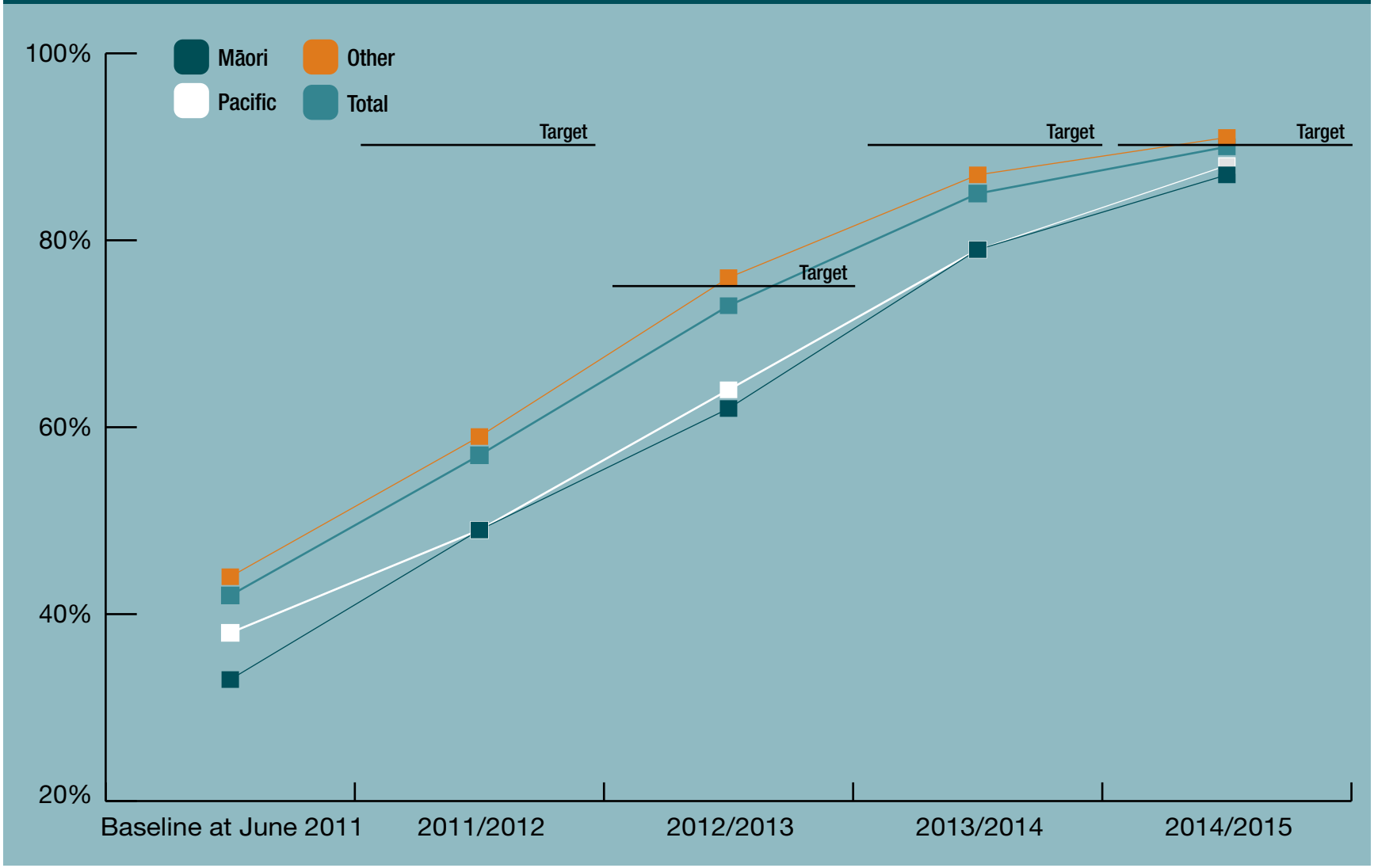
In conjunction with other Midland DHB colleagues, a focus on seamless integration for Year 9 student enrolment with private dentists, flexible delivery of Safety Net services and improving messaging to adolescents are planned in order to increase uptake of this service.

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years



People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percent of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori 33% Pacific 38% Other 44% Total 42%	Māori 79% Pacific 79% Other 87% Total 85%	Māori 90% Pacific 90% Other 90% Total 90%	✗ Māori 87% ✗ Pacific 88% ✓ Other 91% ✓ Total 90%

Significance of measure

Cardiovascular disease is still the leading cause of death in New Zealand, many of these deaths are premature and preventable. Some risk factors for cardiovascular disease are unavoidable, such as age or family history.

Many risk factors are avoidable, such as diet, smoking, and exercise. Either way, by increasing the percentage of people having cardiovascular disease risk assessments the DHB ensure these are identified early and managed appropriately.

Cardiovascular Risk Assessments involves taking a 'whole picture' look at an individuals potential risk of a heart attack or stroke. The doctor will then make recommendations for reducing the risk, such as changing diet, increase exercise and regular monitoring or drug intervention if necessary.

This is one of the national health targets.

Waikato DHB performance

All three Primary Health Organisations made significant progress in 2014/15. At the start of 2014/15 the DHB results started at 86.1 percent and at 30 June 2015 the results were 90.4 percent and the DHB has met the 90 percent target. Initiatives undertaken by the Primary Health Organisations to achieve the target were as follows:

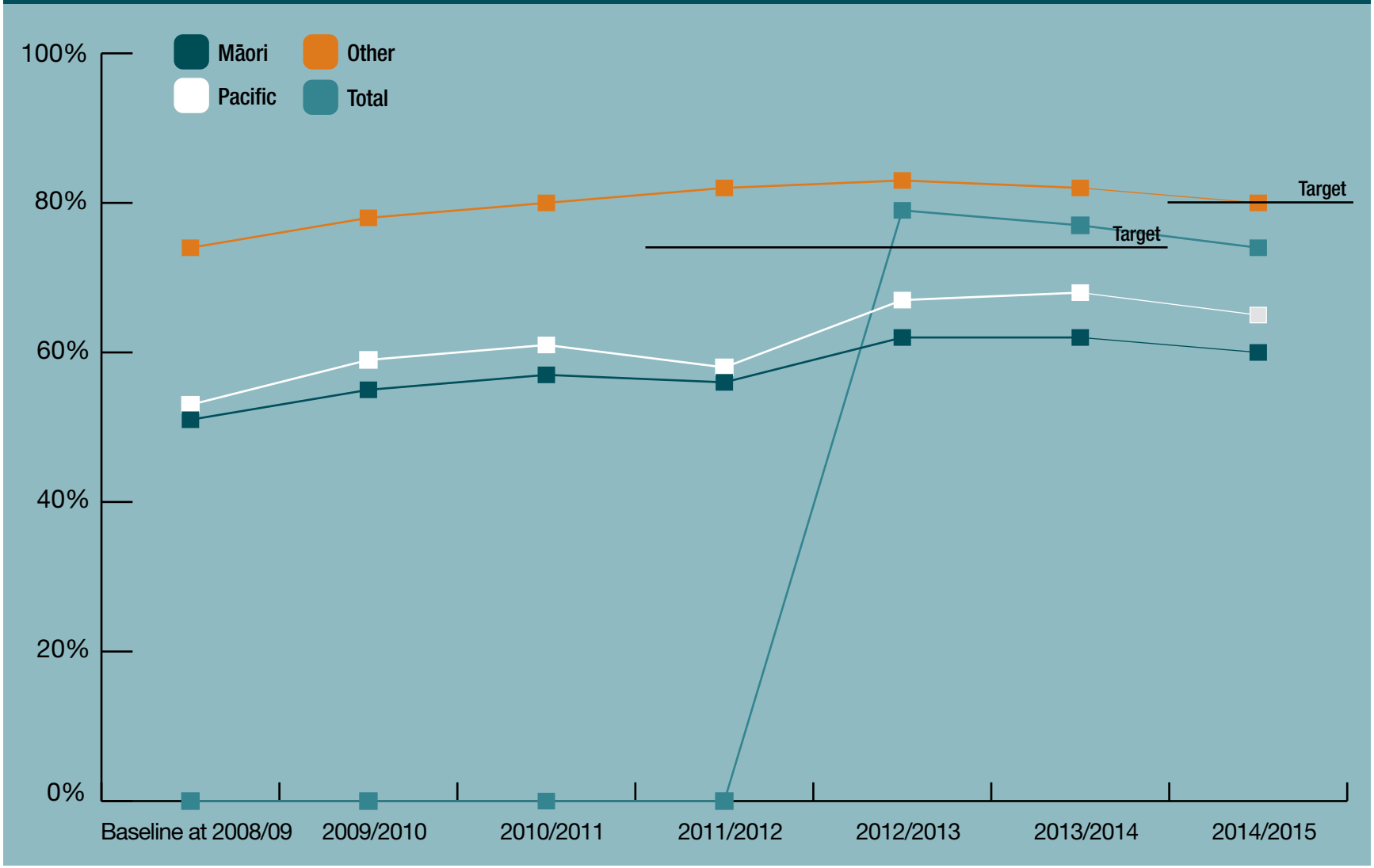
- Virtual Cardiovascular Risk Assessments tool development
- Enhancement of IT tools i.e. dashboards, reminders, recalls
- Upskilling of clinical and support staff
- Payment to practices to strengthen capability and capacity
- Targeting of Hamilton practices
- Being more mobile – reaching marae, workplaces, other relevant community settings
- More access to equipment/disposables associated with point of care testing

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of eligible women (20-69) have a cervical cancer screen every 3 years



People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure

Measure	Baseline 2012/2013	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Māori 62% Pacific 67% Other 83% Total - 77%	Māori 62% Pacific 68% Other 82% Total 77%	Māori 80% Pacific 80% Other 80% Total 80%	✗ Māori 60% ✗ Pacific 65% ✓ Other 80% ✗ Total 74%

Significance of measure

The eligible population for this measure is women aged 20-69 years. A cervical smear test that looks for abnormal changes in cells on the surface of the cervix (the neck of the uterus or womb). Some cells with abnormal changes can develop into cancer if they are not treated.

Treatment of abnormal cells is very effective at preventing cancer. There is a choice of providers for a smear test. A doctor or practice nurse will usually be able to provide this service, the Family Planning Association can offer this service and the Waikato DHB Sexual Health Service will also provide this service as part of a sexual health clinical assessment.

Waikato DHB performance

Performance for the year is disappointing with a three percent drop in coverage though we note some of the difference is artificial as this year's result is based on the new census data, which has a larger denominator. Performance also dipped in April and May, possibly due to the influenza vaccination campaign, which ran later than usual this year.

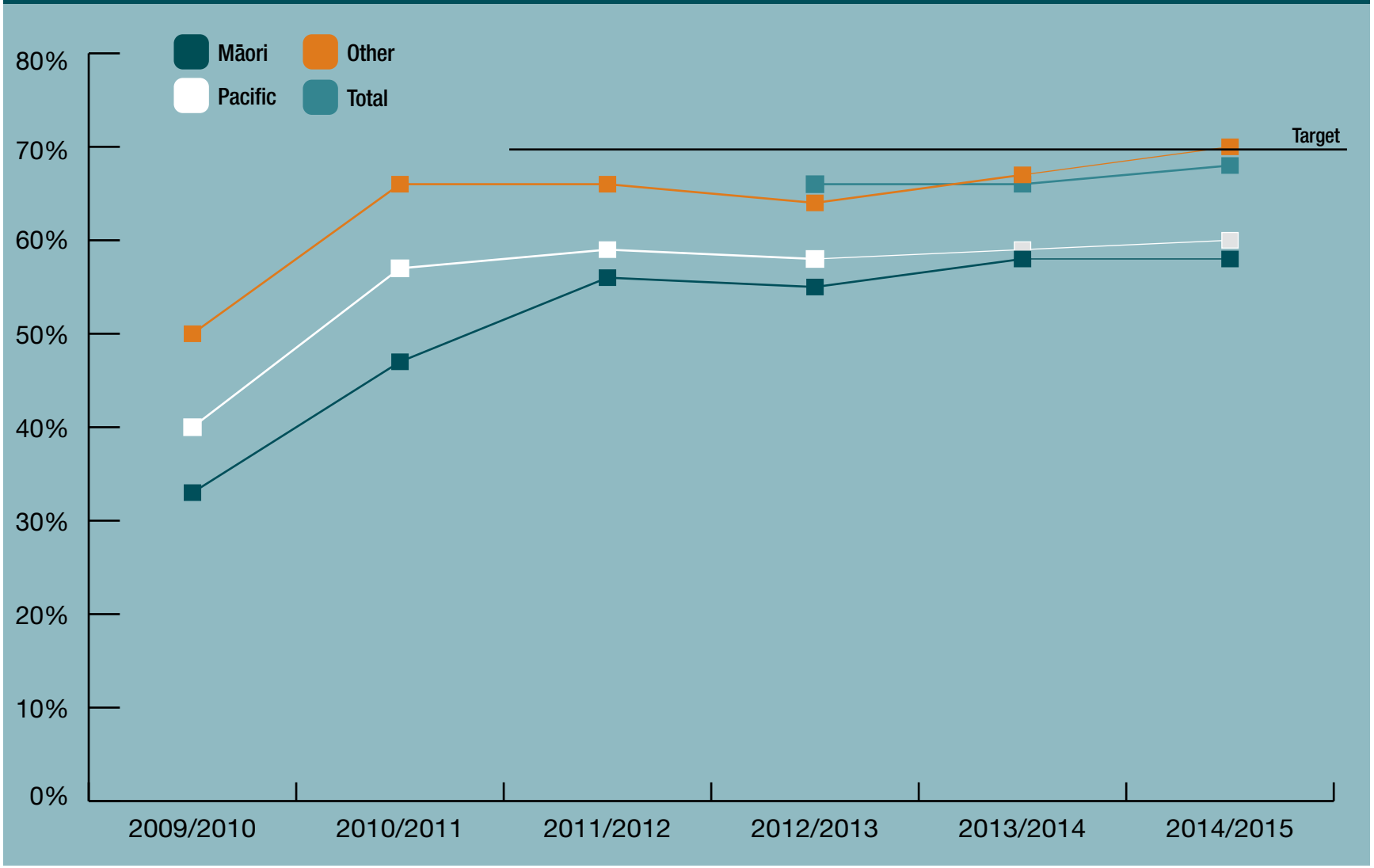
There is a lot of activity planned for 2015/16 including making additional funding available to smear takers to target women who are significantly overdue. This funding recognises the additional effort required to locate and screen this group of women.

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of eligible women (50-69) have a breast screen in the last two years



People stay well in their homes and communities

Long term conditions are detected early and managed well

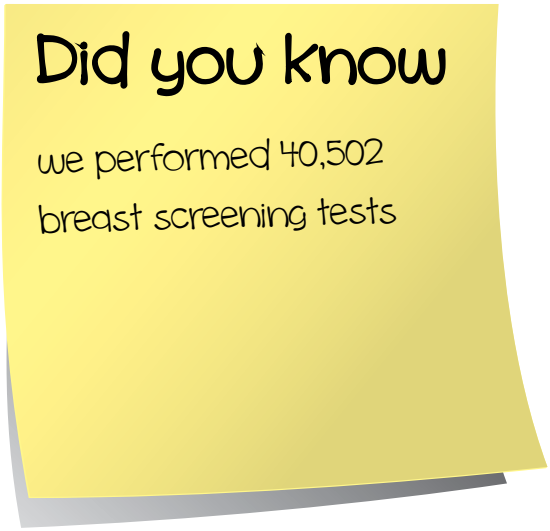
Output measure

Measure	Baseline 2012/2013	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of eligible women (50-69) have a breast screen in the last two years	Māori 56% Pacific 58% Other 82% Total 63%	Māori 58% Pacific 59% Other 67% Total 66%	Māori 70% Pacific 70% Other 70% Total 70%	✗ Māori 58% ✗ Pacific 60% ✓ Other 70% ✗ Total 66%

Significance of measure

Breast cancer is the most common cancer in New Zealand women and as women get older, the risk increases. Of those women who get breast cancer, three quarters are 50 years and over. For women aged 50-65 screening reduces the chance of dying from breast cancer by about 30 percent, and for women aged 65-69, it is reduced by about 45 percent (National Screening Unit, 2014).

Breast screening is provided to reduce women's morbidity and mortality from breast cancer by identifying cancers at an early stage, allowing treatment to be commenced sooner than what might otherwise have been possible.



Waikato DHB performance

This data uses the new census data which reduces the result. If we were comparing the data using the same 2006 projected census baseline, Waikato DHB would show as having reached 70 percent coverage for the first time in its history. Māori coverage was 63 percent and Pacific Island 65 percent using the 2006 projected census data. There have been a variety of strategies employed to increase performance and these have proven to be effective, we will continue to move in the same direction.

To increase Māori coverage, we are making use of some recent evaluation that showed that Māori wahine are less likely to return in a timely manner after their first mammogram. New strategies are therefore being put in place to understand why this occurs and to give this group of women additional information at their first screen to convince them of the importance of returning for their next mammogram in two years' time.

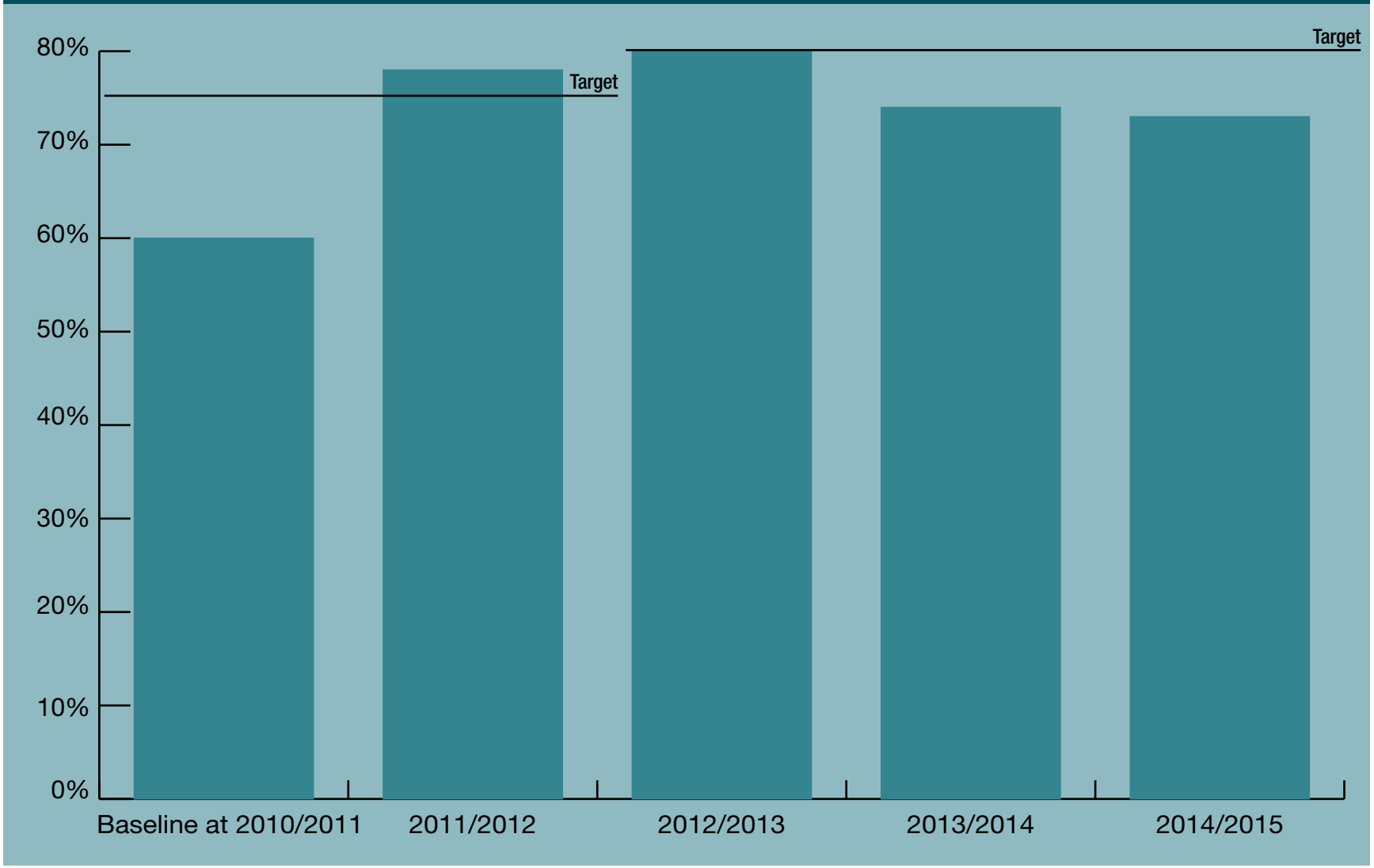
Please note: The 2014/2015 Annual Plan measure stated a three year period for measure, this was an error, the measure remains as it has been: a two year period.

Output measure

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Percentage of Rest Home residents receiving vitamin D supplement from their GP



People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of Rest Home residents receiving vitamin D supplement from their general practitioner	60%	74%	80%	✗ 73%

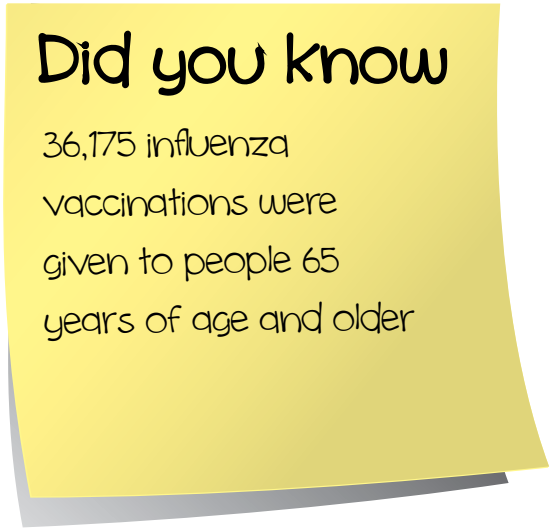
Significance of measure

Vitamin D is a proven way to enhance muscle strength and reduce the risk of falls. When someone living in residential care falls, it will often result in serious injury, reduced mobility and a loss of confidence and independence.

Low vitamin D levels have been linked to many chronic conditions, including rheumatoid arthritis, multiple sclerosis, respiratory diseases, type II diabetes and some cancers.

Waikato DHB performance

We noted that changes in primary care models and high turnover amongst nursing staff in aged care negatively impacted on the Vitamin D Target. We have actively promoted the benefits over the past two quarters and noted that the negative trend is reversing.



Output measure

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Measure	Baseline 2011/2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of eligible population who have had their B4 school checks completed – High Needs	95%	90%	90%	✓ 90%
Percentage of eligible population who have had their B4 school checks completed – Total	81%	90%	90%	✓ 90%

Significance of measure

B4 School Checks are a Ministry of Health specified national programme and includes the Tamariki Ora / Well Child checks done prior to a child turning five. The B4 School Check identifies any health, behavioural or developmental problems that may have a negative impact on the child's ability to learn and take part at school.

Early identification of the child's needs (for example eye exercises to correct a visual issue) allows the child a better start to their primary education.

B4 School Checks are provided free in primary care to Waikato children when they turn four. Waikato DHB Community Services carry out the B4 School Checks for children who don't get to primary care. High Needs is defined as children in high deprivation areas (quintile 5).

Waikato DHB performance

Waikato DHB has continued to fund Primary Health Organisations for B4 school checks which are undertaken by skilled, fully trained practice nurses. In the 2014/15 year we have met both our total and high needs target through this primary care approach. General practices are paid on a fee for service basis. Funding has been top sliced to pay for the B4 School Check Coordinator (based at Midlands Health Network) data entry, and vision hearing checks. Waikato DHBs Community Health Services are able to provide B4 School Checks for those children who are hard to reach. This team also provided immunisations if the child has missed out on early childhood immunisations.

As the Hamilton Children's Team get up and running from September 2015 we will ensure the B4 School Coordinator is involved with the Hamilton Children's team and the referral criteria and consent process so that vulnerable children can be referred to the team through the B4 School Check process.

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Output measure

Measure	Baseline 2013/2014	Previous year 2013/14	Target 2014/15	Result 2014/15
Incidence rates per 100,000 and number for rheumatic fever - **Number of people**	18	18	8	✗ 14
Incidence rates per 100,000 and number for rheumatic fever - **Rate per 100,000**	4.8	4.8	2.1	✗ 3.6

Significance of measure

Reducing the incidences of rheumatic fever is one of the agreed areas for the Better Public Services Target.

Rheumatic fever arises as a result of a throat infection with group A streptococcal bacteria and predominantly affects children between 5 and 14 years of age. In New Zealand evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.

The government has set DHBs with a target of reducing the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Waikato DHB performance

In 2014/15 Waikato DHB had 14 cases of rheumatic fever and although we did not meet our target of eight cases a total of 14 cases is a reduction from our 2013/14 result of 18 cases.

In 2014/15 Waikato DHB committed additional staff to support our rheumatic fever activity and in December 2014 the Ministry approved funding to improve access to rapid response sore throat management services. As of 30 June 2015, there were 158 contracted swabbing services located within GP practices, low decile secondary school health clinics, accident and medical centers, pharmacies and Pathlab sites throughout the Waikato region.

We are pleased to say Waikato DHB have met our rapid response sore throat management coverage target of 80 percent of children and young people from our eligible population having improved access to rapid response sore throat management services. Waikato DHB hopes to see an impact from these services on our 2015/16 rheumatic fever results. Waikato DHB's rheumatic fever prevention plan is being updated to capture the ongoing delivery of sore throat management services in Waikato.

Output measure

Waikato DHB CEO Dr Nigel Murray with Maggie Barry, Minister for Senior Citizens at the Agewise seminar in June 2015

People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure	Baseline 06/12 - 12/12	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	100%	94%	100%	✓ 100%

Significance of measure

It is important to the health and wellbeing of an older person to maintain their functional independence, however as we age we often require assistance. The type and level of assistance is unique to each individuals situation and with a tailored care plan older people can access the assistance they need whilst maintaining their independence.

Comprehensive clinical assessments for older people receiving longterm home support is expected to result in a more unified and improved health and disability system via a common language of assessment. The assessments involve a bio-psycho-social assessment that provides a more holistic view of the older persons needs for a care plan.

Waikato DHB performance

It is mandatory that all new clients assessed for DHB health of older people funded services receive a comprehensive clinical assessment using the InterRAI minimum data set – home care tool or the contact assessment tools.

Waikato DHB assesses 100 percent of new referrals for older people for needs assessment and service coordination to long term home based support services with the InterRAI assessment tool.

Existing health of older people funded clients, whose need for a review or reassessment receive a comprehensive clinical assessment. 100 percent of all clients receiving a comprehensive clinical assessment have an individual care plan.

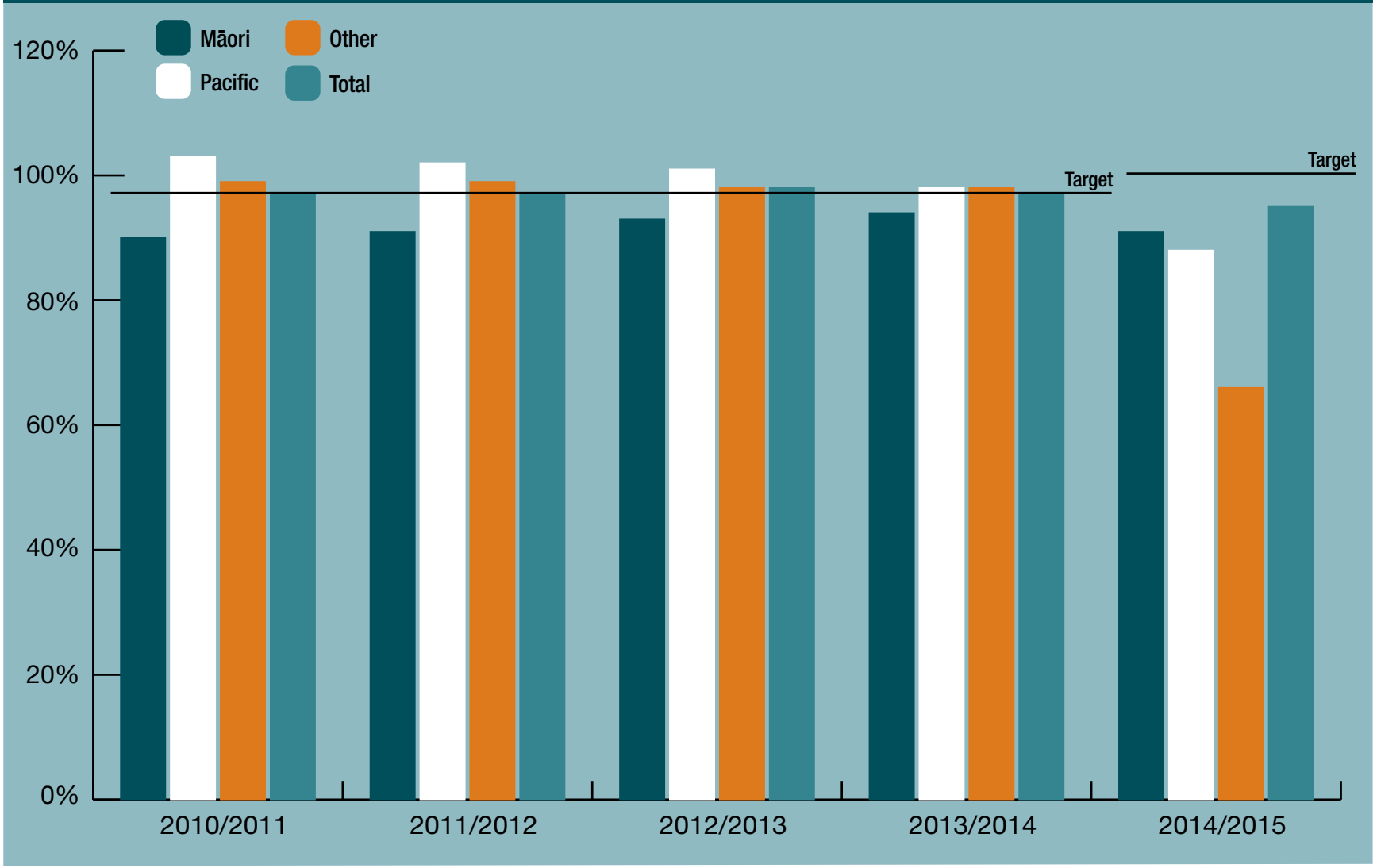
All eligible clients allocated DHB funded services have a completed care plan.

Output measure

People stay well in their homes and communities

More people maintain their functional independence

Percentage of population enrolled with a Primary Health Organisation



People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of population enrolled with a Primary Health Organisation	97%	97%	100%	✗ 95%

Significance of measure

Each GP or medical centre in the Waikato is a member of a primary health organisation. The Waikato has three primary health organisations: Midlands Health Network, Hauraki primary health organisation, and the National Hauora Coalition. The government provides funding to primary health organisations to subsidise visiting fees and prescriptions.

It is voluntary for people to join a primary health organisation, however subsidies are only available to those who have joined.

People are encouraged to join a primary health organisation because access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early.

Māori tend to have lower enrollment rates with primary health organisations than other ethnicities. This is an issue Waikato DHB and the primary health organisations in the Waikato are focusing on by ensuring there are primary health organisation's whose general practice's provide kaupapa health services and that these are promoted in Waikato's communities.

Waikato DHB performance

Reduction in this percentage is due to the population estimate denominator being updated to be based on the new population estimates provided by Stats NZ that are using the latest 2013 Census results as a base.

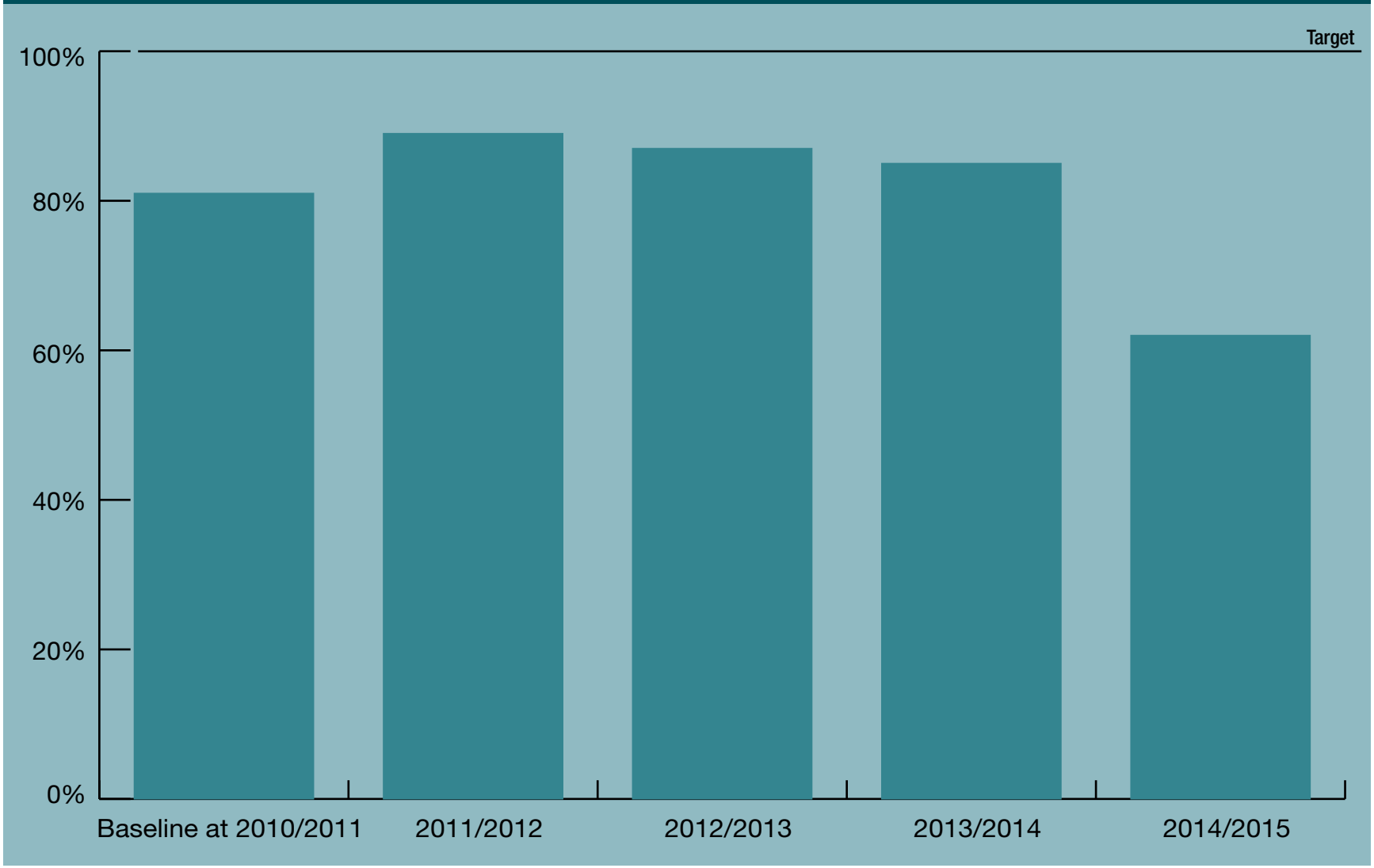
Overall enrollments went up by 3,525 but the percentage drop is due to population increase.

Output measure

People stay well in their homes and communities

More people maintain their functional independence

Percentage of needs assessment and service co-ordination (NASC) waiting times for new assessment within 20 working days



People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of needs assessment and service co-ordination (NASC) waiting times for new assessment within 20 working days	81%	85%	100%	✗ 62%

Significance of measure

Needs Assessment and Service Coordination (NASC) is a tool that provides a more consistent and comprehensive assessment of the older person, which allows for coordination of service requirements such as service capacity needs and planning of service delivery. Ensuring timeliness to NASC allows monitoring of responsiveness and adequate planning for the service demand.

Waikato DHB performance

The results for this measure are sourced from monthly reports provided by our needs assessment and service coordination service. On a month-by-month basis, the service has been seeing 84 percent of clients within the 20 working day time frame. However, a fault in the reporting highlighted clients on the wait list were dropping off at the end of the month making the reporting inaccurate, this issue has been rectified. There has been some recent changes as part of the Disability Support Link review, including fixing the reporting issue and an increase in staff members, which have already shown improvements to ensuring wait times for Needs Assessment and Service coordination wait times are within 20 working days.

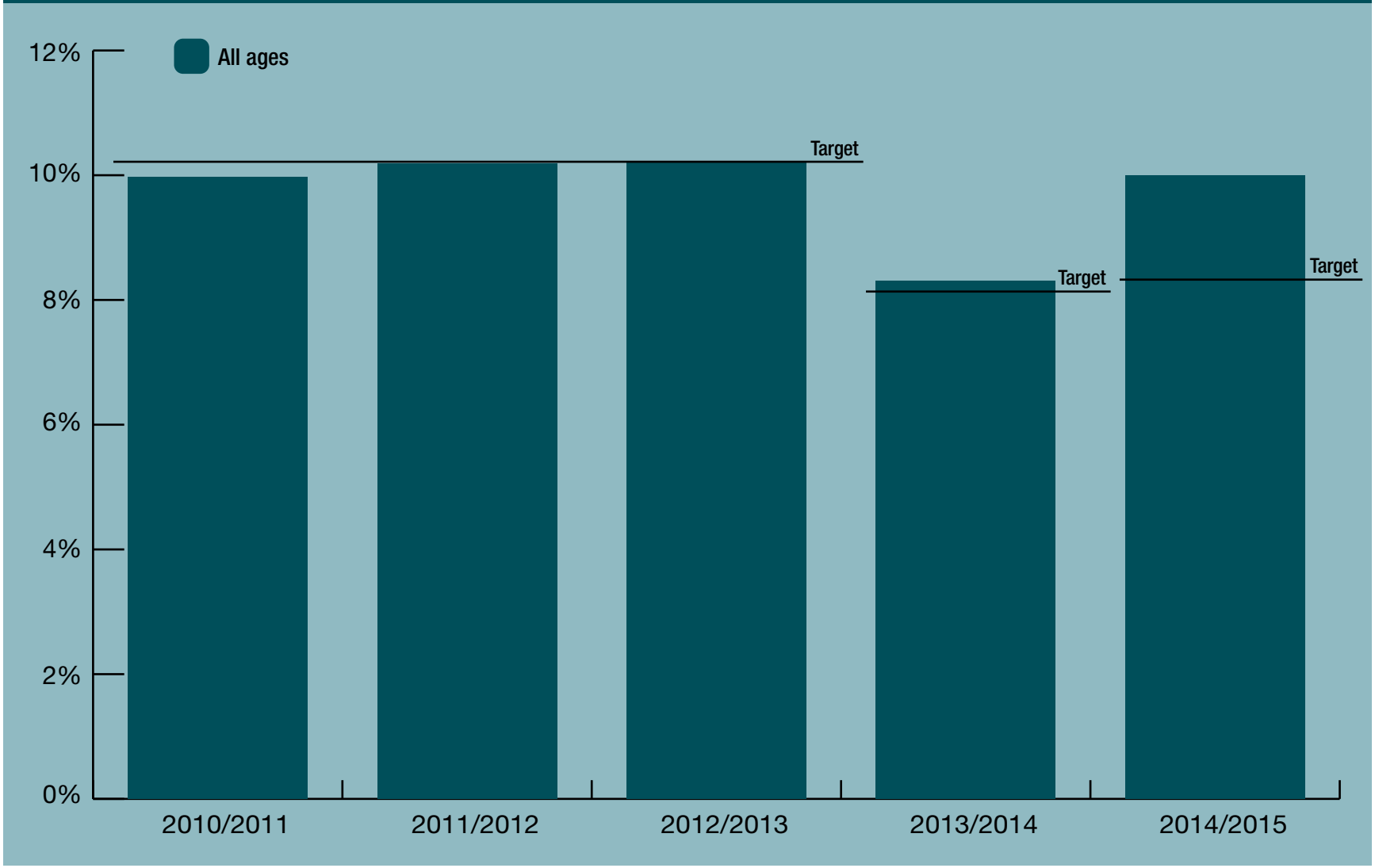
Long-term impact	People receive timely and appropriate specialist care				
Intermediate impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improved health status for those with a severe mental illness and / or addictions	More people with end stage conditions are supported appropriately	Support Services
Impact measures	• Acute re-admission rate • Acute inpatient average length of stay • Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries • Percentage of patients who require radiation or chemotherapy are treated with four weeks	• Percentage of patients waiting longer than four months for their first specialist assessment • Improved access to elective surgery, health target, agreed discharge volumes • Did-not-attend percentage for outpatient services	• Percentage of young people aged 0 -19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks • Percentage of child and youth with a transition (discharge) plan • Average length of acute inpatient stays • Rates of post-discharge community care	• Number of aged residential care facilities utilising advanced directives • Number of first attendances at the Waikato DHB hospital palliative care outpatient service	• Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within six weeks • Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt • Total number of pharmaceutical items dispensed in the community

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Acute re-admission rate



People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 06/10 - 03/11	Previous year 2013/14	Target 2014/15	Result 2014/15
Acute re-admission rate	6.7%	8.3%	≤ 8.2%	✗ 10.0%

Significance of measure

Unplanned re-admissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity.

Re-admissions for unpredicted clinical reasons are important to monitor as they may be an indication of quality of care issues such as whether people are being discharged too quickly or whether appropriate diagnoses are not being made on the index admission.

Emergency departments like Waikato are likely to have high re-admission rates for purely administrative reasons. The same sorts of data issues affect other services such as the Regional Oncology Centre and the Regional Renal Centre, where patients return multiple times within a seven day period as part of their predicted care journey.

Waikato DHB performance

The measurement of this target remains problematic in part because of the number of facilities operated by the Waikato DHB. For example, during 14/15 an explicit decision was made to improve patient safety by reducing the number of overnight ED transfers from some of the remote hospitals where a patient could be safely admitted overnight and then transferred from re-admission at Waikato's base hospital during the day. This safety improvement initiative has had a negative effect on this measure. It is noted that the sector is re-evaluating the measurement methodology and it is anticipated this will result in a more robust KPI framework in 15/16. General Surgery was a specific area of concern.

During 14/15 the DHB commissioned an external review of that service and a series of recommendations resulting from that review will be implemented in the 15/16 year. A reduction in the re-admission rate is one of several expected outcomes. A review of the international literature was conducted in 14/15. That confirmed that a concerted focus on discharge planning and the more active involvement of consumers/whānau in their discharge preparation are the two interventions that are most strongly associated with reducing readmission rates.

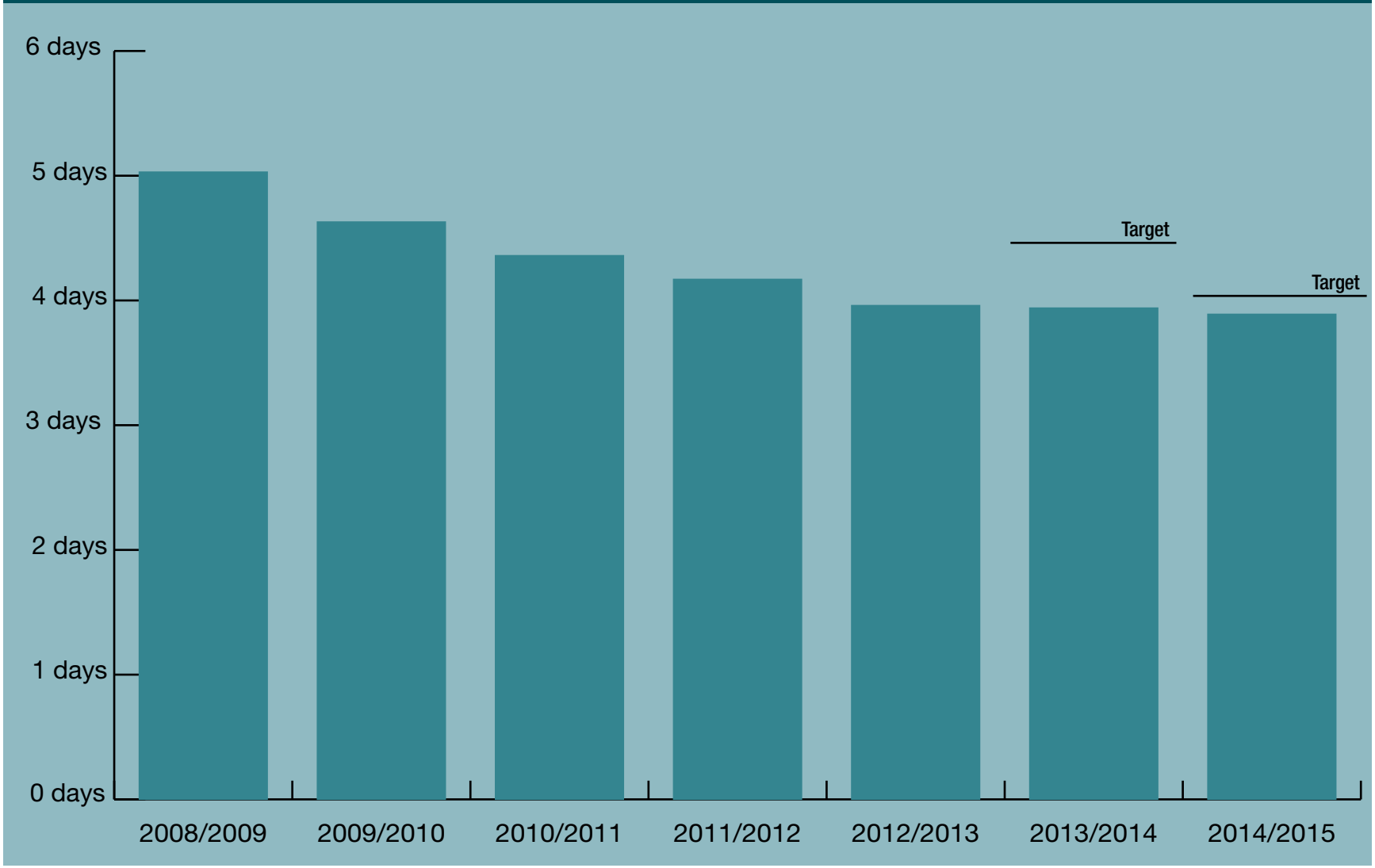
The hospital commenced a broad spectrum programme to improve patient flow, including enhanced discharge planning. This programme drew on the existing Releasing time to Care work that has proven successful in this DHB in addressing other system concerns. The work programme is ongoing and is scheduled to deliver significant benefits during the 2015/16 year. In summary the 14/15 year was a period of investigation, followed by the preparation of system wide changes to improve performance against this measure. A range of specific change initiatives are currently in the early stages of implementation.

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Acute inpatient average length of stay



People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Acute inpatient average length of stay	4.51	3.94 days	≤4.01 days	✓ 3.89 days

Significance of measure

Acute care is a branch of secondary health care where a patient turns up at hospital unexpectedly, and needs to be admitted (for investigation or treatment) there and then. This measure relates to physical health issues.

It is desirable to continue making further reductions to the length of stay for inpatients (where clinically appropriate), since this allows more patients to be processed through hospitals without additional capital investment in hospital beds. This capacity to treat more patients is able to contribute to other areas such as decongestion of emergency departments, or increases in elective surgery. As well as the improvement in throughput, shortened hospital length of stay for patients reduces risks of nosocomial infections and allows patients to return home. In some cases it may also reflect lowered rates of patient complications, or improvements in the time clinical staff are able to give to direct patient treatment.

Waikato DHB performance

Reductions in acute length of stay were achieved. A wide range of initiatives were employed to effect that improvement. These included re-engineering the process by which regional patients with a cute coronary syndrome accessed the cath lab, altering the pre-hospital journey for acute surgical patients presenting to Emergency Department who could be admitted direct to surgery on an arranged basis, and a range of initiatives designed to improve patient flow and improve discharge.

The DHB invested in more acute theatre capacity during 14/15 which has reduced the pre-theatre delays for many acute surgical patients. There was a significant reduction in cardiological demand which has also released capacity to expedite the flow of cardiology patients through the system and significant reductions in length of stay are evident in that area as a result.

Collaborative work between the older persons/rehabilitation service, orthopaedics and general medicine has also had a beneficial impact on acute length of stay. This work will continue to gain momentum during the 15/16 year.

L-R Clinical midwife specialists, Tracey Williams and Judy Murphy, in the women's assessment unit at Waikato Hospital

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 2011/2012	Previous year 2013/14	Target 2014/15	Result 2014/15
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	13%	12%	≤ 16%	✓ 10%

Significance of measure

Caesarean deliveries have a higher risk of operative complications (infections, haemorraghia, visceral injury, thromboembolism). Caesarean sections have some significant associated risks including, increased maternal mortality, maternal and infant morbidity, and increased complications for subsequent deliveries. Through education and advice we wish to see the percentage of caesarean sections decrease over time.

Waikato DHB performance

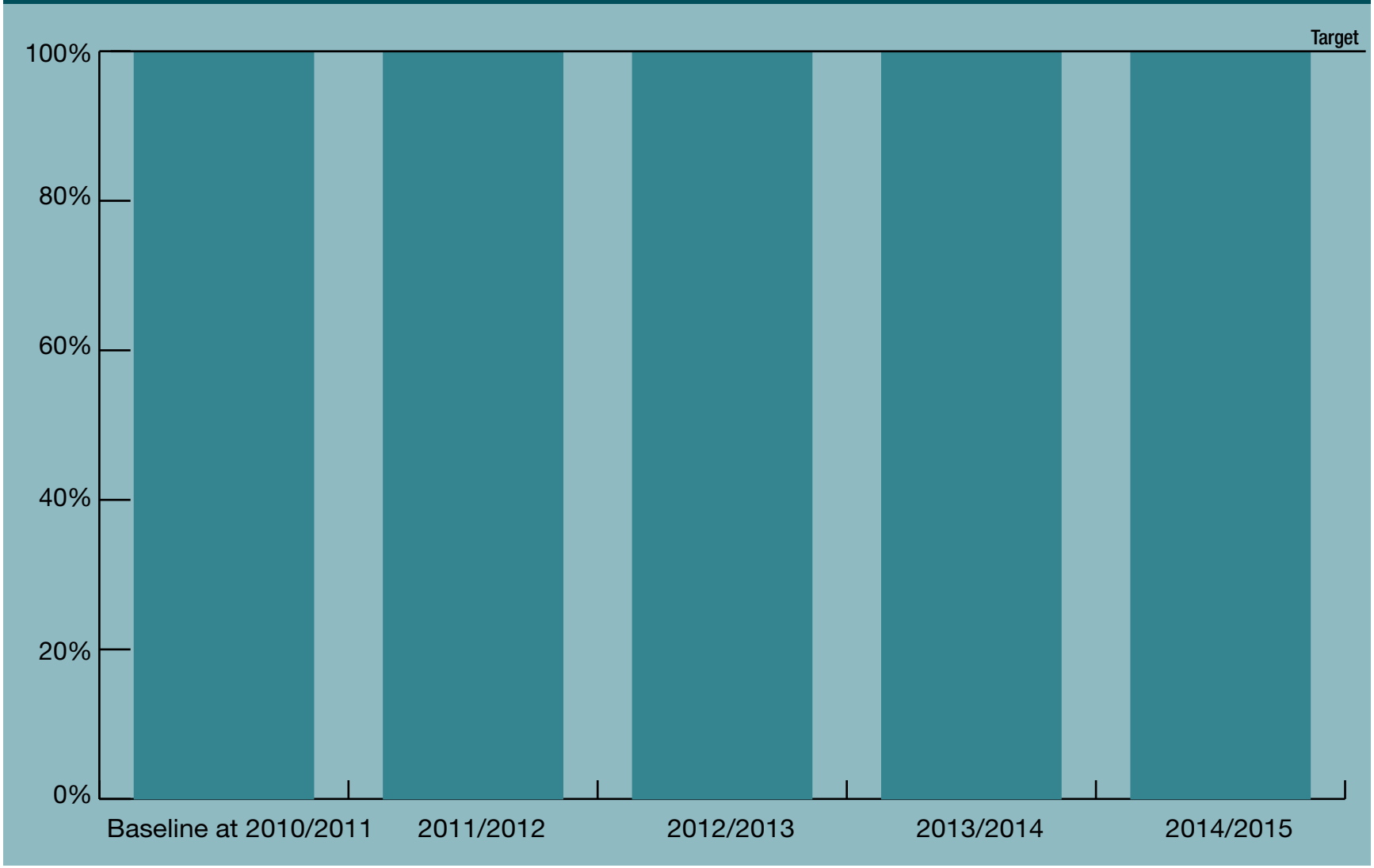
Waikato DHB continues to ensure rates of complications and catastrophes following a caesarean delivery are low. While arranged caesareans are a common procedure, any surgery comes with risk and the Waikato DHB is committed to ensuring mother, baby, and the family and whānau receive the highest quality of pre and post-natal care. We will continue to work towards reducing complications and catastrophe following a caesarean delivery.

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Percentage of patients who require radiation or chemotherapy are treated with four weeks



People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of patients who require radiation or chemotherapy are treated within four weeks	100%	100%	100%	✓ 100%

Significance of measure

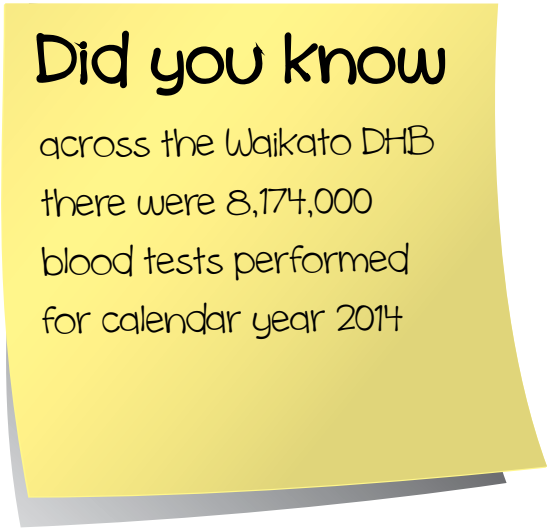
Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Continued performance against this measure not only means that patients requiring radiation or chemotherapy are receiving prompt treatment, it also supports the public's trust in the health and disability system. Services are provided by the Regional Cancer Centre located at Waikato Hospital.

This measure is one of the National Health Targets.

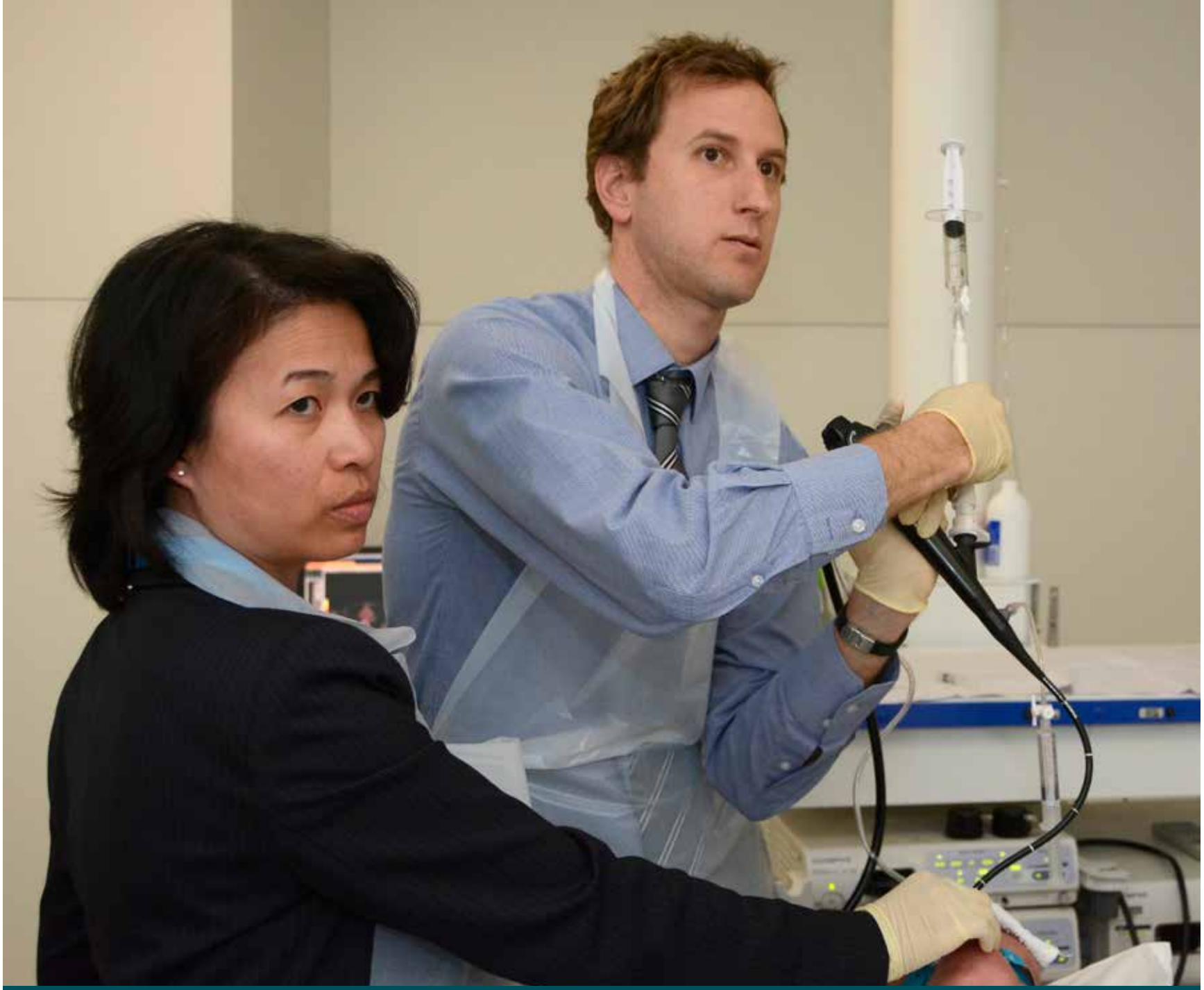
Waikato DHB performance

We have interpreted the four weeks part of the target as being from the decision to treat to treatment start date. The decision to treat is the date the patient signs the consent form for treatment with an oncology clinician through to when their treatment starts.

Please note: Only quarter one was used to report on for the Health Target, however the result of 100 percent listed above was for the full year.



Output measure



L-R Specialist respiratory physician Dr Janice Wong, and registrar Dr Harry Gallagher preforming a bronchoscopy procedure

People receive timely and appropriate specialist care

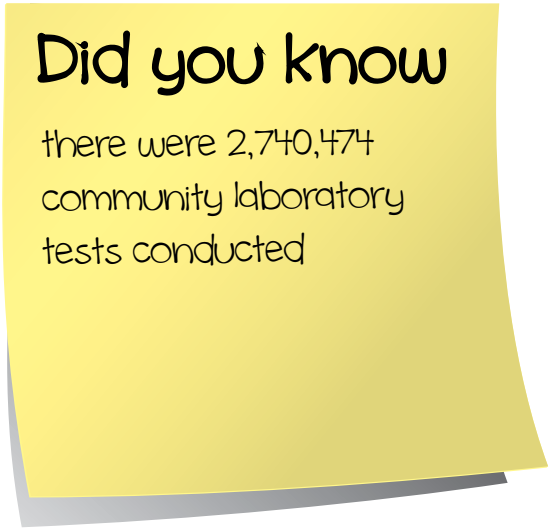
People have appropriate access to elective services

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of patients waiting longer than four months for their first specialist assessment	5.6%	0%	0%	✓ 0%

Significance of measure

Patients have a much better chance of recovering and getting on with their lives where they are diagnosed, treated, and returned home in a timely way.



Waikato DHB performance

We were required to have no patients waiting greater than four months for outpatient first specialist attendances and inpatient elective surgical procedures (including day cases) by 30 December 2015. We have met this target.

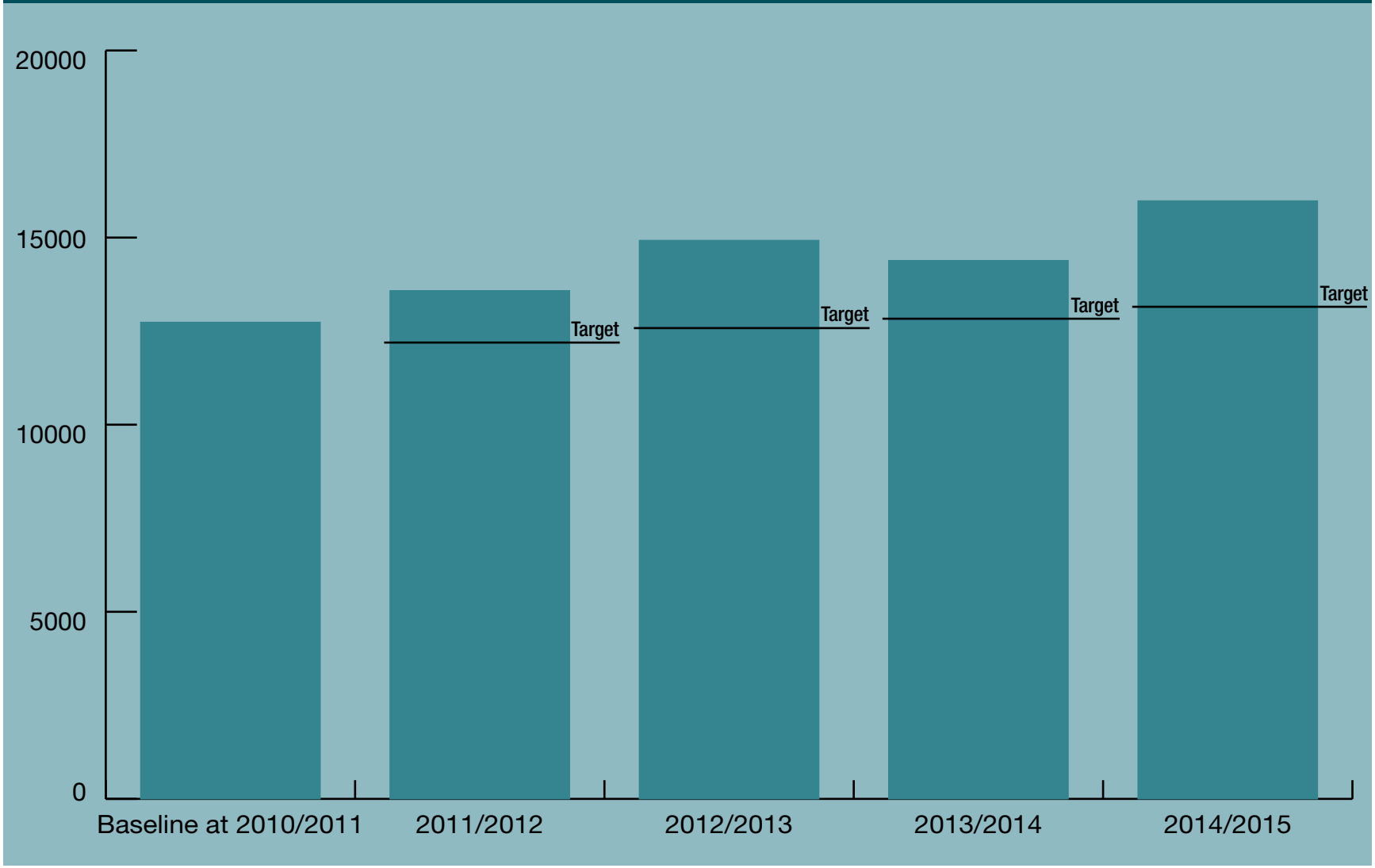
The continued achievement of the target over the past few years reflects an enormous amount of exceptionally hard work from many staff.

Output measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

Improved access to elective surgery, health target, agreed discharge volumes



People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Improved access to elective surgery, health target, agreed discharge volumes	12,737	14,743	13,583	✓ 15,693

Significance of measure

Elective surgery and elective services are important to New Zealanders and the overall health care system due to:

- Improvement in quality of life by reducing pain or discomfort
- Providing treatment, diagnosis, and management of health problems
- Improvement of independence and wellbeing

Increasing delivery should improve access and reduce waiting times, which should increase public confidence that the health system will meet their needs.

This measure is one of the national health targets.

Waikato DHB performance

Waikato DHB met this target for 2014/2015 year, with significantly more elective patients receiving surgery during the year. The result shows a total of 15,693 (115.5 percent) discharges from elective surgery. The DHB exceeded the target in response to the need to reduce waiting times from five to four months during the year and involved the use of both private and public facilities.

Changes to the elective health target:

- From 1 July 2015 the health target for electives will now read ‘an increase in the volume of elective surgery by an average of 4000 per year’ and will have two definition changes:
- All inpatient surgical discharges will be included in this health target, regardless of whether they are discharged from a surgical or medial speciality. This means more consistent recognition of surgical delivery as previously only inpatient elective surgical discharges that were coded within surgical purchase units were counted;
- Inclusion of both ‘elective’ and ‘arranged’ admissions. This means better alignment with international definitions and will include ‘arranged’ admissions (admission between one and six days from the decision to treat).

Sub wait 5 in Meade Clinical Centre

People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Did-not-attend percentage for outpatient services	Māori 17% Pacific 16% Other 18% Total 10%	Māori 22% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	✗ Māori 21% ✗ Pacific 18% ✓ Other 7% ✓ Total 10%

Significance of measure

Reducing 'did not attends' is a key objective in terms of removing waste in the system. Every patient who does not attend their appointment creates a lost opportunity for another patient and incurs costs such as staff time. This measure relates to Waikato DHB outpatient services.

Waikato DHB performance

The did not attend rate amongst Pacific and Māori people remained disappointingly high during 2014/2015. The variability by ethnicity is one aspect of a complex picture, which includes variation by rurality, age and service. Rates of did not attend are highly variable across services, locations and clinics. Best practice options such as patient centered booking and text reminders are being trialled. The use of public health nurses to follow-up on children who do not attend appointments is well embedded. The DHB is placing an increased emphasis on reducing did not attend rates in 2015/2016.

Output measure

People receive timely and appropriate specialist care

Improved health status for those with severe mental illness and / or addictions

Measure	Baseline 2012/2013	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within **3 weeks**	67%	New measure	80%	✗ 75%
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within **8 weeks**	86%	New measure	95%	✗ 91%

Significance of measure

Access and shorter waiting times lead to earlier treatment in the progression of illness which is linked to better outcomes. Timeliness is also a key quality indicator in calls for improvement to the healthcare system.

This measure was introduced nationally for the 2012/13 year. Within three years (i.e. by 2014/15), DHBs are required to achieve performance levels of 80 percent of people referred for non-urgent mental health or addiction services are seen within three weeks and 95 percent of people are seen within 8 weeks. During 2011/12 the Ministry of Health shared data with DHBs on their performance. Using this data DHBs have set and agreed stepped targets over the three year period to ensure the target is met.

Waikato DHB performance

Data quality and timeliness remain an issue across all age-bands, however a process has now been agreed whereby services that are flagged as contributing to poor results will be contacted monthly to identify and understand and resolve both data and service delivery issues.

Due to a 12-month average measure for this indicator any data corrections that impact favourably on the data will not be evident immediately. This measure is reporting to the Ministry of Health on a quarterly basis.

People receive timely and appropriate specialist care

Improved health status for those with severe mental illness and / or addictions

Output measure

Measure	Baseline 2014/2015	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of child and youth with a transition (discharge) plan	New Measure	New Measure	95%	✓ 98%

Significance of measure

Relapse prevention plans identify client's early relapse warning signs and outline what the client can do for themselves and what the service will do to support the client to enable them to stay healthy. Ideally, each plan will be developed with involvement of clinicians, clients and their significant others.

The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each client will know of (and ideally have a copy of) their plan. Maintaining and improving patient engagement through the use of relapse prevention plans will ensure that services are patient-centered and responsive, supporting patients' trust and confidence in services and the health and disability system. Relapse prevention plans also help a DHB to better "know" their long-term clients and provide appropriate services so that the clients are in the best position to contribute to managing their condition. People that are better able to better manage their own health condition retain employment or training/education represents value for money because of the proven reduction in the demand for mental health services and contribution to society.

Waikato DHB performance

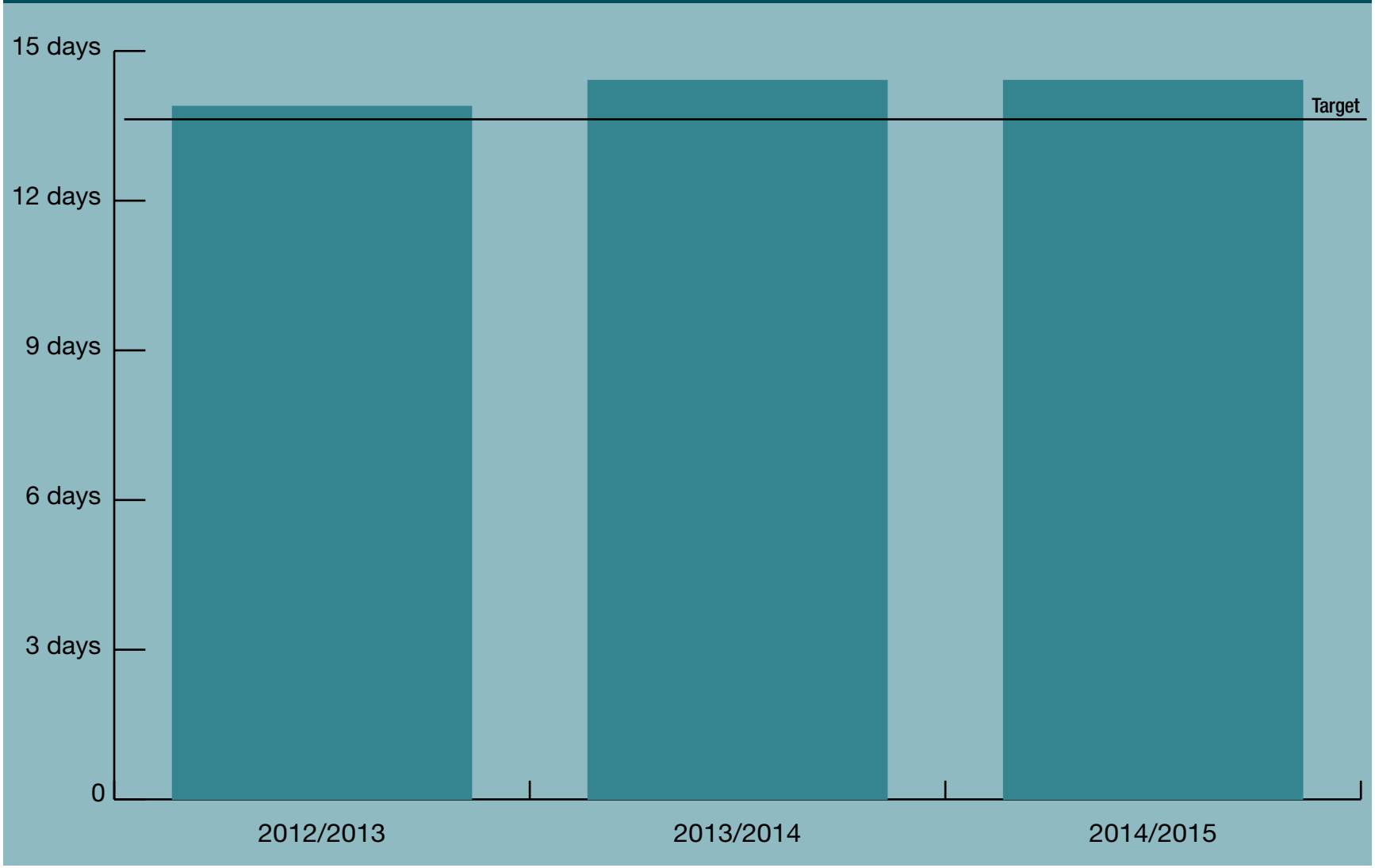
This is a new measure which reflects performance above the target rate. There are clear processes and expectations in place to ensure transition plans are identified and communicated to primary care upon discharge.

Output measure

People receive timely and appropriate specialist care

Improved health status for those with severe mental illness and / or addictions

Average length of acute inpatient stay



People receive timely and appropriate specialist care

Improved health status for those with severe mental illness and / or addictions

Output measure

Measure	Baseline 2013/2014	Previous year 2013/14	Target 2014/15	Result 2014/15
Average length of acute inpatient stay	13.89 days	14.41 days	14-21 days	✓ 14.41 days

Significance of measure

Mental health and addiction services seek to support service users in the least restrictive environment. Performance on this indicator provides some information about the extent to which this is being achieved.

Length of stay is the main driver of variation in inpatient episode cost and reflects differences between mental health service organisations' resources, service practices and service user case mix.

This indicator, alongside others promotes a more complete understanding off an organisation's overall model of service delivery.

Waikato DHB performance

Average length of stay remains at the lower end of the key performance indicator target. This result is slightly higher than the previous year. The service continues to monitor this measure to ensure that we provide least restrictive care and a focus on recovery and flow through the service.

Output measure

Jeni Tuck and Helen Potter District Nurses Te Kuiti Hospital

People receive timely and appropriate specialist care

Improved health status for those with severe mental illness and / or addictions

Output measure

Measure	Baseline 2013/2014	Previous year 2013/14	Target 2014/15	Result 2014/15
Rates of post-discharge community care	82%	82%	90-100%	✗ 87%

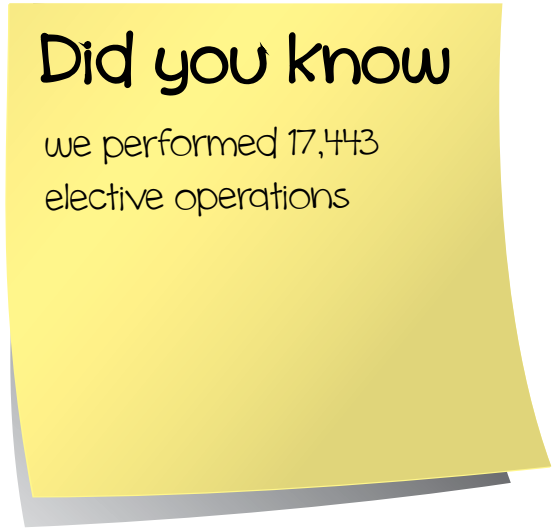
Significance of measure

A responsive support system for people who have required hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital re-admission.

Seven day post-discharge follow-up is one of the key measures in the national mental health and addictions key performance indicator framework, and continued reporting and monitoring has provided a benchmarking opportunity for the service.

Waikato DHB performance

Significant work has continued with teams to focus on the importance of community follow up post discharge within a 7 day period. While under the target there has been an improvement on last years performance. It is anticipated that Circle of care pre discharge meetings will contribute to further improvement in this measure.



Output measure

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Measure	Baseline 2013/2014	Previous year 2013/14	Target 2014/15	Result 2014/15
Number of aged residential care facilities utilising advanced directives	55 (100%)	New Measure	57 (100%)	✓ 57 (100%)

Significance of measure

Advance directives about medical treatment are a facet of patient choice. Patients have the right to use an advance directive, which is defined in the Code of Health and Disability Services Consumers' Rights as "a written or oral directive - a) By which a consumer makes a choice about a possible future health care procedure; and b) That is intended to be effective only when he or she is not competent. The recording of such decisions provides a mechanism for individuals with capacity to say what they would like to happen in the future if their mental capacity becomes impaired. Patients cannot demand or refuse anything in advance that they cannot demand or refuse when conscious and competent.

Waikato DHB performance

All 57 facilities in our district are required to have advance directives in place for each resident. All facilities have a process in place to institute advanced directives. This is covered in the contract with the service provider. Any person assessed using the InterRAI comprehensive assessment system will have this information captured.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Number of first attendances at the Waikato DHB hospital palliative care outpatient service	408	34	< 50	✓ 35

Significance of measure

The Palliative Care team at Waikato Hospital provides physical and emotional care for patients who are in the final stages of their illness when cure or long term control is no longer possible.

The team works closely with Hospice Waikato and with general practitioners.

Waikato DHB performance

Work is planned to occur in 2015/16 to develop a Waikato Palliative Care Strategic Plan which is expected to include a focus on district wide access arrangements and service access for both rural populations and Māori. It is anticipated a meaningful set of measures will become apparent through this process which will influence our reporting and monitoring approaches in the future.

Rennie Forbes Wright, 10 years old

People receive timely and appropriate specialist care

Support services

Output measure

Measure	Baseline 2013/2014	Previous year 2013/14	Target 2014/15	Result 2014/15
Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks - **CT Scans**	66%	66%	90%	✓ 90%
Improved wait times for diagnostic services - accepted referrals for CT and MRI receive their scan within 6 weeks - **MRI scans**	80%	30%	80%	✗ 48%

Significance of measure

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Improving access to diagnostics will improve patient outcomes in a range of areas:

- Cancer pathways will be shortened with better access to a range of diagnostic modalities
- Emergency Department (ED) waiting times can be improved if patients have more timely access to diagnostics
- Access to elective services will improve, both in relation to treatment decision-making, and also improved use of hospital beds and resources
- Workforce opportunities can be explored to consider alternative and more efficient ways of providing diagnostics

Waikato DHB performance

CT target results have been above 95 percent for the last six months and are able to be sustained at that level.

We did not meet the MRI target for the year. Achieving the MRI target required a substantial change in the way that patients were booked, including the development of enhanced interfaces between the booking systems used by the private subcontractors and the DHB. A substantial backlog of children awaiting non-urgent surveillance MRIs also needed to be addressed. The DHB established a work programme to achieve the improvements required by the end of the 2015 calendar year and is currently on track to achieve that goal.

Output measure

People receive timely and appropriate specialist care

Support services

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	99.6%	100%	99.6%	✓ 100%

Significance of measure

By definition, a laboratory test is a medical procedure that involves testing a sample of blood, urine or other biological specimen. It is used to evaluate how your body is functioning, detect, diagnose and monitor diseases and illnesses.

Timely turn around of tests supports clinical diagnosis and enables early intervention and treatment.

Waikato DHB performance

Pathlab is the main community laboratory service provider for the Waikato DHB. They provide high-quality service and timely turnaround of test, as evidenced by their 100 percent of all laboratory tests being completed and communicated to the referring practioners within 48 hours of receipt.

Pathlab updates technology regularly to ensure turnaround times for referrers are as fast as possible.

Did you know

we had 106,130 people present at the Emergency Department across the Waikato DHB

- Waiora Waikato Hospital Campus had 72,207
- Thames Hospital had 15,255
- Te Kuiti, Taumarunui and Tokoroa combined had 18,668

People receive timely and appropriate specialist care

Support services

Output measure

Measure	Baseline 2010/2011	Previous year 2013/14	Target 2014/15	Result 2014/15
Total number of pharmaceutical items dispensed in the community	5,339,890	5,475,980	Between 5,000,000 and 5,500,000	✗ 5,762,057

Significance of measure

Pharmaceuticals are an important resource in improving health outcomes. Subsidised pharmaceuticals are dispensed by 84 pharmacies across the Waikato district.

The total number of dispensed items is used as a proxy for access to pharmacy, however this only relates to prescribed items dispensed and does not take account of the "over the counter medicines", natural healthcare products or other primary healthcare services provided by pharmacies.

The complexity of issues that surround the number of items that may be dispensed includes pharmac funding, expiry of copyright, disease states and prescriber activity (GP willingness to prescribe medicines) to name but a few. Because of this, it is difficult to set a meaningful target that will both indicate a satisfactory level of achievement and when the provision of medicines reaches higher than expected levels.

Waikato DHB performance

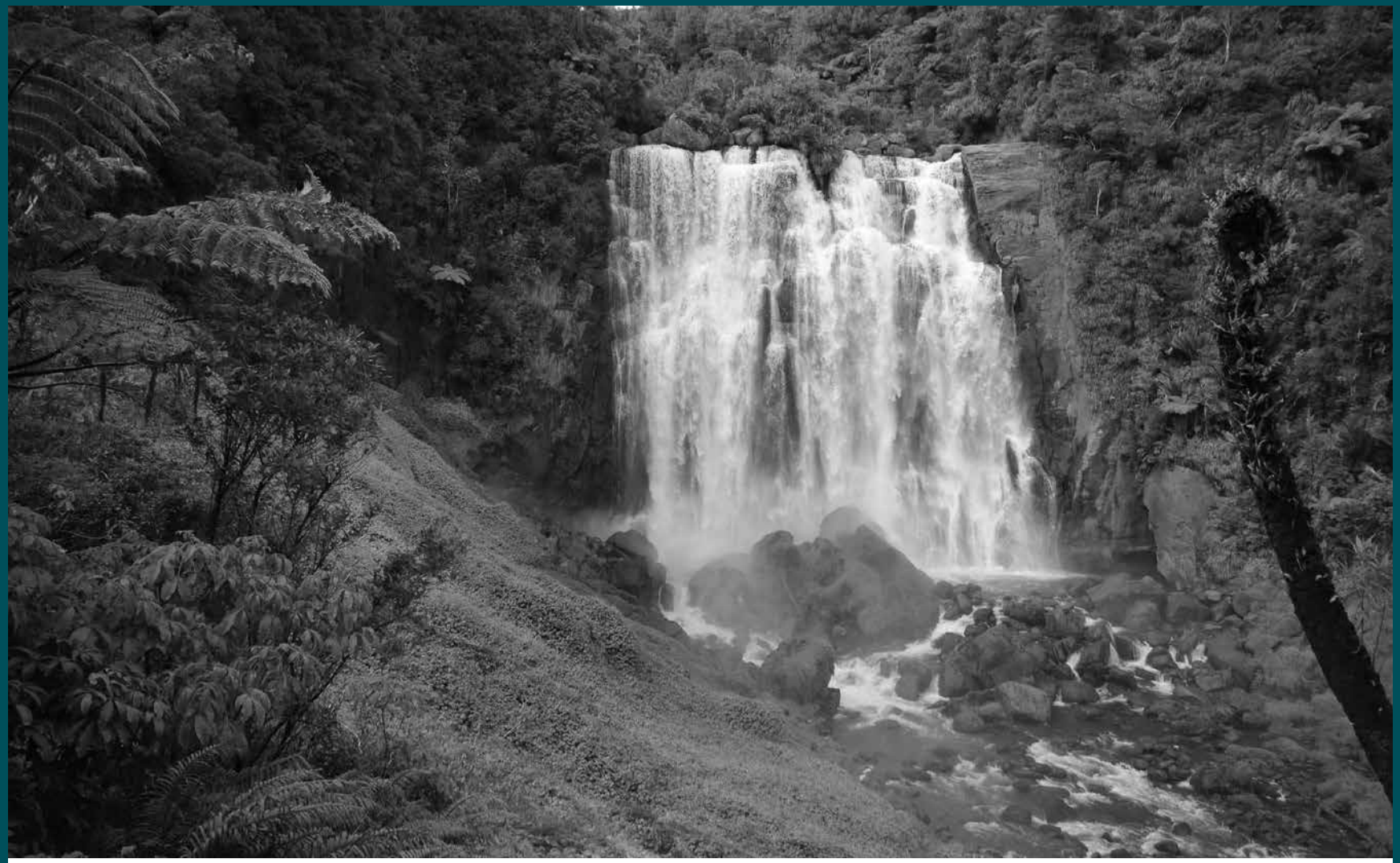
Whilst the lower target level appears to have been exceeded by some 5.22 percent, some of the difference may be related to data discrepancies. Due to an issue in the national pharmacy data warehouse, it has not been possible to replicate the methodology used to get to the 2013/14 figure, which was based on dispensed items.

Pharmacists have up to four months to lodge claims for dispensed pharmaceuticals, however the majority of those claims are made within a three month period. We are therefore using a 12 month period to the end of March each year for comparison purposes.

We have been able to get comparative figures for the 12 months ended 31 March 2014 and for the 12 months ended 31 March 2015 using items claimed for the 12 months. Using this approach the total number of items for 2014 would have been 5,528,290 resulting in a year on year increase of 4.2 percent by 31 March 2015.

National year on year growth for the same period was only 1.97 percent according to figures provided by the DHB Shared Services community pharmacy team and there are no compelling reasons for the Waikato to be substantially different other than increased prescriber activity. Under the previous years target this result would be seen as a positive result.

Part 3 Financial Statements



Marakopa falls, near Waitomo

Statement of comprehensive revenue and expense

For the year ended 30 June 2015

	Note	Group 2015 Budget	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Revenue		**$000**	**$000**	**$000**	**$000**	**$000**
Patient care revenue	1	1,218,368	1,237,402	1,206,336	1,237,402	1,206,336
Other revenue	2	15,852	16,982	15,427	16,689	16,069
Finance revenue	3	1,405	2,027	1,505	1,782	1,338
Total income		1,235,625	1,256,411	1,223,268	1,255,873	1,223,743
Expenses						
Personnel costs	4	493,717	497,880	482,822	497,880	482,822
Depreciation	5	38,760	33,585	34,425	33,585	34,425
Amortisation	6	7,176	4,168	4,006	4,168	4,006
Outsourced services		36,867	51,932	52,966	51,932	52,966
Clinical supplies		126,687	132,377	127,367	132,377	127,367
Infrastructure and non-clinical expenses		63,331	69,598	62,896	69,598	62,896
Other district health boards		54,720	51,345	48,895	51,345	48,895
Non-health board providers		380,014	380,359	373,285	380,359	373,285
Other operating expenses	7	7,244	10,342	7,017	10,329	7,002
Finance costs	8	10,673	9,553	10,248	9,553	10,248
Capital charge	9	16,464	17,749	16,015	17,749	16,015
Total expenses		1,235,653	1,258,888	1,219,942	1,258,875	1,219,927
Share of associate surplus/(deficit)	10	-	(5)	5	(5)	5
Share of joint venture surplus/(deficit)	11	-	67	26	67	26
Surplus/(deficit)		(28)	(2,415)	3,357	(2,940)	3,847
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	-	30,681	-	30,681
Total comprehensive revenue and expense for the year		(28)	(2,415)	34,038	(2,940)	34,528

The accompanying notes form part of the financial statements.

Explanations of major variances to budget are provided in note 33.

Statement of changes in equity

For the year ended 30 June 2015

	Note	Group			Parent	
		2015 Budget	2015 Actual	2014 Actual	2015 Actual	2014 Actual
		$000	$000	$000	$000	$000
Balance at 1 July		212,502	244,782	212,928	239,657	207,313
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(28)	(2,415)	3,357	(2,940)	3,847
Other comprehensive income/(expense)		-	-	30,681	-	30,681
Total comprehensive revenue and expense for the year		(28)	(2.415)	34,038	(2,940)	34,528
Owner transactions						
Capital contributions from the Crown		-	-	10	-	10
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement		-	-	-	(1)	-
Balance at 30 June	12	210,280	240,173	244,782	234,522	239,657

The accompanying notes form part of the financial statements.

Explanations of major variances to budget are provided in note 33.

Did you know

100,872 Heart and Diabetes checks were undertaken at GP practices during 2014/15

Statement of financial position

As at 30 June 2015

	Note	Group 2015 Budget	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Assets		$000	$000	$000	$000	$000
Current assets						
Cash and cash equivalents	13	5,585	5,483	5,029	-	-
Receivables	14	21,227	29,564	22,865	29,403	22,845
Prepayments	15	3,618	10,098	4,805	10,098	4,805
Inventories	16	7,986	9,937	9,063	9,937	9,063
Non-current assets held for sale	17	-	40	40	40	40
Total current assets		38,416	55,122	41,802	49,478	36,753
Non-current assets						
Property, plant and equipment	5	553,675	563,559	583,311	563,559	583,311
Intangible assets	6	26,245	23,886	20,842	23,886	20,842
Investment in associate	10	36	31	36	31	36
Investment in joint venture	11	190	287	220	287	220
Total non-current assets		580,146	587,763	604,409	587,763	604,409
Total assets		618,562	642,885	646,211	637,241	641,162

	Note	Group 2015 Budget	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Liabilities		$000	$000	$000	$000	$000
Current liabilities						
Cash and cash equivalents	13	-	-	-	20	91
Borrowings	18	31,803	9,227	17,210	9,227	17,210
Employee entitlements	19	85,141	95,753	88,208	95,753	88,208
Trade and other payables under exchange transactions	20	38,487	60,946	58,077	60,933	58,062
Trade and other payables under non-exchange transactions	20	6,524	9,153	10,890	9,153	10,890
Provisions	21	32	554	631	554	631
Total current liabilities		161,987	175,633	175,016	175,640	175,092
Non-current liabilities						
Borrowings	18	231,859	212,335	212,355	212,335	212,355
Employee entitlements	19	14,326	14,076	13,566	14,076	13,566
Provisions	21	110	668	492	668	492
Total non-current liabilities		246,295	227,079	226,413	227,079	226,413
Total liabilities		408,282	402,712	401,429	402,719	401,505
Net assets		210,280	240,173	244,782	234,522	239,657
Equity						
Crown equity (Contributed capital)	12	79,458	79,467	81,662	79,467	81,662
Revaluation reserve	12	52,730	83,411	83,411	83,411	83,411
Retained earnings (Accumulated surplus/(deficit))	12	72,537	71,644	74,584	71,644	74,584
Trust funds	12	5,555	5,651	5,125	-	-
Total equity		210,280	240,173	244,782	234,522	239,657

Explanations of major variances to budget are provided in note 33.
The accompanying notes form part of the financial statements.

For and on behalf of the board

Bob Simcock, Chair
Waikato DHB, 28 October 2015

Sally Christie, Deputy Chair
Waikato DHB, 28 October 2015

Statement of cash flows

For the year ended 30 June 2015

	Note	Group 2015 Budget	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Cash flows from operating activities		$000	$000	$000	$000	$000
Operating receipts		1,234,496	1,249,426	1,219,587	1,249,133	1,220,229
Interest received		1,200	1,886	1,502	1,782	1,338
Payments to suppliers		(660,068)	(697,353)	(666,129)	(697,353)	(665,826)
Payments to employees		(493,025)	(489,802)	(475,930)	(489,787)	(475,930)
Interest paid		(10,673)	(9,538)	(10,097)	(9,538)	(10,097)
Payments for capital charge		(16,464)	(18,254)	(15,960)	(18,254)	(15,960)
Goods and services tax (net)		98	(1,331)	1,905	(1,331)	1,905
Net cash flows from operating activities	22	55,564	35,034	54,878	34,652	55,659
Cash flows from investing activities						
Purchase of property, plant and equipment		(20,686)	(22,956)	(48,925)	(22,956)	(48,925)
Purchase of intangible assets		(9,277)	(1,427)	(1,742)	(1,427)	(1,742)
Purchase of investments		(5,200)	-	-	-	-
Receipts from sale of property, plant and equipment		-	-	6	-	6
Net cash flows from investing activities		(35,163)	(24,383)	(50,661)	(24,383)	(50,661)

	Note	Group 2015 Budget	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Cash flows from financing activities		$000	$000	$000	$000	$000
Capital contribution from the Crown		-	-	-	-	-
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		-	-	-	-	-
Repayment of borrowings		(9,356)	(8,004)	(2,688)	(8,004)	(2,688)
Net cash flows from financing activities		(11,550)	(10,198)	(4,882)	(10,198)	(4,882)
Net increase/(decrease) in cash and equivalents		8,851	453	(665)	71	116
Cash and cash equivalents at beginning of year		(3,266)	5,030	5,694	(91)	(207)
Cash and cash equivalents at end of year	13	(5,585)	5,483	5,029	(20)	(91)

No equipment was acquired by means of finance leases during the year (2014:$117,974).

Explanations of major variances to budget are provided in note 33.
The accompanying notes form part of the financial statements.

Notes to the financial statements

Statement of accounting policies

Reporting entity

Waikato District Health Board ("Waikato DHB") is a District Health Board established by the New Zealand Public Health and Disability Act 2000 and is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled and operates in New Zealand.

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. Its 50% share of its associate, Urology Services Limited, and 20% share of its jointly controlled entity, HealthShare Limited, is equity accounted. These entities are incorporated and domiciled in New Zealand.

Waikato DHB's activities are the purchasing and the delivering of health services, disability services, and mental health services to the community within its district. Waikato DHB does not operate to make a financial return. Waikato DHB has designated itself and its group as a Public Benefit Entity (PBE) for financial reporting purposes.

The financial statements are for the year ended 30 June 2015, and were authorised for issue by the Board on 28 October 2015.

Basis of preparation

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

Statement of compliance

The financial statements have been prepared in accordance with the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practices in New Zealand (NZ GAAP).

These financial statements have been prepared in accordance with, and comply with, Tier 1 PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There were no material adjustments arising on transition to the new PBE accounting standards.

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

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

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

Summary of significant accounting policies

Subsidiaries

Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the economic entity for the financial year. Consolidated financial statements have been prepared to include Waikato Health Trust due to the control that Waikato DHB has over the appointment and removal of the Trustees of Waikato Health Trust. Transactions between Waikato DHB and the Waikato Health Trust have been eliminated for consolidation purposes.

Associates

Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

The financial statements include Waikato DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence begins until the date that significant influence ceases.

Joint ventures

Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement.

The financial statements include Waikato DHB's interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases. When Waikato DHB's share of losses exceeds its interest in a joint venture, Waikato DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Waikato DHB has incurred legal or constructive obligations, or made payments on behalf of a joint venture.

Budget figures

The group budget figures are made up of the Waikato DHB's Annual Plan which was tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Waikato DHB in preparing these financial statements.

Revenue

Revenue from exchange transactions is measured at the fair value of consideration received or receivable, taking into account the amount of any trade discounts and volume rebates allowed by the Waikato DHB.

Revenue from non-exchange transactions is revenue other than revenue from exchange transactions, such as donations, grants and transfers.

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

Ministry of Health (MoH) revenue
Waikato DHB is primarily funded through revenue received from MoH, which is restricted in its use for the purpose of Waikato DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder. Revenue from MoH is recognised as revenue when earned. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the funding arrangements.

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

Revenue from other district health boards
Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. MoH pays Waikato DHB with monthly amount based on estimated patient treatment costs for non-Waikato DHB residents. An annual revenue washup occurs at year end to reflect the actual number of non-Waikato DHB patients treated at Waikato DHB.

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

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

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

Grants received
Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donations and bequests
Donations and bequests to Waikato DHB are recognised as non-exchange revenue when control over the asset is obtained. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive revenue and expense.

Capital charge

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

Borrowing costs

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

Finance lease

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 are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased term 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 certainty as to whether Waikato 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.

An operating lease is a lease that does not transfer substantially all the risks and

rewards incidental to ownership of an asset. 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 over the lease term as an integral part of the total lease expense.

Foreign currency transactions

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

Cash and cash equivalents

Cash and cash equivalents include cash on hand and bank overdrafts.

Receivables

Short-term debtors and other receivables are recognised at their face value, less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that the Waikato DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost and adjusted where 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 cost and net realisable value. The amount of any write-down for the loss of service potential is recognised as an expense in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and its fair value less costs to sell.

Impairment losses for write-downs of non-current assets held for sale are recognised in expenses. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have previously been recognised.

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

Property, plant and equipment

Classes of property, plant and equipment
The asset classes of property, plant and equipment are:

- freehold land
- freehold buildings
- plant, equipment and vehicles

Land and buildings
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 impairments losses.

Revaluations
Land and buildings are revalued to fair value with sufficient regularity to ensure that the carrying amount does not differ materially to fair value, and at least every five years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and buildings revaluation movements are classified 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 as a movement in the revaluation reserve in the statement of comprehensive revenue and expense, but is recognised in the expense section of the statement of comprehensive revenue and expense. 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, with the remainder then recognised as a movement in the revaluation reserve in the statement of 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 Waikato 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 its fair value as at the date of acquisition.

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefit or service potential associated with the item will flow to Waikato 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.

Disposal
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.

Depreciation
Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set 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 the major classes of property, plant and equipment have been estimated as:

Class of asset	Estimated life	Depreciation rate
Buildings	3 - 85 years	1.2- 33.3%
Plant, equipment and vehicles	2 - 35 years	2.5 - 50.0%

The residual value and useful life of assets is reviewed and adjusted if applicable, at balance sheet date.

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

Intangible assets

Software acquisition and development
Acquired software licences 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.

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 estimated useful lives and associated amortisation rates of the major classes of intangible assets are:

Type of asset	Estimated life	Amortisation rate
Computer software	2 - 10 years	10 - 50%

Impairment of property, plant, equipment and intangible assets

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

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

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

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

The reversal of an impairment loss is recognised as an expense in the statement of comprehensive revenue and expense.

Payables

Short term payables are recorded at their face value.

Borrowings

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

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

Employee entitlements

Short-term employee entitlements
Employee benefits that are due to be settled within twelve 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 but not yet taken, continuing medical education leave and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

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

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

- likely future entitlements accruing to staff, based on years of service, years to entitlement, 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, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within twelve months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

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

Defined benefit schemes
Employer contributions to the Defined Benefit Plan Contributors Scheme are a multi-employer defined benefit scheme managed by the Board of Trustees of the National Provident Fund. 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 or deficit of the scheme will affect future contributions by individual employers as there is no prescribed basis for the allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

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

ACC Partnership Programme
The liability for the ACC Partnership 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 employee remuneration levels and history of employee claims and injuries. Expected future payments are discounted using market yields on New Zealand government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash out flows.

Repairs to motor vehicles provision
A provision is provided for the costs of repairing motor vehicles at the end of their operating lease period before return to the lessor.

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

Demolition
A provision for demolition is recognised when an approved detailed formal plan for the demolition has either been announced publicly or for which demolition has already commenced.

Equity

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

- Crown equity;
- Retained earnings;
- Revaluation reserves; and
- Trust funds.

Revaluation reserves
These reserves relate to the revaluation of land and buildings to fair value.

Trust funds
Trust funds represent the unspent amount of restricted donations and bequests received.

Income tax

Waikato DHB is defined as a public authority in the Income Tax Act 2007 and consequently is exempt from the payment of income tax. Accordingly no provision has been made for income tax.

Goods and services tax (GST)

All items in the financial statements are presented exclusive of 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. Commitments and contingencies are disclosed exclusive of GST.

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

Cost allocation

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

Direct costs are those costs directly attributable 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 output classes. Indirect costs are charged to output classes based on cost drivers and related activity and 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.

The cost allocation methodology has been updated since the date of the last audited financial statements.

Critical accounting estimates and assumptions

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

Land and buildings revaluations
The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 5.

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 requires Waikato DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset.

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

Retirement gratuities and long service leave
Note 19 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Critical judgements in applying accounting policies

Management has exercised a critical judgement in applying accounting policies for determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

Notes to the Financial Statements

1: Patient care revenue	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Non-exchange transactions	$000	$000	$000	$000
Health and disability services (MoH)	1,042,019	1,020,296	1,042,019	1,020,296
Patient co-payments	1,053	1,063	1,053	1,063
Exchange transactions				
Health and disability services (MoH)	27,699	28,918	27,699	28,918
ACC contract revenue	14,493	10,741	14,493	10,741
Revenue from other district health boards	126,689	121,982	126,689	121,982
Clinical training agency revenue	10,571	10,712	10,571	10,712
Other patient care related revenue	14,878	12,624	14,878	12,624
Total patient care revenue	1,237,402	1,206,336	1,237,402	1,206,336

2: Other revenue	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Non-exchange transactions				
Donations and bequests received	933	541	53	94
Grants received	-	-	587	1,089
Exchange transactions				
Rental revenue	1,157	1,061	1,157	1,061
Net gain on sale of property, plant and equipment	-	23	-	23
Other revenue	14,892	13,802	14,892	13,802
Total other revenue	16,982	15,427	16,689	16,069

Other revenue includes revenue from parking, cafeterias, drug trials, accommodation and rentals.

3: Finance revenue (revenue from exchange transactions)	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Interest revenue	2,027	1,505	1,782	1,338
Total finance revenue	2,027	1,505	1,782	1,338

4: Personnel costs	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Salaries and wages	476,127	463,838	476,127	463,838
Increase/(decrease) in liability for employee entitlements	8,055	6,228	8,055	6,228
Defined contribution plan employer contributions	13,698	12,756	13,698	12,756
Total personnel cost	497,880	482,822	497,880	482,822

5: Property, plant and equipment	Group Actual				
Movements for each class of property, plant and equipment are as follows:	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2013	28,480	396,971	182,246	99,807	707,504
Additions	-	-	(2,595)	45,087	42,492
Transfers	-	105,647	27,731	(133,378)	-
Disposals	-	(43)	(10,462)	-	(10,505)
Revaluation adjustment	1,045	(22,368)	-	-	(21,323)
Balance at 30 June 2014	29,525	480,207	196,920	11,516	718,168
Balance at 1 July 2014	29,525	480,207	196,920	11,516	718,168
Additions	-	-	-	16,702	16,702
Transfers	-	14,173	10,804	(24,524)	453
Disposals	-	-	(2,871)	-	(2,871)
Impairment	-	(3,218)	-	-	(3,218)
Balance at 30 June 2015	29,525	491,162	204,853	3,694	729,234

5: Property, plant and equipment (continued)	Group Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2013	-	43,301	119,607	-	162,908
Depreciation charge for the year	-	18,906	15,519	-	34,425
Disposals	-	(39)	(10,433)	-	(10,472)
Revaluation adjustment	-	(52,004)	-	-	(52,004)
Balance at 30 June 2014	-	10,164	124,693	-	134,857
Balance at 1 July 2014	-	10,164	124,693	-	134,857
Depreciation charge for the year	-	18,240	15,345	-	33,585
Disposals	-	-	(2,767)	-	(2,767)
Balance at 30 June 2015	-	28,404	137,271	-	165,675
Carrying amounts					
At 1 July 2013	28,480	353,670	62,639	99,807	544,596
At 30 June 2014	29,525	470,043	72,227	11,516	583,311
At 1 July 2014	29,525	470,043	72,227	11,516	583,311
At 30 June 2015	29,525	462,758	67,582	3,694	563,559

5: Property, plant and equipment (continued)	Parent Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2013	28,480	396,971	182,246	99,807	707,504
Additions	-	-	(2,595)	45,087	42,492
Transfers	-	105,647	27,731	(133,378)	-
Disposals	-	(43)	(10,462)	-	(10,505)
Revaluation adjustment	1,045	(22,368)	-	-	(21,323)
Balance at 30 June 2014	29,525	480,207	196,920	11,516	718,168
Balance at 1 July 2014	29,525	480,207	196,920	11,516	718,168
Additions	-	-	-	16,702	16,702
Transfers	-	14,173	10,804	(24,524)	453
Disposals	-	-	(2,871)	-	(2,871)
Impairment	-	(3,218)	-	-	(3,218)
Balance at 30 June 2015	29,525	491,162	204,853	3,694	729,234

5: Property, plant and equipment (continued)	Parent Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2013	-	43,301	119,607	-	162,908
Depreciation charge for the year	-	18,906	15,519	-	34,425
Disposals	-	(39)	(10,433)	-	(10,472)
Revaluation adjustment	-	(52,004)	-	-	(52,004)
Balance at 30 June 2014	-	10,164	124,693	-	134,857
Balance at 1 July 2014	-	10,164	124,693	-	134,857
Depreciation charge for the year	-	18,240	15,345	-	33,585
Disposals	-	-	(2,767)	-	(2,767)
Balance at 30 June 2015	-	28,404	137,271	-	165,675
Carrying amounts					
At 1 July 2013	28,480	353,670	62,639	99,807	544,596
At 30 June 2014	29,525	470,043	72,227	11,516	583,311
At 1 July 2014	29,525	470,043	72,227	11,516	583,311
At 30 June 2015	29,525	462,758	67,582	3,694	563,559

Valuation
The most recent valuation of land and buildings was carried out by M.J. Snelgrove, an independent registered valuer with Colliers International and a member of the New Zealand Institute of Valuers. The valuation was carried out at 30 June 2014.

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

5: Property, plant and equipment (continued)

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 intensively.

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

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

- 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.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Waikato DHB's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value. These valuations included adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

Restrictions
Waikato 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 land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Waikato 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 under the Treaty of Waitangi Act 1975 cannot be quantified and it is therefore not reflected in the value of the land.

Property, plant and equipment under construction
Buildings work in progress at 30 June 2015 is $1.2m (2014: $7.3m) and capital commitments is $3.8m (2014: $10.2m). Plant, equipment and vehicles work in progress at 30 June 2015 is $2.5m (2014: $4.2m) and capital commitments is $1.5m (2014: 2.2m).

6: Intangible assets

	Group 2015 Actual			
	Internally generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2013	386	39,288	5,817	45,491
Additions	-	4,869	8,196	13,065
Disposals	-	(1,764)	(3,969)	(5,733)
Balance at 30 June 2014	386	42,393	10,044	52,823
Balance at 1 July 2014	386	42,393	10,044	52,823
Additions	144	6,759	7,817	14,720
Disposals	-	(1,347)	(7,478)	(8,825)
Reclassifications	-	(36)	-	(36)
Balance at 30 June 2015	530	47,769	10,383	58,682
Accumulated amortisation and impairment losses				
Balance at 1 July 2013	88	29,313	-	29,401
Amortisation charge for the year	48	3,958	-	4,006
Disposals	-	(1,426)	-	(1,426)
Balance at 30 June 2014	136	31,845	-	31,981
Balance at 1 July 2014	136	31,845	-	31,981
Amortisation charge for the year	69	4,099	-	4,168
Disposals	-	(1,347)	-	(1,347)
Reclassifications	-	(6)	-	(6)
Balance at 30 June 2015	205	34,591	-	34,796
Carrying amounts				
At 1 July 2013	298	9,975	5,817	16,090
At 30 June 2014	250	10,548	10,044	20,842
At 1 July 2014	250	10,548	10,044	20,842
At 30 June 2015	325	13,178	10,383	23,886

6: Intangible assets (continued)

Parent 2015 Actual	Internally generated	Other	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2013	386	39,288	5,817	45,491
Additions	-	4,869	8,196	13,065
Disposals	-	(1,764)	(3,969)	(5,733)
Balance at 30 June 2014	386	42,393	10,044	52,823
Balance at 1 July 2014	386	42,393	10,044	52,823
Additions	144	6,759	7,817	14,720
Disposals	-	(1,347)	(7,478)	(8,825)
Reclassifications	-	(36)	-	(36)
Balance at 30 June 2015	530	47,769	10,383	58,682
Accumulated amortisation and impairment losses				
Balance at 1 July 2013	88	29,313	-	29,401
Amortisation charge for the year	48	3,958	-	4,006
Disposals	-	(1,426)	-	(1,426)
Balance at 30 June 2014	136	31,845	-	31,981
Balance at 1 July 2014	136	31,845	-	31,981
Amortisation charge for the year	69	4,099	-	4,168
Disposals	-	(1,347)	-	(1,347)
Reclassifications	-	(6)	-	(6)
Balance at 30 June 2015	205	34,591	-	34,796
Carrying amounts				
At 1 July 2013	298	9,975	5,817	16,090
At 30 June 2014	250	10,548	10,044	20,842
At 1 July 2014	250	10,548	10,044	20,842
At 30 June 2015	325	13,178	10,383	23,886

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

7: Other operating expenses

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	**$000**	**$000**	**$000**
Net impairment of trade receivables	327	89	327	89
Audit fees for the audit of the financial statements	204	205	191	190
Board members' remuneration and expenses	383	369	383	369
Koha and donations	16	17	16	17
Operating lease expenses	6,090	5,999	6,090	5,999
Impairment on property, plant and equipment	3,218	-	3,218	-
Loss on disposal of property, plant and equipment	104	-	104	-
Loss on disposal of intangible assets	-	338	-	338
Total other operating expenses	10,342	7,017	10,329	7,002

Waikato DHB pays audit fees for the audit of financial statement to Audit New Zealand. Total amount for the period ended 30 June 2015 was $191,000 (2014:$190,000).

8: Finance costs

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	**$000**	**$000**	**$000**
Interest and financing expenses	9,553	10,248	9,553	10,248
Total finance cost	9,553	10,248	9,553	10,248

9: Capital charge

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	**$000**	**$000**	**$000**
Capital charge	17,749	16,015	17,749	16,015
Total capital charge	17,749	16,015	17,749	16,015

Waikato DHB pays a capital charge to the Crown every six months. This charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the period ended 30 June 2015 was 8% (2014:8%).

10: Investment in associate

a: General information

Name of entity	Principal activities	Interest held at 30 June 2015	Balance date
Urology Services Limited	Provision of urology services	50%	30 June

b: Summary of financial information on associate (100%)

2015 Actual	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
Urology Services Limited	1,041	978	63	6,038	1
	1,041	978	63	6,038	1
2014 Actual					
Urology Services Limited	1,087	1,016	71	5,910	10
	1,087	1,016	71	5,910	10

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
c: Share of profit of associate (50%)	$000	$000	$000	$000
Share of profit before tax	(5)	5	(5)	5
Less: Tax expense	-	-	-	-
Share of profit after tax	(5)	5	(5)	5
d: Investment in associate (50%)				
Carrying amount at beginning of year	36	31	36	31
Share of associate surplus/(deficit)	(5)	5	(5)	5
Carrying amount at end of year	31	36	31	36

e: Share of associates contingent liabilities and commitments	The associate has no contingent liabilities or contracted commitments at balance date. Waikato DHB is not jointly or severally liable for the liabilities owing at balance date by the associate.

11: Investments in joint venture

a: General information

Name of entity	Principal activities	Interest held at 30 June 2015	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
b: Carrying amount of investment	$000	$000	$000	$000
Opening balance	220	194	220	194
Share of joint venture surplus/(deficit)	67	26	67	26
Closing balance	287	220	287	220
c: Summary of Waikato DHB's interests in HealthShare Limited (20%)				
Current assets	666	527	666	527
Non-current assets	2,237	581	2,237	581
Current liabilities	(1,213)	(738)	(1,213)	(738)
Non-current liabilities	(1,404)	(150)	(1,404)	(150)
Net assets	286	220	286	220
Revenue	2,199	1,538	2,199	1,538
Expenses	(2,114)	(1,512)	(2,114)	(1,512)
Share of surplus of joint venture	85	26	85	26

12: Equity	Group				
Reconciliation of movement in equity	Trust Funds $000	Crown Equity $000	Revaluation Reserve $000	Retained Earnings $000	Total Equity $000
Balance at 1 July 2013	5,615	83,846	52,730	70,737	212,928
Total comprehensive revenue/(expense)	(490)	-	30,681	3,847	34,038
Capital contributions from the Crown	-	10	-	-	10
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Balance at 30 June 2014	5,125	81,662	83,411	74,584	244,782
Balance at 1 July 2014	5,125	81,662	83,411	74,584	244,782
Total comprehensive revenue/(expense)	525	-	-	(2,940)	(2,415)
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Other movement	1	(1)	-	-	-
Balance at 30 June 2015	5,651	79,467	83,411	71,644	240,173

Trust funds
The Trust funds represent the Waikato Health Trust (formerly the Health Waikato Charitable Trust) which was incorporated in 1993 as a charitable trust in accordance with the provisions of the Charitable Trust Act 1957, and registered with the Charities Commission. Under the Trust Deed the Trustees are appointed by Waikato DHB, with these Trustees acting independently in accordance with their fiduciary responsibilities under trust law.

Transactions between Waikato DHB and Waikato Health Trust are disclosed in note 28.

12: Equity (continued)	Parent			
Reconciliation of movement in equity	Crown Equity $000	Revaluation Reserve $000	Retained Earnings $000	Total Equity $000
Balance at 1 July 2013	83,846	52,730	70,737	207,313
Total comprehensive revenue/(expense)	-	30,681	3,847	34,528
Capital contributions from the Crown	10	-	-	10
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Balance at 30 June 2014	81,662	83,411	74,584	239,657
Balance at 1 July 2014	81,662	83,411	74,584	239,657
Total comprehensive revenue/(expense)	-	-	(2,940)	(2,940)
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	(1)	-	-	(1)
Balance at 30 June 2015	79,467	83,411	71,644	234,522

13: Cash and cash equivalents	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Cash at bank and on hand	(20)	(91)	(20)	(91)
Trust funds	5,503	5,120	-	-
Total cash and cash equivalents	5,483	5,029	(20)	(91)

14: Receivables	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Ministry of Health trade receivables	9,086	2,958	9,086	2,958
Other trade receivables	5,333	3,479	5,172	3,459
Total trade receivables	14,419	6,437	14,258	6,417
Ministry of Health accrued revenue	10,771	13,329	10,771	13,329
Other accrued revenue	4,374	3,099	4,374	3,099
Total receivables	29,564	22,865	29,403	22,845
Total receivables comprises:				
Receivables from non-exchange transactions	4,886	5,232	4,886	5,232
Receivables from exchange transactions	24,678	17,633	24,517	17,613

Receivables and accrued revenue are shown net of impairment losses (provision for doubtful debts) amounting to $0.54 million (2014:$0.94 million). The carrying value of debtors and other receivables approximates their fair value.

The ageing profile of receivables and their impairment is:

14: Receivables (continued)	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Receivables - gross	$000	$000	$000	$000
Not past due	18,885	19,383	18,724	19,363
Past due 0-30 days	3,648	2,910	3,648	2,910
Past due 31-120 days	4,288	750	4,288	750
Past due 121-360 days	2,974	404	2,974	404
Past due more than 1 year	311	363	311	363
	30,106	23,810	29,945	23,790
Receivables - impairment	$000	$000	$000	$000
Not past due	-	-	-	-
Past due 0-30 days	-	-	-	-
Past due 31-120 days	226	178	226	178
Past due 121-360 days	24	404	24	404
Past due more than 1 year	292	363	292	363
	542	945	542	945
Net receivables	$000	$000	$000	$000
Not past due	18,885	19,383	18,724	19,363
Past due 0-30 days	3,648	2,910	3,648	2,910
Past due 31-120 days	4,062	572	4,062	572
Past due 121-360 days	2,950	-	2,950	-
Past due more than 1 year	19	-	19	-
	29,564	22,865	29,403	22,845

All receivables greater than 30 days in age are considered to be past due. The provision for impairment has been calculated based on a review of significant debtor balances and a collective assessment of all debtors (other than those determined to be individually impaired) for impairment. The collective impairment assessment is based on an analysis of past collection history and bad debt write-offs.

Individually impaired receivables are assessed as impaired due to the significant financial difficulties being experienced by the debtor and management concluding that the likelihood of the overdue amounts being recovered is remote.

14: Receivables (continued)	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Movements in provision for impairment of trade receivables are as follows:	$000	$000	$000	$000
At 1 July	945	1,150	945	1,150
Additional provisions made/ (reversed) during the year	327	69	327	69
Receivables written off during the year	(750)	(291)	(750)	(291)
Receivables recovered during the year	20	17	20	17
At 30 June	542	945	542	945

15: Prepayments	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Prepayments	10,098	4,805	10,098	4,805
Total prepayments	10,098	4,805	10,098	4,805

16: Inventories	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Pharmaceuticals	765	454	765	454
Surgical and medical supplies	8,288	7,791	8,288	7,791
Other supplies	884	818	884	818
Total inventories	9,937	9,063	9,937	9,063

The amount of inventories recognised as revenue due to change in stock value during the year was $1,350,000 (2014: $307,000), which is included in the infrastructure and non-clinical expenses line item in the statement of comprehensive revenue and expense.
Write-down of inventories amounted to $380,000 for 2015 (2014:$316,000). There have been no reversals of write-downs. The provision for obsolete inventories adjustment recognised in the statement of comprehensive revenue and expense for the year ended 30 June 2015 was $448,000 (2014:$Nil). No inventories are pledged as security for liabilities.

17: Non-current assets held for sale

Waikato DHB owns land which has been classified as held for sale following the Board's approval to sell the properties as they will provide no future use to the DHB.

Non-current assets held for sale	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Land	40	40	40	40
Total non-current assets held for sale	40	40	40	40

18: Borrowings	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Current portion	$000	$000	$000	$000
Loan from Health Benefits Limited	8,928	15,677	8,928	15,677
Loan from HealthShare Limited	-	1,303	-	1,303
Loan from Energy Efficiency and Conservation Authority	199	154	199	154
Finance leases	100	76	100	76
	9,227	17,210	9,227	17,210
Non-current portion				
Crown loans	211,659	211,659	211,659	211,659
Loan from Energy Efficiency and Conservation Authority	377	274	377	274
Finance leases	299	422	299	422
	212,335	212,355	212,335	212,355
Loan facility limits				
Crown loans	211,762	211,659	211,762	211,659
Loan from Health Benefits Limited	65,376	63,432	65,376	63,432

The interest rate terms are spread over a period between one and seven years from balance date to manage interest rate risk. The loan facilities do not mature on the interest rate maturity dates.

18:Borrowings (continued)

The fair value of Crown loan borrowings is $220.8 million (2014:$214.3 million). Fair value has been determined based on Government bond rate plus 15 basis points, and is based on mid-market pricing.

The Crown loans are secured by a negative pledge. Without the Ministry of Health's prior written consent Waikato DHB can not perform the following actions:

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

Analysis of finance leases	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Minimum lease payments payable	$000	$000	$000	$000
No later than one year	100	76	100	76
Later than one year and not later than five years	299	422	299	422
Later than five years	-	-	-	-
Total minimum lease payments	399	498	399	498
Future finance charges	(81)	(49)	(81)	(49)
Present value of minimum lease payments	318	449	318	449
Present value of minimum lease payments payable:				
No later than one year	98	74	98	74
Later than one year and not later than five years	220	375	220	375
Later than five years	-	-	-	-
Total present value of minimum lease payments	318	449	318	449

18:Borrowings (continued)

Finance leases

Finance lease liabilities are effectively secured because the rights to the asset revert to the lessor on default.

The fair value of finance leases is $317,000 (2014: $449,000). Fair value has been determined by using a discount rate of 4.59%.

Description of finance leases

The DHB has entered into contracts for the supply of consumables and reagents which includes the use of clinical analysing equipment.

At expiration of the agreements, the ownership of the equipment will transfer to Waikato DHB, so has been deemed to be finance leases.

19: Employee entitlements	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Current portion	$000	$000	$000	$000
Liability for long service leave	2,623	2,722	2,623	2,722
Liability for retirement gratuities	2,985	2,844	2,985	2,844
Liability for annual leave	54,873	50,150	54,873	50,150
Liability for sick leave	1,150	786	1,150	786
Liability for continuing medical education leave and expenses	11,600	11,222	11,600	11,222
PAYE payable	6,172	6,008	6,172	6,008
Salary and wages accrual	16,350	14,476	16,350	14,476
	95,753	88,208	95,753	88,208
Non-current portion				
Liability for long service leave	1,136	966	1,136	966
Liability for sabbatical leave	3,470	3,394	3,470	3,394
Liability for retirement gratuities	9,470	9,206	9,470	9,206
	14,076	13,566	14,076	13,566

19: Employee entitlements (continued)

Key assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advise from an independent actuary. A weighted average discount rate of 3.4% (2014:4.5%) and a salary inflation factor of 3.5% (2014:3.5%) were used.

20: Trade and other payables

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
	$000	$000	$000	$000
Payables under exchange transactions				
Creditors	60,573	57,624	60,560	57,609
Revenue received in advance	373	453	373	453
Total payables under exchange transactions	60,946	58,077	60,933	58,062
Payables under non-exchange transactions				
ACC levy payable	2,492	2,393	2,492	2,393
GST payable	6,661	7,992	6,661	7,992
Capital charge to the Crown	-	505	-	505
Total payables under non-exchange transactions	9,153	10,890	9,153	10,890
Total payables	70,099	68,967	70,086	68,952

Creditor 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.

21: Provisions

	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	514	576	514	576
Motor vehicle repairs on disposal	40	55	40	55
	554	631	554	631
Non-current liabilities				
Motor vehicle repairs on disposal	668	492	668	492
	668	492	668	492

Movements for each class of provision	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2013	648	368	1,016
Additional provisions made	319	360	679
Amounts used	(391)	(181)	(572)
Balance at 30 June 2014	576	547	1,123
Balance at 1 July 2014	576	547	1,123
Additional provisions made	351	293	644
Amounts used	(413)	(132)	(545)
Balance at 30 June 2015	514	708	1,222

21: Provisions (continued)

ACC Partnership Programme

Waikato DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all claims costs for a period of five years and up to a specified maximum amount. At the end of the five year period, Waikato DHB pays a premium to ACC for the value of residual claims, and from that point the liablility for ongoing claims passes to ACC.

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies;
- induction training on health and safety;
- actively managing workplace injuries to ensure that employees return to work as soon as practical;
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

Waikato DHB is not exposed to any significant concentrations of insurance risk, as work-related injuries are generally the result of an isolated event involving an individual employee.

An external independent actuarial valuer, Aon Hewitt, has calculated the ACC Partnership Programme liablity as at 30 June 2015. The valuer has attested that they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liablility. There are no qualifications contained in the valuer's report.

A prudent margin of 11% (2014:11%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. This is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are:

- pre valuation date claim inflation of 50% of movements in the Consumer Price Index and 50% of the movements in the Average Weekly Earnings index;
- post valuation date claim inflation of 2.1% per annum (2014:2.5%); and
- a discount factor of 3.00% for 30 June 2015 (2014:2.95%).

Motor vehicle repairs on disposal

In respect of a number of its leased vehicles, Waikato DHB is required to make provision for motor vehicles repairs for return to owner at the end of the lease of the motor vehicles.

22: Reconciliation of surplus/(deficit) for the period with net cash flows from operating activities

	Note	Group 2015 Actual	Group 2014 Actual	Parent 2015 Actual	Parent 2014 Actual
		$000	$000	$000	$000
Net surplus/(deficit)		(2,415)	3,357	(2,940)	3,847
Add/(less) non-cash items:					
Depreciation	5	33,585	34,425	33,585	34,425
Amortisation	6	4,168	4,006	4,168	4,006
Impairment of property, plant and equipment	7	3,218	-	3,218	-
Bad and doubtful debts	7	327	89	327	89
Share of associate (surplus)/deficit	10	5	(5)	5	(5)
Share of joint venture (surplus)/deficit	11	(67)	(26)	(67)	(26)
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	2, 7	104	(23)	104	(23)
Net loss/(gain) on disposal of intangible assets	7	-	338	-	338
(Increase)/decrease in fixed asset creditor		(311)	(452)	(311)	(452)
Add/(less) movements in statement of financial position items:					
(Increase)/decrease in inventories	16	(874)	(1,180)	(874)	(1,180)
(Increase)/decrease in receivables	14	(6,699)	(1,867)	(6,558)	(1,864)
(Increase)/decrease in prepayments	15	(5,293)	(1,307)	(5,293)	(1,307)
Increase/(decrease) in employee entitlements	19	8,055	6,228	8,055	6,228
Increase/(decrease) in trade and other payables	20	1,132	11,686	1,134	11,974
Increase/(decrease) in provisions	21	99	107	99	107
Increase/(decrease) in finance leases	18	-	(498)	-	(498)
Net cash flows from operating activities		35,034	54,878	34,652	55,659

23: Capital commitments and operating leases

Capital commitments	Group 2015 Actual $000	Group 2014 Actual $000	Parent 2015 Actual $000	Parent 2014 Actual $000
Buildings	3,796	10,220	3,796	10,220
Plant, equipment and vehicles	1,524	2,208	1,524	2,208
Intangible assets	998	706	998	706
Total capital commitments	6,318	13,134	6,318	13,134

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

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

	Group 2015 Actual $000	Group 2014 Actual $000	Parent 2015 Actual $000	Parent 2014 Actual $000
Not later than one year	4,925	4,622	4,925	4,622
Later than one year and not later than five years	7,808	7,518	7,808	7,518
Later than five years	64	15	64	15
	12,797	12,155	12,797	12,155

Waikato DHB leases a number of buildings, vehicles and office equipment under operating leases. The leases typically run for a period of 3-5 years for buildings, 1-3 years for office equipment and 6 years for vehicles. In the case of leased buildings, lease payments are adjusted every 1-5 years to reflect market rentals. None of the leases includes contingent rentals.

A significant portion of the total non-cancellable operating lease expense relates to the lease of motor vehicles. Waikato DHB does not have an option to purchase the assets at the end of lease term. There are no restrictions placed on Waikato DHB by its leasing arrangements.

24: Contingencies

Contingent liabilities	Group 2015 Actual $000	Group 2014 Actual $000	Parent 2015 Actual $000	Parent 2014 Actual $000
Personal grievances	170	210	170	210
Legal proceedings and disputes by third parties	-	10	-	10
	170	220	170	220

The contingent liabilities relate to a number of claims involving medical and employment issues which may ultimately result in legal action. The actual timing and amounts will be determined by outcome of personal grievance processes and legal proceedings.

Contingent assets
Waikato DHB has no contingent assets at 30 June 2015 (2014:$Nil).

25: Client funds

Waikato DHB administers certain funds on behalf of clients. These funds are held in a separate bank account and any interest earned is allocated to the individual client balances. Therefore, the transactions during the year and the balance at 30 June are not recognised in the Statement of Comprehensive revenue and expense, Statement of Financial Position or Statement of Cash Flows.

	2015 Actual $000	2014 Actual $000
Balance at 1 July	20	19
Receipts	71	77
Payments	(72)	(76)
Balance at 30 June	19	20

26: Financial instruments

Waikato DHB's activities expose it to a variety of financial instrument risks. Waikato 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.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Waikato DHB, causing it to incur a loss.

Waikato DHB places its cash balances with high-quality financial institutions via a national DHB shared banking arrangement facilitated by Health Benefits Limited.

Concentrations of credit risk from trade receivables are limited due to the Ministry of Health being the largest single debtor (57% at 30 June 2015). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

Liquidity risk

Liquidity risk represents the ability for Waikato DHB to meet its contractual obligations and its liquidity requirements on an ongoing basis. Waikato DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the management of Crown loans.

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contratual maturity date. The amounts disclosed are contractual undiscounted cash flows.

	Group 2015 Actual						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,659	211,659	-	-	-	-	211,659
Loans from Energy Efficiency and Conservation Authority	576	576	77	77	154	268	-
Loan from Health Benefits Limited	8,928	8,928	8,928	-	-	-	-
Trade and other payables	70,099	70,099	70,099	-	-	-	-
	291,262	291,262	79,104	77	154	268	211,659

	Parent 2015 Actual						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,659	211,659	-	-	-	-	211,659
Loans from Energy Efficiency and Conservation Authority	576	576	77	77	154	268	-
Loan from Health Benefits Limited	8,928	8,928	8,928	-	-	-	-
Trade and other payables	70,086	70,086	70,086	-	-	-	-
	291,249	291,249	79,091	77	154	268	211,659

26: Financial instruments (continued)

	Group 2014 Actual						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,659	211,659	-	-	-	-	211,659
Loans from Energy Efficiency and Conservation Authority	428	428	77	77	154	120	-
Loan from Health Benefits Limited	15,677	15,677	15,677	-	-	-	-
Loan from HealthShare Limited	1,303	1,303	1,303	-	-	-	-
Trade and other payables	68,967	68,967	68,967	-	-	-	-
	298,034	298,034	86,024	77	154	120	211,659

	Parent 2014 Actual						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,659	211,659	-	-	-	-	211,659
Loans from Energy Efficiency and Conservation Authority	428	428	77	77	154	120	-
Loan from Health Benefits Limited	15,677	15,677	15,677	-	-	-	-
Loan from HealthShare Limited	1,303	1,303	1,303	-	-	-	-
Trade and other payables	68,952	68,952	68,952	-	-	-	-
	298,019	298,019	86,009	77	154	120	211,659

Market risk
Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Waikato 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 or future cash flows of a financial instrument will fluctuate due to changes in market interest rates. Waikato DHB's exposure to fair value interest rate risk is limited to its cash balance held under a contract with Health Benefits Limited through a national DHB shared banking arrangement. Health Benefits Limited actively manages this risk. The exposure to fair value interest rate risk for long term borrowings is low due to long term borrowings generally being held to maturity.

Fair value interest rate sensitivity analysis
In managing fair value interest rate risks Waikato DHB aims to reduce the impact of short-term fluctuations on revenue and expenses. Over the longer-term, however, permanent changes in interest rates would have an impact on revenue and expenses.

At 30 June 2015, it is estimated that a general increase of one percentage point in interest rates would decrease the group surplus by approximately $144,000 (2014:$200,000).

Currency risk
Currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Waikato DHB's currency risk is mainly limited to purchases of large clinical equipment from overseas. Waikato DHB uses forward currency contracts or options to hedge its foreign currency risk. Waikato DHB hedges trade payables denominated in a foreign exchange currency for large transactions and where necessary the forward exchange contracts or options are rolled over at maturity.

As at 30 June 2015 Waikato DHB had no forward foreign currency agreements outstanding (2014:$Nil).

It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies would not have a material effect on the net result.

27: Capital management

Waikato DHB's capital is its equity, which comprises Crown equity, accumulated surpluses, revaluation reserves and trust funds. Equity is represented by net assets. Waikato 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. Waikato DHB has complied with the financial management requirements of the Crown Entities Act 2004 during the year. Waikato DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure that it effectively achieves its objectives and purposes, while remaining a going concern.

28: Related parties

Identity of related parties
Waikato DHB has a related party relationship with the Waikato Health Trust, Urology Services Limited, HealthShare Limited and with its Board members.

Transactions with the Waikato Health Trust, HealthShare Limited and Urology Services Limited are priced on an arm's length basis.

	2015 Actual	2014 Actual
Loans from related parties	**$000**	**$000**
HealthShare Limited	-	1,303
	-	1,303

Ownership
Waikato DHB is a crown entity in terms of the Crown Entities Act 2004, and is a wholly owned entity of the Crown. The Crown significantly influences the role of Waikato DHB as well as being its major source of revenue. During the year Waikato DHB received $1.07 billion (2014:$1.049 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2015 was $19.857 million (2014:$16.287 million). Waikato DHB incurred a capital charge of $16.0 million (2014:$16.5 million) to the Government during the year.

Significant transactions with government-related entities
Waikato DHB has received funding from ACC for the year ended 30 June 2015 of $14.5 million (2014:$10.7 million) to provide health services.

28: Related parties (continued)

Revenue earned from other DHBs for the care of patients outside of the Waikato DHB district for the year ended 30 June 2015 was $126.2 million (2014:$122.0 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2015 was $50.4 million (2014:$48.9 million).

Collective, but not individually significant, transactions with government-related entities
In conducting its activities, Waikato DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies is based on the standard terms and conditions that apply to all tax and levy payers. Waikato DHB is exempt from paying income tax.

Waikato DHB also purchased goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended the 30 June 2015 totalled $16.2 million (2014:$17.6 million). These purchases included the purchase of electricity from Meridian Energy and Genesis, air travel from Air New Zealand, postal services from New Zealand Post and blood products from NZ Blood Service.

HealthShare Limited
HealthShare Limited is a company, established in February 2001 by the five District Health Boards in the Midland Region under a joint venture agreement, which provides regional services for these District Health Boards. No dividends have been received from HealthShare Limited.

As at 30 June 2015, HealthShare Limited had total assets of $14.516 million (2014:$5.721 million) and total liabilities of $13.083 million (2014:$4.716 million).

During the year Waikato DHB received $1,859,000 (2014: $611,906) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $4,642,000 (2014:$4,619,833) for services provided.

As at 30 June 2015 Waikato DHB owed HealthShare Limited $664,000 (2014:$311,517), and HealthShare Limited owed Waikato DHB $793,000 (2014:$13,184).

The Group's investment in HealthShare Limited has not been accounted for using the proportionate method in the parent financial statements as it is not considered material. HealthShare Limited has been accounted for using the equity method.

28: Related parties (continued)

Urology Services Limited
Urology Services Limited was set up on 1 October 1996 and provides urological services to the Waikato DHB district.

No dividends have been received from Urology Services Limited. During the period Waikato DHB received inpatient urological services from Urology Services Limited of $5.8 million (2014: $5.75 million). Waikato DHB recieved facility and management service fees of $2.9 million (2014: $2.8 million) from Urology Services Limited. During the period Waikato DHB's share of revenue amounted to $3.02 million (2014:$2.95 million) from Urology Services Limited.

As at 30 June 2015 Waikato DHB owed Urology Services Limited $559,470 (2014: $556,108), and Urology Services Limited owed Waikato DHB $638,094 (2014: $599,400)

Waikato Health Trust
Waikato Health Trust (formerly the Health Waikato Charitable Trust) was incorporated in 1993 as a charitable trust in accordance with the provisions of the Charitable Trust Act 1957. Under the Trust Deed the trustees are appointed by the Waikato DHB, these trustees acting independently in accordance with their fiduciary responsibilities under trust law. The trustees at 30 June 2015 are Pippa Mahood and Maureen Chrystall. The purpose of the Trust is to fund health or disability services, related services or projects, health research or education and other appropriate health related purposes within the communities served by Waikato DHB.

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $0.586 million (2014:$1.089 million). There was $Nil owing to Waikato District Health Board at 30 June 2015 (2014:$Nil).

NZ Health Partnerships Limited
NZ Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 shares (10.17%). At 30 June 2015 these shares had a Nil value.

Key management personnel
Board members' interests where transactions have been completed at arm's length during the financial year are: Waikato Regional and District Councils for the provision of environmental services, Te Korowai Hauora O Hauraki (a non profit incorporated Society) for the provision of General Practitioner clinical services, Midland Cardiovascular Services for the provision of clinical services, the Hamilton City Council for the provision of water supplies, sewage disposal and refuse collection, LIFE Unlimited for the provision of clinical services, Massey University for staff training and development, University of Auckland for the provision of clinical services and for staff training and development, Osteopathic Medicine Clinic for the provision of clinical services, University of Waikato for staff training and development and Braemar Hospital for the provision of clinical services.

Executives' interests where transactions have been completed at arm's length during the financial year are HealthShare Limited where Craig Climo, Nigel Murrary, Neville Hablous and Brett Paradine were directors, Health Benefits Limited where Craig Climo was a director, Waikato Health Trust where Mary Anne Gill, Maureen Chrystall and Pippa Mahood were Trustees, Wolstencroft & Associates where Ian Wolstencroft was a shareholder and director, and Urology Services Limited where Maureen Chrystall was a director.

29: Key management personnel remuneration

Compensations
There were no loans to board members during the year ended 30 June 2015 (2014:$Nil).

The Waikato DHB has a standard Directors and Officers Insurance Policy. No claims were made under this policy during the year ended 30 June 2015 (2014:$Nil).

Remuneration
Key management includes the Board and executive management including the Chief Executive. Key management compensation for the period was as follows:

	2015 Actual	2014 Actual
	$000	$000
Board members		
Salaries and other short-term benefits	348	350
Contributions to superannuation schemes	-	-
Members	11	14
Executive management team		
Salaries and other short-term benefits	3,398	2,722
Contributions to superannuation schemes	100	77
Full-time equivalent members	16	12

29 :Key management personnel remuneration (continued)

Total remuneration and compensation to close members of the family of key management personnel occured within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the Waikato DHB would have adopted if dealing with that individual at arm's length in the same circumstances

Board members	No. of meetings eligible to attend 2015	No. of meetings actually attended 2015	Remuneration 2015 Actual	Remuneration 2014 Actual
			$	$
Bob Simcock	39	33	56,813	31,355
Sally Christie	35	34	36,000	36,875
Crystal Beavis	25	23	29,000	14,758
Andrew Buckley	30	30	30,250	29,250
Martin Gallagher	29	26	28,000	27,750
Tania Hodges	29	27	27,250	14,758
Pippa Mahood	20	18	27,500	27,063
Sharon Mariu	22	21	28,563	27,688
Gay Shirley	34	33	29,500	29,000
Clyde Wade	30	26	27,750	28,250
Ewan Wilson	22	16	27,250	28,000
Harry Mikaere	-	-	-	13,500
Graeme Milne	-	-	-	28,875
Deryck Shaw	-	-	-	12,750
			347,876	349,872

June 2015 meeting attendances will be paid in the next financial year.

Non-board members who attended committee meetings	No. of meetings eligible to attend 2015	No. of meetings actually attended 2015	Remuneration 2015 Actual	Remuneration 2014 Actual
			$	$
Paul Malpass	6	5	1,250	1,000
Robyn Klos	6	6	1,500	1,000
Ned Wikaira	6	6	1,500	-
Ross Lawrenson	9	9	2,250	1,500
John Macaskill-Smith	9	7	1,750	1,250
John McIntosh	9	7	1,750	750
Fungai Mhlanga	9	7	1,750	1,750
Ken Price	6	5	1,250	250
David Slone	9	7	1,750	1,500
Piki Taiaroa	5	4	1,000	-
Mary Burdon	6	6	1,500	250
David Stewart	6	6	1,500	250
Yvonne Boyes	4	2	500	250
Rob Vigor-Brown	4	4	1,000	250
Alisa Gathergood	5	5	1,250	250
Ron Scott	5	5	1,250	250
			22,750	10,500

30: Employee remuneration

Employee remuneration over $100,000 ($10,000 bands)	2015 Actual	2014 Actual
100,001 - 110,000	123	113
110,001 - 120,000	93	75
120,001 - 130,000	66	63
130,001 - 140,000	43	45
140,001 - 150,000	21	27
150,001 - 160,000	28	13
160,001 - 170,000	22	24
170,001 - 180,000	24	20
180,001 - 190,000	23	25
190,001 - 200,000	16	24
200,001 - 210,000	23	21
210,001 - 220,000	21	17
220,001 - 230,000	17	23
230,001 - 240,000	21	23
240,001 - 250,000	17	10
250,001 - 260,000	26	22
260,001 - 270,000	15	18
270,001 - 280,000	16	16
280,001 - 290,000	20	8
290,001 - 300,000	9	19
300,001 - 310,000	19	18
310,001 - 320,000	13	13
320,001 - 330,000	9	4
330,001 - 340,000	12	6
340,001 - 350,000	4	10

30: Employee remuneration (continued)

Employee remuneration over $100,000 ($10,000 bands)	2015 Actual	2014 Actual
350,001 - 360,000	2	2
360,001 - 370,000	-	3
370,001- 380,000	4	5
380,001 - 390,000	2	1
390,001 - 400,000	-	1
400,001 - 410,000	3	1
410,001 - 420,000	-	1
420,001 - 430,000	1	-
430,001 - 440,000	1	-
440,001 - 450,000	1	-
490,001 - 500,000	-	1
540,001 - 550,000	-	1
610,001 - 620,000	1	-
680,001 - 690,000	-	1
	716	674

Of the 716 (2014:674) employees shown above, 85.47% or 612 (2014:574) are or were clinical employees.

The remuneration of the Chief Executive for the year ended 30 June 2015 was in the $440,001 to $450,000 band (2014:$490,001 - $500,000). Unlike the other employees shown above, the remuneration of the Chief Executive is calculated on a total remuneration basis and includes non-monetary benefits.

30: Employee remuneration (continued)

Termination payments
During the year the Board made payments to 14 employees (2014:8) in respect of the termination of employment with Waikato DHB.

	2015 Actual	2014 Actual
	$000	$000
Amount paid	330	328

31: Subsequent event

There are no significant or material events subsequent to balance date.

32: Comparative information

Comparative figures have been restated where necessary to align with current year disclosures.

33: Explanation of financial variances from budget

Waikato DHB recorded a net deficit of $2.415 million against its budgeted deficit of $0.028 million. Explanations of major variances are:

Variances in comprehensive revenue and expenses
Waikato DHB recorded a $2.387 million favourable variance to budget. This includes:

- revenue is $20.786 million favourable due to additional funding for extra health services delivered
- interest, depreciation and capital charge costs is $5.010 million favourable due to slower than planned capital expenditure and impact of building revaluations
- personnel costs are $4.163 million unfavourable due to extra health services delivered and annual leave not taken
- outsourced services are $15.065 million unfavourable due to higher outsourcing of clinical services to meet elective targets

33: Explanation of financial variances from budget (continued)

- clinical supplies are $5.690 million unfavourable partly due to higher than planned use of drugs purchased in Oncology, and higher purchases of plates and screws in the Orthopeadics department
- other operating expenses are $3.098 million unfavourable due to a building impairment charge

Variances in statement of changes in equity
The deficit was $2.387 million favourable to budget due to the statement of comprehensive revenue and expense explanations provided above

Variances in financial position
Current assets are $16.700 million higher than budget. This includes:

- prepayments are $6.480 million higher than budget due to contracts entered into requiring payment upfront
- receivables are $8.337 million higher than budget mainly due to a large Ministry of Health contract unpaid at balance date

Current liabilities are $13.646 million higher than budget mainly due to creditors tracking higher than budget

Non-current assets are $7.617 million higher than budget due to revaluation reserve increase in 2014 and work in progress catergorisation in 2015

Non-current liabilities are $19.216 million lower than budget due to a budgeted long term loan not drawn at balance date

Variances in cash flows

- Net cash flows from operating activities are $20.530 million lower than budget due to higher outsourcing of clinical services to meet elective targets
- Net cash flows from investing activities are $10.780 million lower than budgeted due to timing and split of planned capital expenditure

34: Adjustments arising on transition to the new PBE accounting standards

Reclassification adjustments
There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments
There have been no recognition or measurement adjustments relating from the transition to the new PBE standards.

Part 4 Audit Report

Some of Waikato Hospitals Radiotherapy team L-R: Alicia O'Connor (RT), Dr Angela Allen (Rad Onc), Dr Roger Huang (Rad Onc), Koki Mugabe (Physicist), Joy Utting (Onc Nurse)

Audit report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Waikato District Health Board and group's
financial statements and performance information
for the year ended 30 June 2014

The Auditor-General is the auditor of Waikato District Health Board (the Health Board) and group. The Auditor-General has appointed me, J R Small, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 142 to 176, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, 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 that comprises the statement of service performance on pages 44 to 139 and the report about outcomes on pages 24 to 28.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 142 to 176:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board and group's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

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

Reason for our qualified opinion

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

Our audit opinion on the performance information of the Health Board and group for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 24 to 28 and 44 to 139:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 22 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board and group. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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

J R Sawalli
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand