Annual Report

for the year ended 30 June 2014

Waikato District Health Board

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

Edward John Meade McKibbin, 3, the great grandson of Dr Meade, cutting a ribbon to open the new Meade Clinical Centre

Statement of Responsibility for the Year Ended 30 June 2014

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 2014 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 2014 fairly reflect the financial position and operations of Waikato District Health Board.

Signed on behalf of the Board

Bob Simcock, Chair
22 October 2014

Sally Christie, Deputy Chair
22 October 2014

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 2013/14 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 2013/14 Annual Plan.

- Name of DHB: Waikato District Health Board
- Address: P.O.Box 934, 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

Contents

Aerial shot of Waiora Waikato hospital

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!’

Board statement

It is my pleasure to report on a year of great change with completion of Waikato DHB's massive building programme, continual improvement in our health targets' performance, recruitment of a new chief executive and changes in Board membership.

I have been chair since December 2013 so am reporting on a year largely led by Graeme Milne.

Throughout the year, we strengthened our focus on quality as a priority so we can achieve the best outcomes for our patients and clients.

The people in our care are at the heart of all we do.

As an example, for five years, we have made the Productive Wards – Releasing Time to Care both on wards in our hospitals and in the community, a quality priority.

The programme has helped front line clinical staff spend more time on patient care, reduced waste and improved efficiency.

In the following pages, you can read Waikato DHB's performance story for the year starting 1 July 2013.

To make the most of our resources, Waikato DHB set the following goals in the 2013-2014 Annual Plan:

- Improve productivity
- Plan and work more co-operatively
- Be more effective in quality improvement, innovation and implementation of ideas
- Identify and achieve savings to sustain a healthy future.

We finished the year with a $3.8 million surplus, $2 million favourable to budget. This reflects well on everyone involved particularly our dedicated staff who in the face of a number of challenges helped us continue to "build healthy communities".

We celebrated the end of the 10-year $500 million building programme with the opening of the Red Corridor in the Meade Clinical Centre on 30 June 2014, the final day of the financial year and unveiled the Timeline, a visual display of Waikato Hospital's 127-year history, celebrating the occasion with our staff.

These events marked the successful completion of a building programme that came in on time and on budget and demanded a lot from staff in every part of the organisation. I thank them for their patience and flexibility as they have grappled with the challenges of delivering increasing levels of service in what has often been a building site.

The completion of this work was a credit to all the people involved in programme management, design, build, professional advice, DHB management and staff.

Throughout the health sector demand for services continues to grow faster than the resources available to deliver them. This challenge has been magnified for this DHB because of the need to manage the construction programme at the same time.

The national health targets continue to challenge us and throughout the year, staff put in substantial effort and our performance against targets improved dramatically (see pages 16 and 17).

This improvement demonstrates that by constantly focusing on better ways to deliver services we can respond to the challenges that will continue to be with us.

We came close to achieving the acute six-hour target of having 95 percent of patients admitted, discharged or transferred within six hours from the DHB's four emergency departments in Hamilton, Taumarunui, Thames and Tokoroa.

By year's end, nearly 15,000 people received elective surgery at Waikato DHB - 1,400 more than the target set by the Ministry of Health. Meeting the waiting time targets proved challenging however, they are under better control and in line with Government's expectations.

We achieved the other two hospital targets, shorter waits for cancer treatment and greater help for smokers to quit. We will need to work more closely with our primary care partners to achieve the other targets of increased immunisation and more heart and diabetes checks.

Our Primary Care partners continued to play an increasingly important role in helping to deliver the right care at the right time and in the right place for people in our community.

We had the microscope on us during part of the year with the Ministry of Health putting us on performance watch. This is not surprising given the re-building project but it is our goal to return to a normal monitoring regime as quickly as possible.

On top of that, at my request, the Ministry undertook a review of Waikato DHB in preparation for the appointment of our incoming chief executive. The report contained the helpful ideas and opinions of our staff whose observations formed the bulk of the review. It indicated the areas the DHB is doing well in and where it needs to improve.

The report reinforced my view that Waikato DHB delivered good health outcomes for the people of the Waikato during trying times, which included a Global Financial Crisis and the massive building programme.

During the second half of the financial year, we provided weekly reports to the Ministry against the following areas:

- Six-hour target
- Elective services
- Acute coronary syndrome
- Cardiac surgery
- Radiation oncology waiting times.

That reporting helped us focus on those areas, which help us improve the health of our population and reduce health inequalities.

Post the Canterbury earthquake, all building owners have had to reassess the seismic risks of their properties. We have assessed the standard of all our buildings and our focus is
on ensuring the safety of our staff and visitors. It affects none of our hospital wards.

During the year we consulted with the public on a proposal to close the DHB owned and operated primary birthing facilities at Morrinsville and Te Awamutu. Both units have had very low use and the costs per birth are much higher than other similar maternity facilities. Understandably the affected communities expressed some concern during the consultation. As a result, the board asked for proposals that might meet both the interests of the communities and the board's need for a better allocation of resources. The reaction we have seen so far is encouraging. We will make a decision over the facilities' future in the next financial year.

I wish to recognise the outstanding contributions made to Waikato DHB by Graeme Milne, after five years as Chair, and Craig Climo, after seven years as CEO. Both men led Waikato DHB through a time that involved massive change, which positioned us well to face the challenges ahead.

Dr Nigel Murray replaced Craig and the Board has challenged him to improve the quality of care we provide to the people of the Waikato. I look forward to working with him as we continue our work to enable people in our communities to live healthy lives.

At the local body elections in October 2013, we saw the return of eight board members we welcomed three new members, Crystal Beavis, Tania Hodges and myself as chair.

Two appointed board members stood down – Harry Mikaere and Deryck Shaw. Harry's seven years were significant for his championing of Maori health and it is pleasing that he continues that service to his people

in the role of Iwi Māori Council chair. Given the size and health need of our local Māori population of 82,000, having that continuity is vital as we work to support initiatives for Māori against national health priorities.

We continue to work closely with Deryck in his role as chair of our neighbouring Lakes DHB.

Finally, I would like to thank our staff for their continued dedication to the task of delivering good health care and advice to our community. While we sometimes get it wrong, we deliver great care most of the time. We must listen and learn from those whose expectations we don't meet. We should also hear the messages of thanks that come from the overwhelming majority of the people we serve.

Bob Simcock

Chair

Bob Simcock

Waikato DHB Chair (from 9 December 2013)

Appointed: 9 December 2013

- Chairman, Hamilton Science Awards Trust
- Chairman, Hamilton Youth Search and Rescue Trust
- Director, Rotorua 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.

Sally Christie

Deputy Chair

Re-elected: 9 December 2013

Partner, Mr Michael O'Donnell, works for Workwise

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
- Director, Strategic Lighting Partnerships Ltd
- Life Member, Diabetes Youth New Zealand Inc
- Trustee, BBA Family Trust
- Trustee, JGB Trust
- Trustee, CJB Trust
- Employee, University of Waikato (MOU with Waikato DHB to pursue mutual interests in research and education)

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
- 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.

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)

Wife employed by Presbyterian Support Services 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 Custodian Ltd
- Director, Ngati Pahauwera Tiaki Custodian Ltd
- Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)
- Trustee and Shareholder, Whanau.com Trust
- Ministerial Appointee, Council of Te Wananga o Aotearoa
- Justice of the Peace

Husband is a Ministry of Education employee.

Pippa Mahood

Re-elected: 9 December 2013

- Life Member, Hospice Waikato
- Member, Opus Trust Board
- Member, Institute of Healthy Aging Governance Group

Husband retired respiratory consultant from Waikato Hospital.

Harry Mikaere

Term concluded and not re-appointed: 9 December 2013

- Chair, Iwi/Māori Council
- Chair, Te Korowai Hauora O Hauraki
- Chair, Hauraki PHO
- Chair, Tainui Waka Alliance
- Director, Hauraki Fishing Group
- Director, Taimoana Marine Farms Ltd
- Director, New Zealand Aquaculture Ltd
- Chair, Waikato whānau Ora Regional Leadership Forum
- Shareholder, Coromandel Marine Farmers Ltd

Part owner of Phoenix House Resthome and Hospital with wife, which is leased to daughter and son-in-law, Riana and John Manuel, which holds contracts with Waikato DHB to provide aged care, primary care and transitional care.

Sharon Mariu

Re-appointed: 9 December 2013

- Chair, Oraukura 3 Inc
- Director and Shareholder, Register Specialists Ltd
- Director and Shareholder, THS & Associates Ltd
- Ministerial Appointee, National Health Committee

Graeme Milne

Waikato DHB Chair (from 18 May 2009)

Resigned: December 2013

- Chairman, New Zealand Pharmaceuticals Ltd
- Chairman, Synlait Milk Ltd
- Chairman, Terracare Ltd
- Chairman, Johnes Disease Research Consortium
- Chairman, Rural Broadband Initiative National Advisory Committee
- Director, Farmers Mutual Group
- Director, New Zealand Institute for Rare Disease Research Ltd
- Director, Genesis Power Ltd
- Director, Alliance Group Ltd
- Member, Massey University School of Advanced Engineering and Technology
- Advisory Board
- Trustee, Rockhaven Trust
- Partner, GR & JA Milne.

Deryck Shaw

Term concluded and not re-appointed: December 2013

- Director and Owner, APR Consultants Ltd
- Director and Shareholder, APR Group
- Director and Shareholder, Principal Holdings Rotorua Ltd
- Partner, Shaw Property Partnership
- Chair, Lakes District Health Board
- Chair, Rotorua United AFC – not for profit soccer/football club
- Chair, New Zealand Walking Association
- Board Member, NZ Māori Arts and Crafts Institute – Te Puia
- Board Member, Waikato Bay of Plenty Football
- Vice President, IML Walking Association
- Member, Rotary Club of Rotorua West
- Committee Member, Bay of Plenty Branch, NZ Institute of Directors, not for profit organisation and no fee (voluntary).

Gay Shirley

Re-appointed: 9 December 2013

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

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

Ewan Wilson

Re-elected: 9 December 2013

- Hamilton City Councillor
- Director and Shareholder, MEW Developments Ltd
- Director, Grand Journey by Wilson Tours Ltd
- Director, Wilson Aviation Ltd

Daughter is an employee of Waikato DHB

Part 1 Overview

Introduction

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2014. 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 2012/13 - 2014/15 and Annual Plan 2012/13.

Our focus is to provide services for our population, which 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 2013/2014 year, we received approximately $1.049 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. These services are funded and contracted nationally.

During 2013/14 approximately 60 percent of funding received by Waikato DHB was used to directly provide hospital and health services. The remaining 40 percent was used to fund contracted services provided by non-government organisations (NGOs), primary health care organisations (PHOs), Māori providers, Pacific providers, aged residential care, other DHBs, 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).

L-R Faye Cowen, Elaine Parker, Marie Borland, Dale Hedge and Alison Bussey from Breast Screening Aotearoa

Diagram: Our Performance Story

1. 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	

2. 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 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					

3. 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	Rural

4. Service performance

Long-term impacts	People 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 • 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 hospitalised smokers offered advice to quit • Percentage of eight month olds fully immunised • Percentage of infants who are fully or exclusively breastfed	• Percentage of children (0-4) enrolled in DHB funded dental services • Percentage of population enrolled with a PHO • Percentage of eligible women (50-69) have a breast screen in the last 3 years • Percentage of Rest Home residents receiving vitamin D supplement from their GP • 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	• Acute re-admission rate • Percentage of patients waiting longer than five months for their first specialist assessment • Improving the percentage of long-term clients with up to date relapse prevention/treatment plans

Output Classes

Output classes	Prevention services	Early detection and management services	Intensive assessment and treatment services	Rehabilitation and support services

Stewardship

Stewardship	Workforce	Performance Management	Clinical Integration / Collaboration / Partnerships	Information

Our Organisational Profile

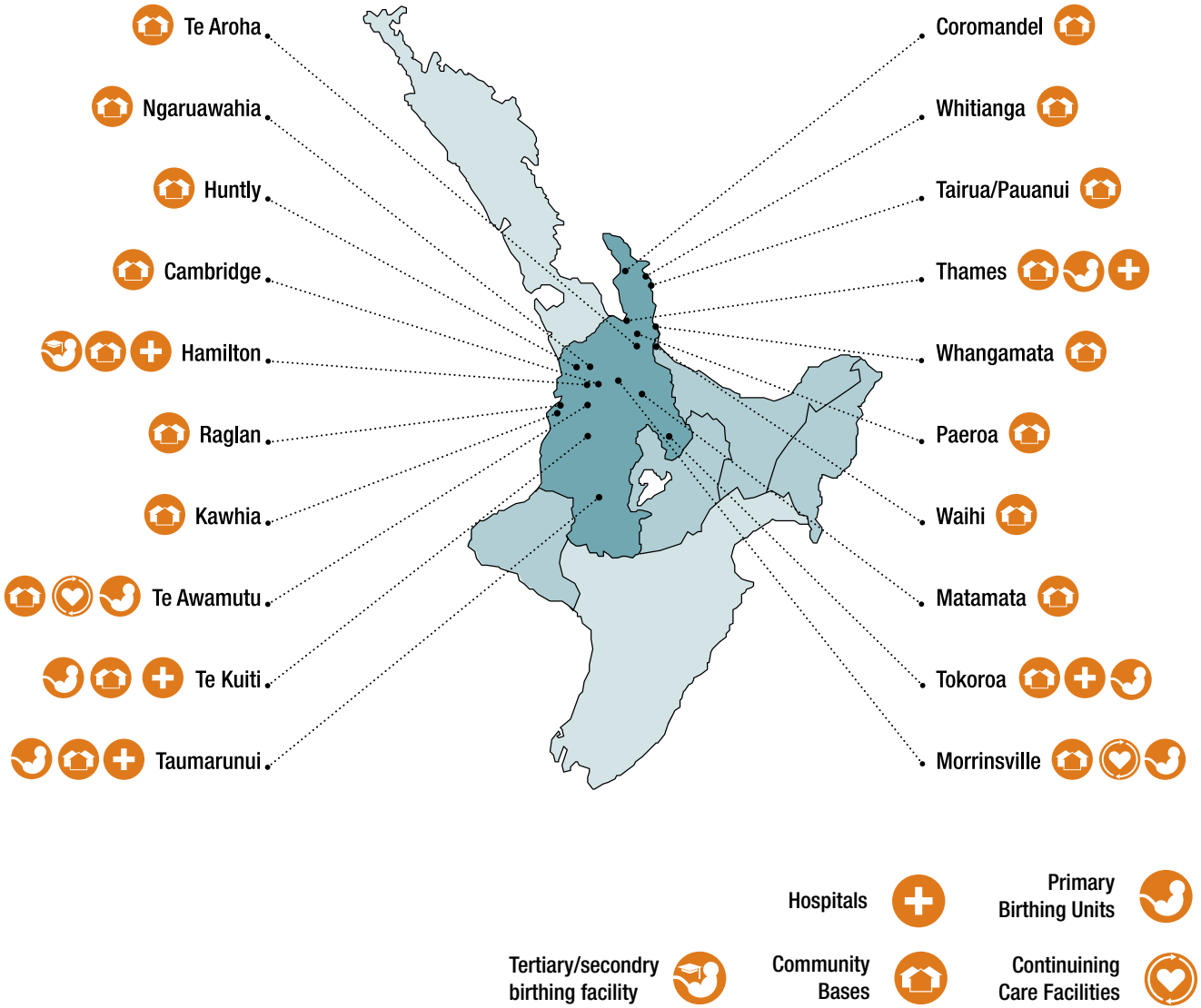
Waikato DHB
employs over
6,000 people

Plans, funds and provides hospital and health services to around 373,220 people who live within the Waikato DHB boundaries

Provides tertiary services (such as highly complex surgery) to the Midland regional population of more than 844,000

Covers a widespread geographical area; almost eight 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 2013/14, our projected population was 373,220. 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 2011/12 and 2025/26). 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 2013/14) 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 acknowledgment of the status of iwi in the Waikato, gives us a strong commitment to partner with 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.

Almost 42 percent of our population live in rural areas, and 60 percent live outside Hamilton city. 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 provide some 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 DHBs 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.

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. During the 2013/14 year an election was held, this resulted in a few changes to the Board Members for the Waikato DHB. Graeme Milne completed his time as Chair on 8th of December 2013 and Bob Simcock was appointed Chair of the Board as of 19th of December 2013. In December 2013, the chief executive Craig Climo announced his resignation effective mid-July 2014. The new chief executive, Nigel Murray, 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; 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

The following table provides an overview of our workforce demographics.

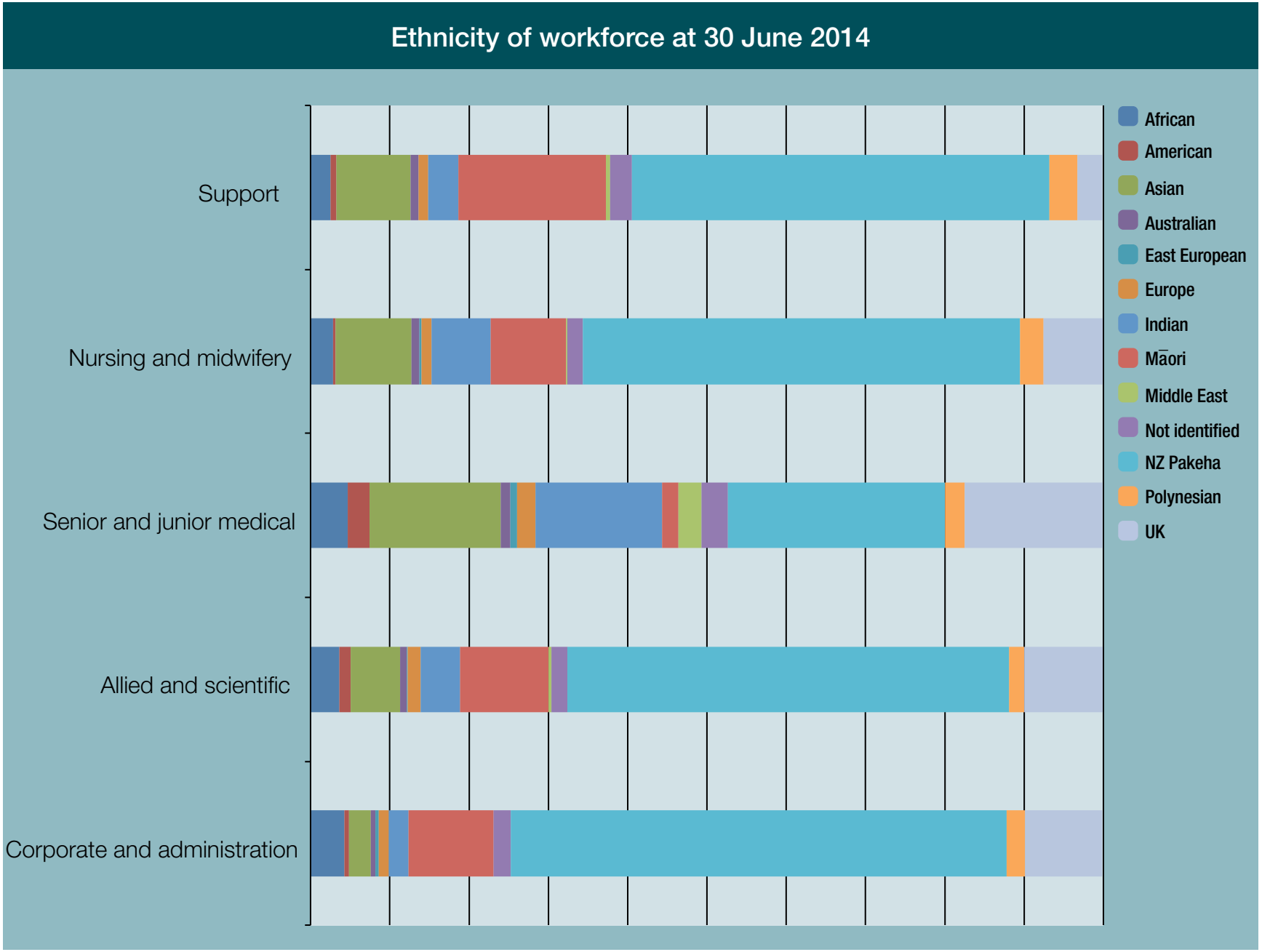
Professional Group	Headcount	Contracted full time equivalents	Average Age (years)	Female (headcount)	Male (headcount)
Corporate and Administration	1,173	1,049	50	979	194
Allied and scientific	1,152	977	43	901	251
Senior and junior medical	726	665	41	268	458
Nursing / midwifery	3,018	2,376	45	2,667	351
Support	397	324	48	206	191
Total	6,466	5,391	45	5,021	1,445

Key information about our workforce demographics is as follows:

- The average age of our staff is 45.26, which is consistent with last year (45.6). Our national data shows that DHBs have a more concentrated distribution of employees in the higher age groups (45+) than the national labour market average, and less concentration in the younger age groups.
- Our gender mix continues to be 78 percent female and 22 percent male. This is the same as last year (2012/13) and the year before (2011/12).
- Over the last 12 months the total number and percentage of Māori we employ has risen slightly from 9.5 percent to 9.7 percent of the total workforce, representing some 631 individuals. The largest number of which are employed as nurses (287).

Programmes to manage and develop our workforce are explained under our organisational and workforce development priority in this report

Ethnicity of workforce at 30 June 2014



Functions of a DHB

As a DHB we:

- Plan in partnership with key stakeholders the strategic direction for health and disability services
- 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 community 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, 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**

Lynette Robinson, Physiotherapist for Te Kuiti and Taumarunui Hospitals

Planning and funding health and disability services

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

- Assessing our 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 our 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 our 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.

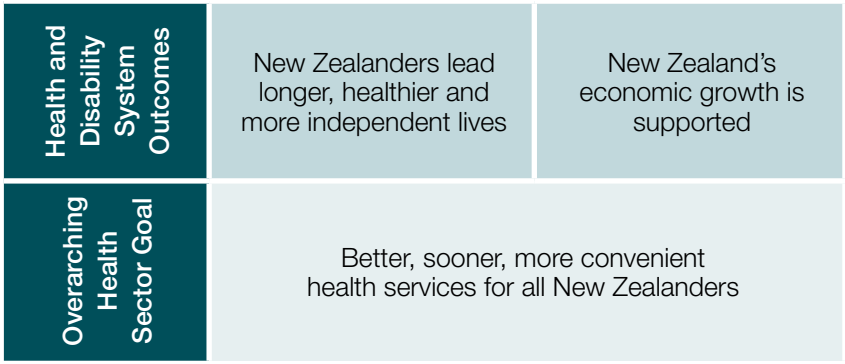
In order to live within the available funding whilst maintaining sustainable services it is essential to ensure that services are funded at appropriate levels and that value from health expenditure is maximised in terms of both health gain and the DHBs priorities. Additional focus in these areas have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

Planning is an integral part of purchasing and providing healthcare services. Planning is undertaken in partnership with key stakeholders.

Wintec Student Nurse, Sirwan Khalandi and Tania Te Wano, Charge Nurse Manager, Te Kuiti Hospital

National Performance Story

The following diagram is part of our wider performance story (see pages 16 and 17) and shows the national strategic direction.



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 PHOs) 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 f or DHBs 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 other publications or reports.

We do not always meet the Health Targets, however we ensure 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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	86%	87%	88%	94%	89%	94%	88%	93%
All DHBs	92%	93%	93%	94%	94%	94%	93%	94%

More information about our results and performance is on page 65.

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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	108%	116%	111%	113%	116%	113%	115%	111%
All DHBs	105%	105%	105%	105%	106%	105%	107%	106%

More information about our results and performance is on page 123.

Increased immunisation

Target: 85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014.

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

This age group for this target has changed from two year olds in 2011/12 to eight month olds for the 2012/13 year onwards. More information about our results and performance is on page 81.

Shorter waits for cancer treatment radiotherapy

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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	100%	99.5%	100%	100%	99.7%	100%	100%	100%
All DHBs	100%	99.9%	100%	100%	99.9%	100%	100%	100%

More information about our results and performance is on page 119.

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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	93%	96%	94%	97%	93%	96%	96%	96%
All DHBs	94%	96%	95%	95%	95%	95%	96%	96%

More information about our results and performance is on page 75.

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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	42%	62%	46%	68%	51%	73%	61%	84%
All DHBs	40%	60%	43%	66%	51%	72%	57%	86%

More information about our results and performance against both parts of this target is on page 73.

More heart and diabetes checks

Target: At least 90 percent 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	2012/2013	2013/2014	2012/2013	2013/2014	2012/2013	2013/2014
Waikato DHB	60%	75%	63%	77%	67%	79%	73%	85%
All DHBs	52%	69%	55%	73%	59%	78%	67%	84%

More information about our results and performance is on page 95.

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

Regional Services Plan Priorities

The Midland DHBs produced a Regional Service Plan (RSP) for the 2013/14 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 table summarises the service and infrastructure priorities in the RSP.

In addition to the areas of work outlined in the RSP, the Midland DHB region Chairs and Chief Executives recently agreed to focus on two additional areas being:

- paediatrics
- health of older people

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.

Service Priorities	Infrastructure Priorities
Vulnerable Services • Maternity services • Renal services • Health of older people • Radiology	• Clinical Information systems • Workforce • Māori Health
National Priority Services • Cardiac services • Elective services • Stroke services • Mental health and addictions network • Cancer control • Child Health • Rheumatic Fever	**Key Enablers** • Health Quality and Safety Commission • National Health Committee • Capital and Asset Planning • Midland Regional Training Network
Regional activities • Smokefree • Midland regional trauma system	

Regional Outcomes

During 2013/14, the Midland DHBs identified some common outcome measures that we could monitor across the Midland region. A small set of health measures will 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. These measures are:

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 people of New Zealand's 5-14 years population and the percentage of obese people 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.

The six measures identified above will be reported on in the 2014/15 Annual Report as they were only agreed upon during the 2013/14 year. The exception is the average life expectancy at birth information for our region as this has been an ongoing measure. The figures for 2007-09 for the region are outlined in the following table.

2007 - 2009 average life expectancy	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

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.

Local Performance Story

Waikato DHB continues to deliver improvements in health outcomes. During 2013/14 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 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)	87.4% (2011/13)	89.5%
Excellent, very good or good parent-rated health – 0–14 years (Waikato DHB)	97.6% (2006/07)	96.6% (2011/13)	98.0%

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 is expected the next release of the life expectancy data will be in mid-2015 due to the cancellation of 2011 Census.

Our priorities

Our 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. Performance has improved, however more can be achieved.

Our local priority 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.

This is not listed in our performance story table, however it is a priority area for which requires monitoring.

Bob Stone, Unit Charge MRT at Taumarunui Hospital

Madhu Nahna, Charge Scientist at Te Kuiti Hospital

Financials

Our final financial result for 2013/14 was $3.8 million, which compares favourably with our planned budget of a $1.8 million surplus.

Cost of Service Statement by Group for the year ended 30 June 2014	Parent 2014 Actual	Parent 2014 Budget	Parent 2013 Actual
Income	**$000**	**$000**	**$000**
Funder	1,134,235	1,127,466	1,105,983
Governance and Planning	5,557	5,257	5,214
Provider	747,536	740,731	722,818
Eliminations	(663,585)	(661,894)	(649,038)
	1,223,743	1,211,559	1,184,977
Expenditure			
Funder	1,085,789	1,087,443	1,063,460
Governance and Planning	5,969	5,899	5,095
Provider	791,754	778,311	763,429
Eliminations	(663,585)	(661,894)	(649,038)
	1,219,927	1,209,759	1,182,946
Share of associate surplus/(deficit)	5	-	1
Share of joint venture surplus/(deficit)	26	-	156
Surplus/(deficit)	3,847	1,800	2,188

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

Did you know

14,457 Diabetes Checks / Diabetes Care Improvement Packages were undertaken in 2013/14

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 RSP, as described in the regional performance section. Other examples of regional collaboration include 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:

- Collaborative approach across the Midland Region for general public health workforce professional development
- Communication and actions as required to support national Public Health Clinical Network
- Regular public health regional teleconferences and forums for staff groups
- Development of regional protocols for an identified list of communicable diseases
- Explored opportunities to collaborate in the areas of health intelligence and health needs analysis
- Collaborative approach to the development of service contingency plans for each unit linking to regional support as appropriate
- Midland Maternity and the Rural Health Advisory Group are continuing to work together to look at rural maternity services
- Undertook a six month trial of a regional cataract pathway
- Commenced work on a regional theatre production planning model for orthopaedic surgery
- Successful transition of Tairawhiti District Health adult medical oncology, radiation oncology and haematology services from MidCentral DHB to the Midland region with a post-implementation evaluation completed
- Development of a customised patient tracking trauma database (subject to national security and sovereignty standards) to form the core of the regional Trauma Quality Improvement Programme.

Quality improvement

Quality improvement has been a significant focus over the past seven years with a variety of improvements being made each year. We have begun implementing the Quality Strategy that was recently developed. The strategy 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 will 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.

Caption

Jen Riley, one of the Project Energise staff

Early intervention for healthy eating and activity (Project Energize)

Project Energize is a programme delivered to primary and intermediate schools in the Waikato and has been running since 2005. Funding for the programme comes from the Waikato DHB in partnership with Sport Waikato and is delivered by Sport Waikato. The aims of the programme are to teach healthy eating and physical activity to children between 5 and 12 years old. Relationships are well established with Health Waikato, Alliance PHOs 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 WHO Health Promoting School framework, demonstrating there is evidence that Project Energize is improving the health and wellbeing of children.

A number of articles have been published in the 2013/14 year in reputable journals and presentations have been delivered at the:

- Obesity Australia's December 2013 summit
- FILEX Health and Fitness Convention Melbourne
- Regional Sports Trust

Working with primary care to reduce the impact of cardiovascular disease and diabetes

We have continued to work with our primary care partners to reduce the impact of cardiovascular disease and diabetes. We provided funding to our three primary care partners to enable implementation of their respective long term conditions programmes (which include a focus on the More Heart and Diabetes Checks Health Target and Diabetes Care Improvement Packages). Our primary care partners use the allocated funding to support and incentivise performance of their practices.

This funding is allocated to practices through a funding allocation model which covers inputs, outputs and outcomes:

- Capacity funding - calculated in year one based on high needs; year two based on numbers in stratified risk categories with different categories buying different levels of intervention
- Coverage funding - as practices achieve agreed coverage targets in three bands in year one and then active care plans for year two; then the funding is adjusted to reflect that the harder to reach are being actively managed.
- Quality funding - year one coverage targets and some outcome; year two moving to less coverage and greater outcome

More smokers make more quit attempts

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 towards achieving the goal includes:

- Continuation of Waikato DHB tobacco control steering group to ensure a unified approach to meeting national, regional and local strategies
- We have refreshed our local tobacco control plan
- Continued engagement with our primary care partners to share information about the health target and monitor actual performance against planned performance
- Progress in developing an action plan for better help for pregnant smokers to quit
- Increased education with retailers

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 2013/2014 includes:

- Review of rapid response and discharge management services including Supported Transfer and Accelerated Rehabilitation Teams (START)
- Continued with benchmarking readmission rates for the DHB's 65 year old plus population
- All aged related residential care (ARRC) facilities in our area have commenced and/or engaged with the national training programme
- Continued to provide primary care and aged residential care sectors with access to Waikato DHB gerontology specialist advice; forty to fifty hours per week is available for health professionals in primary care and aged residential care to consult with specialist Health of Older People (HOP) services
- Worked towards the access to General Practicioners being 24 hours a day, seven days a week for older people in aged residential care
- Used 2007 Ministry of Health Elder Abuse Guidelines to develop local implementation plan
- Began implementation of initiatives outlined in local Elder Abuse Guidelines Implementation Plan

Organisational and workforce development

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.

Safety culture
The Waikato DHB has embarked on a long-term programme to improve safety culture. The focus is on inherent human behaviours and their influence on culture and includes staff safety, process and system safety, and patient safety. The safety culture working group has been formed comprising representatives from various departments and unions to oversee the initial stages of the project. The Board of Clinical Governance will oversee the whole project. Work has begun to increase awareness about the safety culture and what it means within the DHB. The next stage is to survey staff about their perceptions of the safety culture, which will be used to inform strategy moving forward.

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 PGY1 level registrars 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 PGY1 level registrars begin orientation before they start, information is available when they want it, and learning is experiential which makes the session relevant and interesting.

Employee development, promotion and exit

Health Care Assistant Training

Since 2010, the Waikato DHB has been establishing and implementing a training programme for health care assistants. The training programme is a level 3 qualification on the NZQA framework. The modules include code of rights, cultural safety, service delivery, supporting activities of daily living, and infection control.

In 2010, we piloted the programme with 13 health care assistants working in the newly established Supported Transfer and Accelerated Rehabilitation Team (START). The START team provides services to avoid admission and support discharge. In 2012, 50 more health care assistants completed the qualification using the DHBs training material and the Industry Training Organisations (ITO) assessments. Since then a further 80 trainees graduated from the fully integrated programme. By integrating the programme, the Waikato DHB has been able to streamline the delivery for all concerned. There are now 106 health care assistants enrolled on the programme including psychiatric assistants, allied health assistants, as well as health care assistants.

Another DHB has commenced delivering the Waikato DHB training package on Monday 9 June 2014. A local rest home and retirement village will be delivering the package soon.

Health Care Assistanct, Pania Kokiri

Health Care Assistanct, Shona Farrell

The Waikato DHB is collaborating with Te Wananga Aotearoa and Careerforce ITO to make similar and targeted training available to community health workers employed by Non-Government Organisations.

Exiting information

The DHB has revised its exiting policy and process so that more information about why people are leaving is captured. The process change was needed because the DHB could not capture exiting data if a person had more than one reason. The top ten reasons that make up 50 percent of why people leave. These are shown below.

The top ten reasons that make up 50 percent of why people leave	
1	Relocation
2	Overseas
3	Transfer within the Waikato DHB
4	I want to spend more time with my family
5	Out of health sector
6	New job has better career prospects
7	Ceasing work all together
8	New job has a higher salary
9	End of employment agreement
10	New job has better challenges and is more interesting

Nursing Entrant Training Programme / Honours programme

This year the Nursing Entrant Training Programme (NETP) took 92 newly graduated nurses and supported them to complete their postgraduate certificate and improve their nursing skills with a few continuing towards completion of the 18-month DHB honours programme. The DHB retained at least 88 percent of them in permanent nursing positions following completion of the programme.

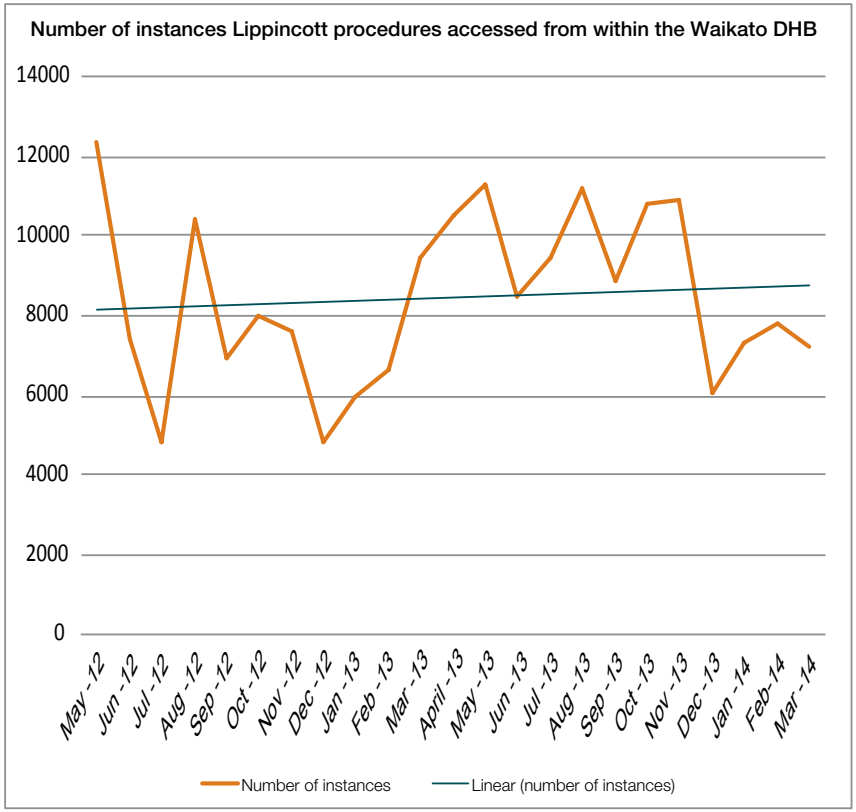
The honours programme is a new partnership initiative between DHB and University of Auckland that provides a pathway for leadership development alongside clinical development. The nurses nominated to undertake the programme carry out a research project that the DHB determines and have mentoring with various members of the executive as a group. The benefits are that the DHB can determine a stream of research activity (7 last year and 5 this year) related to nursing practice. The first cohort will be completing soon. Their research will be compiled and used to inform nursing leadership, workforce development, and where there are opportunities for practice growth.

Longitudinal research into the effectiveness of postgraduate papers on clinical decision making in a variety of settings is underway. The outcome will be used to inform future education supported by the DHB.

Lippincott Procedures

This is an on-line 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.

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



Flexibility and work design

Roster review for resident doctors

Arising from industrial negotiations, the DHB is working 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.

Dedicated education units

DHB is running a pilot that commenced in March in Older Persons and Rehabilitation Service and in April in orthopaedics. The pilot shifts 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.

Remuneration, recognition and conditions

Staff Service Recognition Programme 2014

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 2014 there were 483 staff invited to participate in the Staff Service Recognition Programme, with 76 staff celebrating 30 years or more of continuous service and one staff member celebrating 50 years of continuous service.

The Chief Executive, Board Members of Waikato DHB, members of the executive group, supporting managers, and colleagues attend the presentations. Family and friends are also welcome.

Harassment and bullying prevention

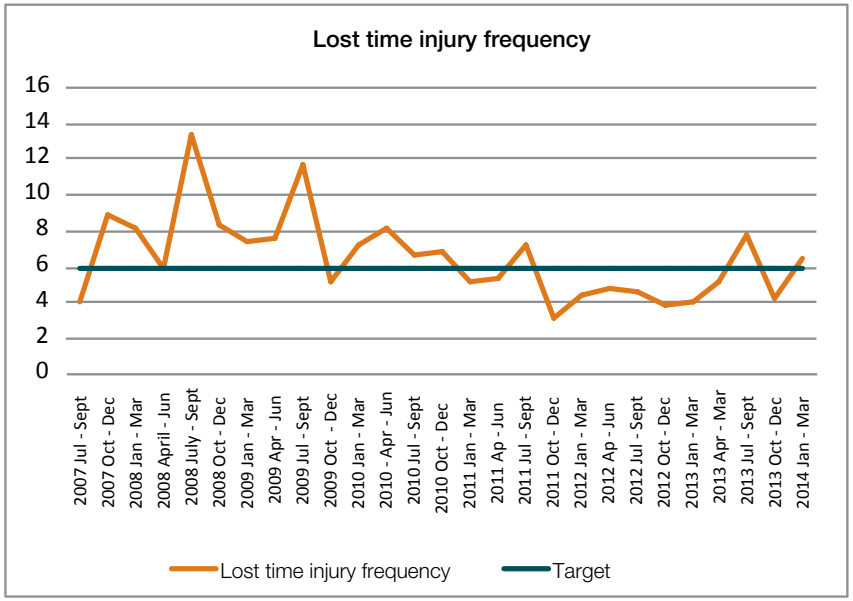
Since November 2012, the DHB has provided training to 109 managers, staff, and union delegates about how to manage harassment and bullying in the workplace. An independent review of the suite of activities for harassment and bullying has been completed and a number of enhancements will be made including promoting the existence of the policy to new staff as part of their orientation.

Safe and healthy environment

Lost time injury frequency rate

The lost time injury frequency rate is a gauge of the effectiveness of workplace safety programmes. The occurrence of workplace injuries results in employee's inability to work. It is calculated by dividing the number of injuries over the number of hours worked.

The graph below indicates that the DHBs lost time injury frequency rate is trending downwards and is hovering around the national target of 5.85. Waikato DHB has one of the lowest rates in the country.



Dr Humphrey Pullon nears the finish of the Round the Bridges 2013

Round the bridges

For the last six years, the Waikato DHB has mustered a sizable team for the annual Round the Bridges event in Hamilton. In 2013, 465 DHB staff enrolled in the event. The event is a walk / run over 6 or 12 kilometres. Preparation for the event sees DHB staff in training mode to increase their fitness, and on the day, staff from all over the organisation come together spending time with people who they would not normally at the fun city wide event.

ACC partnership programme

Commencing on the 19th August 2013 for a four-day period the Waikato DHB was independently audited by ACC for its continuance in the ACC Partnership Programme. The audit, which focused on the DHB's health and safety management practices, claims management practices, site visits as well as employee and management focus groups was successfully completed. The audit findings confirmed that the DHB regained its tertiary level status under the programme after dropping to secondary level in 2012. The auditor in her report identified significant improvements to monitoring contractor performance, the establishment of a contractor oversight group and increased post contract evaluations. Other improvements to patient handling, staff wellness and security also received notable mention.

A small number of minor recommendations were received relating to policy dates and approved representative training were received all of which have been actioned and rectified.

Did you know

Waikato DHB is one of the biggest employers in the Waikato

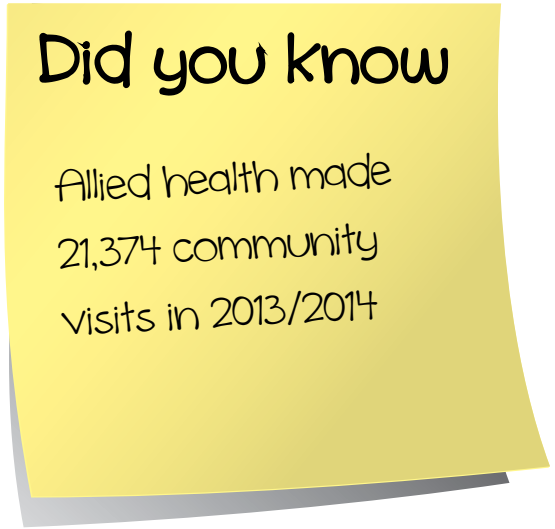
Rural

Tokoroa

With almost $2.1 million capital investment from Waikato DHB (which will be received from tenants as lease costs), two unused wards at Tokoroa Hospital have been transformed into modern facilities that house a medical centre and a family GP practice, a pharmacy, and a wide range of other primary health services.
The project started with design work and tendering in April 2013, and tenants had all moved in and opened for services by 20 January 2014.
Leadership and wider community support was vital in the project. As well as Waikato DHB, those involved over many years include:

- Raukawa Trust Board (Raukawa is the iwi of the area)
- Midlands Health Network - the Public Health Organisation (PHO) with three GP practices in Tokoroa
- South Waikato Pacific Islands Community Services
- South Waikato District Council and Mayor

The new space at the hospital has created an environment that better services patient needs but is also more attractive for staff to work in.
The co-location project is a first step towards better integration of health services in Tokoroa.



Taumarunui

We have continued working with healthcare services and providers to progress the healthcare model for Taumarunui. In September 2013, a formal presentation of the model of care was made to the governance group and the model approved.

The work completed this year includes:

- Work stream project manager in place
- Service Directory - paper / electronic copies
- Integrated Health Workforce and Services Group
- Established relationship between hospital, community, pharmacy and other key health providers
- Improved understanding between providers about what they provide
- Two Integrated pathways developed – respiratory and pharmacy
- First integrated training session planned
- Developing multidisciplinary environment
- GPs and hospital doctors meeting
- Emerging referral process to improve patient experience / journey

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.

Meade Clinical Centre - Completed June 2014 Cost ($130m)

A major new five-level 39,000m2 building contains a large portion of Waikato Hospital's clinics, a new Critical Care area (High Dependency Unit and Intensive Care Unit), additional theatres and interventional suites, as well as a new Radiology department. The building links directly to the Hague Road Carpark Building.

- **Stage 1** - clinics, endoscopy, High Dependency (completed late 2012)
- **Stage 2** - interventional suites, some theatres and Critical Care (completed late 2013)
- **Stage 3** - Radiology (completed April 2014)
- **Stage 4** - completion of Meade Clinical Centre including opening of corridor linking routes (completed June 2014)

Meade Clinical Centre Atrium

Aerial shot the Meade Clinical Centre

Sub wait area, level 1, Meade Clinical Centre


New ICU space, Meade Clinical Centre

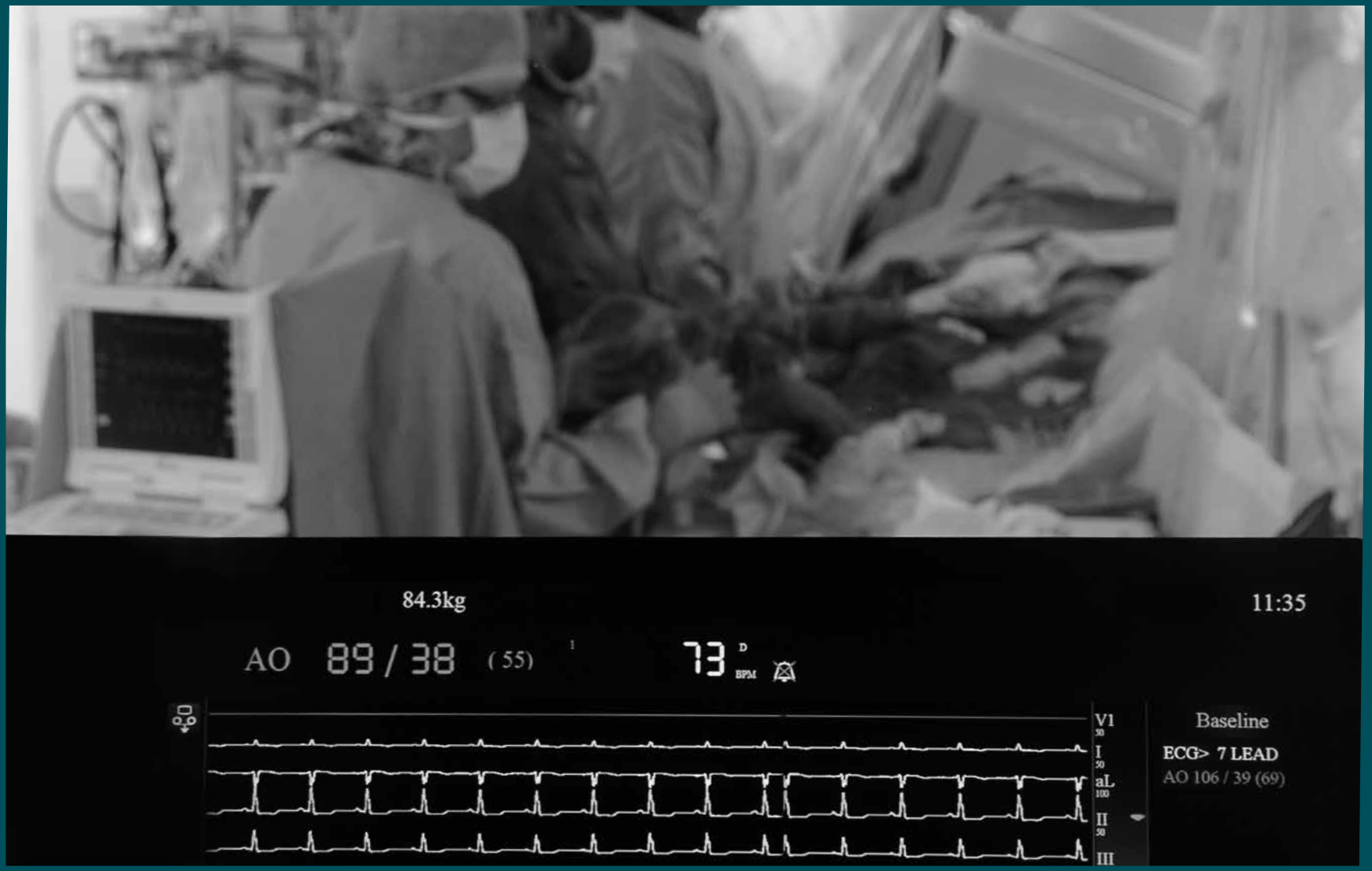
South Waikato Health Centre - Completed Jan 2014 Cost $2.1m

Two unused wards at Tokoroa Hospital were transformed into modern facilities that house a medical centre and a family GP practice, a pharmacy, and new physiotherapy gym and a wide range of other primary health services.


New Interventional suite, Meade Clinical Centre


Tokoroa medical centre

Part 2 Statement of Service Performance



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 2013/14 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 2012/13 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 2013/14.

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 impacts. The measures reported on in this section of the report all align to an intermediate impact and a long-term impact.

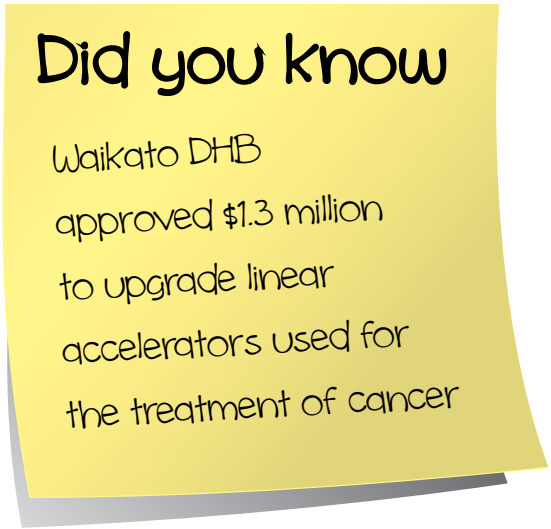
Long-term impacts	People are supported to take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• 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 care • People have appropriate access to elective services • Improved health status for people with a severe mental illness • More people with end stage conditions are appropriately supported

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 2013/14. 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 2013/14 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 2014

	Parent 2014 Actual	Parent 2014 Budget	Parent 2013 Actual
Income	**$000**	**$000**	**$000**
Intensive assessment and treatment services	751,916	774,998	736,799
Early detection and management	270,229	256,709	263,263
Prevention	29,044	20,955	27,025
Rehabilitation and support	139,681	128,415	127,068
	1,190,870	1,181,077	1,154,155
Expenditure			
Intensive assessment and treatment services	780,378	804,984	757,025
Early detection and management	237,856	219,538	230,875
Prevention	30,389	28,690	28,798
Rehabilitation and support	138,431	127,865	135,426
	1,187,054	1,181,077	1,152,124
Share of associate surplus/(deficit)	5	-	1
Share of joint venture surplus/(deficit)	26	-	156
Surplus/(deficit)	3,847	-	2,188

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.

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

✓ Achieved

✗ Not achieved

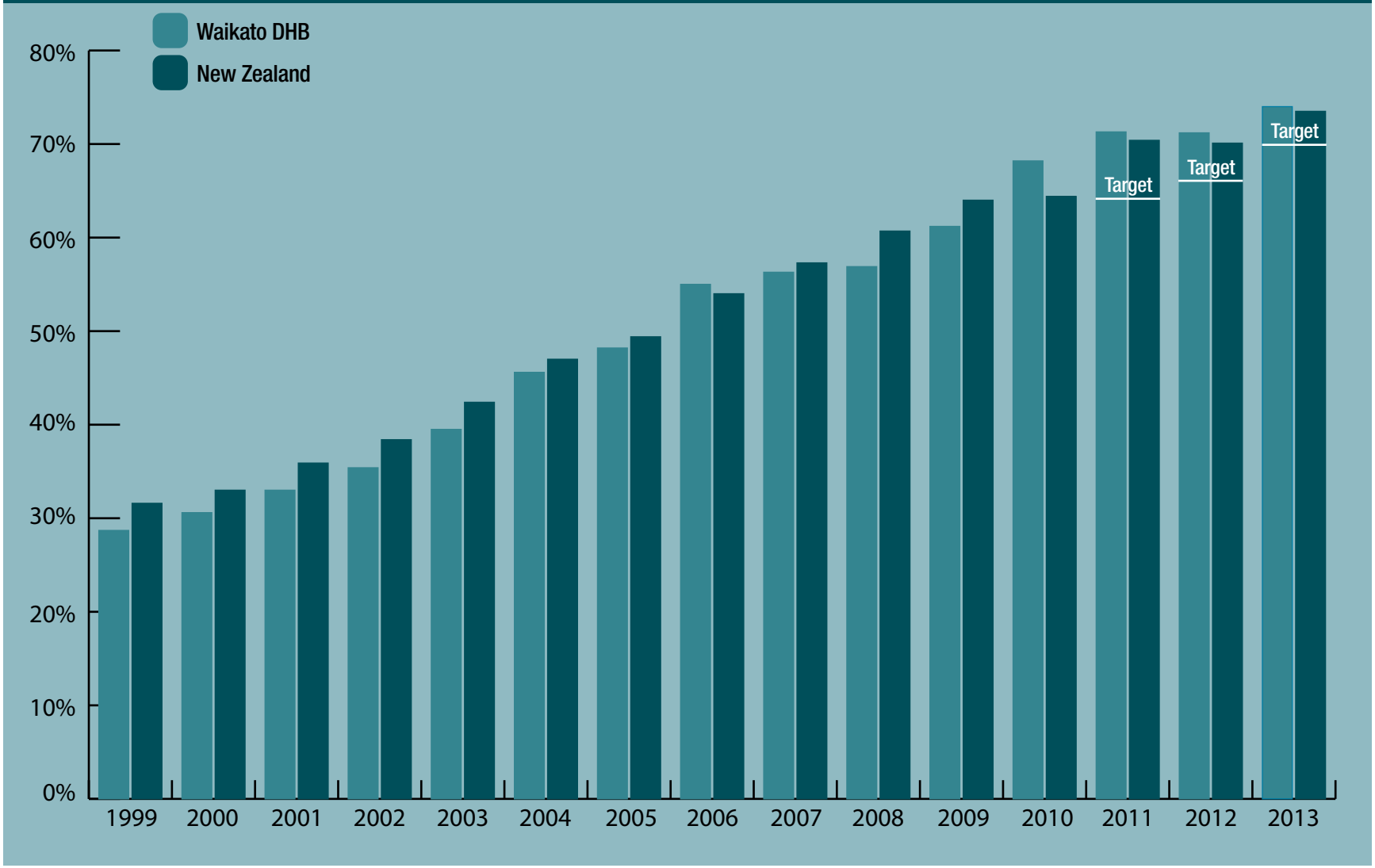
Long-term impact	**People are supported to take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Impact measures	• An increase in the percentage of Year 10 students who have never smoked	• Three year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

Impact measure

People take greater responsibility for their health

Fewer people smoke

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



People take greater responsibility for their health

Fewer people smoke

Impact measure

Measure	Baseline 2009	Previous year 2012	Target 2013	Result 2013
An increase in the percentage of Year 10 students who have never smoked	60.5%	71.2%	70.5%	✓ 74.0%

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.

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

This result is based on a calendar year (2013) as it links with the school calendar year. The 2012/13 Annual Report noted this measure would be monitored as the results from 2011 and 2012 had been at the 71 percent mark suggesting the results may be at a plateau. The 2013 calendar year shows an increase of nearly 3 percent from the previous year and nearly 4 percent above the target. Results for the 2013/14 Annual Report suggest a return to an upwards tracking trend. The measure will continue to be monitored to see if the target should be increased.

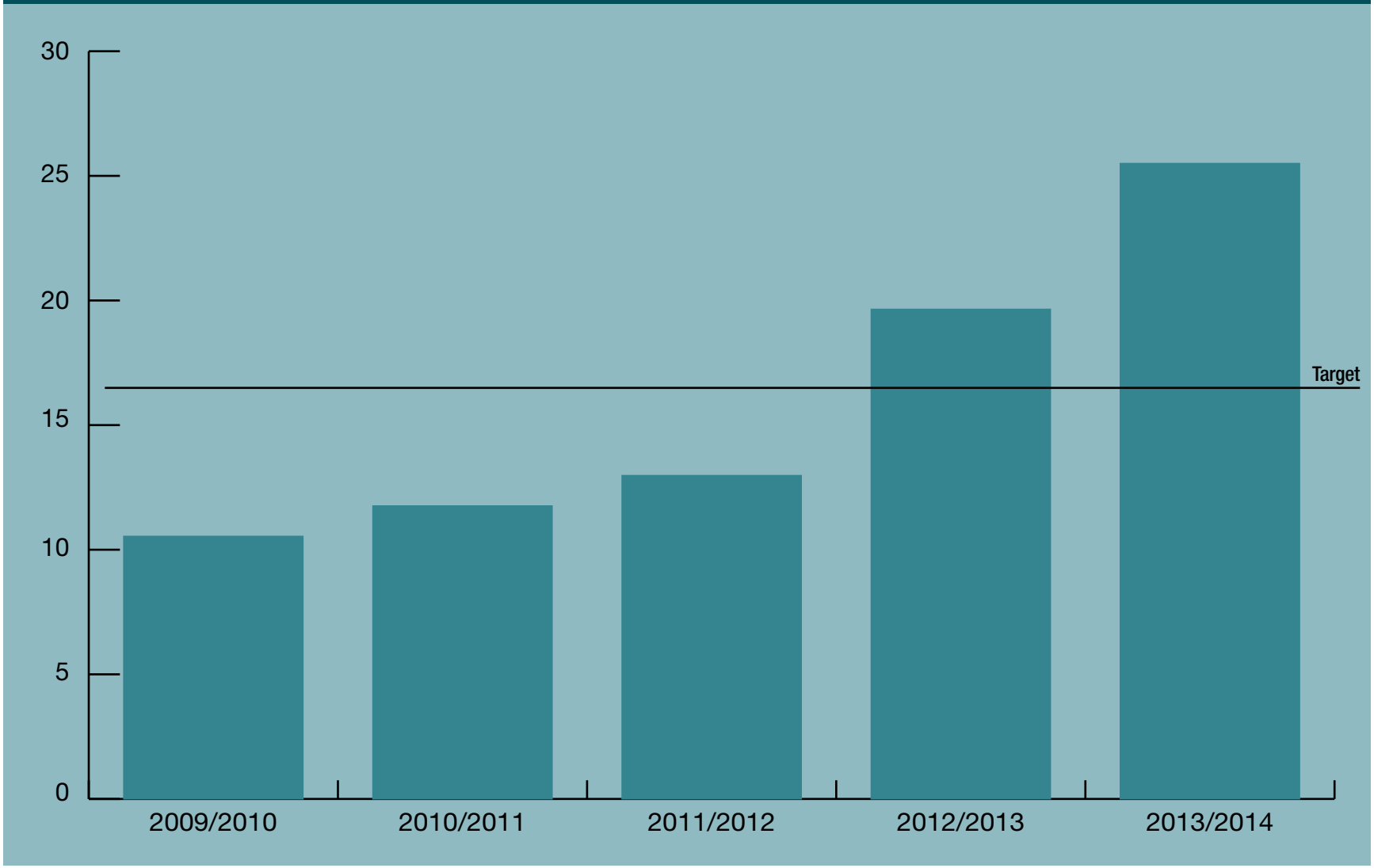
Please Note: The baseline published in the 2012/13 Annual Report was incorrect, the baseline published in the 2013/14 Annual Plan and in this Annual Report is the correct baseline

Impact measure

People 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 take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure

Measure	Baseline 2009-2012	Previous year 2012/2013	Target 2013/2014	Result 2013/2014
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	16.75	19.65	<16.56	✗ 25.5

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.

Waikato DHB performance

In the 2013/14 year we had 23 vaccine preventable hospital admissions for the 0 – 14 year old age group. While it is less than the 2012/13 of 28 admissions, it is too high.

The 23 admissions relate to cases of measles (43.48 percent) and whooping cough (56.52 percent).

This year there was a large number of cases of measles reported in our district and a comprehensive response to this has been implemented. We expect this will reduce the numbers of hospital admissions for measles in 2014/15.

Admissions due to whooping cough have reduced from 28 in 2012/13 to 13 this year. We are expecting that the strategies already in place will continue to result in reductions in this area.

The reporting process has highlighted some anomalies with the definition used to identify the baseline and set the target. This identified that the baseline for this measure is 12.98 per 100,000.

Impact measure

People take greater responsibility for their health

Improving health behaviours

Measures	Baseline 2006 / 2007	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Decrease in the percentage of people considered obese	28.3%	34.3%	<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.

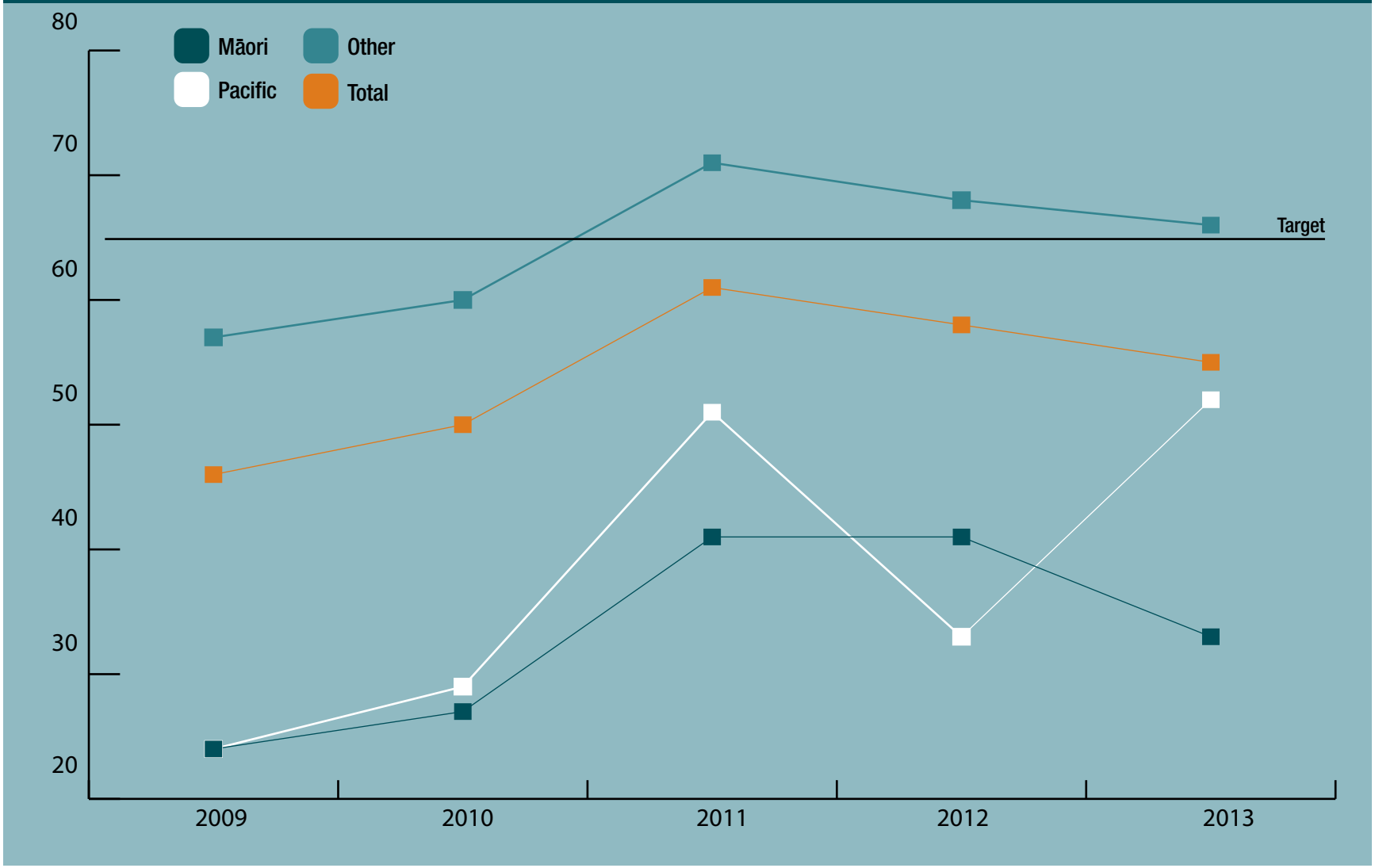
Long-term impact	**People stay well in their homes and communities**			
Intermediate impacts	An improvement in childhood oral health	Long term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence
Impact measures	• An Increase in the percentage of children who are caries free at age five	• Ambulatory sensitive hospitalisations per 100,000 for congestive heart failure	• A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable	• Increase in the average age of entry to age related residential care (years)

Impact measure

People stay well in their homes and communities

An improvement in childhood oral health

An increase in the percentage of children who are caries free at age five



People stay well in their homes and communities

An improvement in childhood oral health

Impact measure

Measure	Baseline 2010	Previous year 2012	Target 2013	Result 2013
An increase in the percentage of children who are caries free at age five	Māori 27% Pacific 29% Other 60% Total 50%	Māori 41% Pacific 33% Other 68% Total 58%	Māori 65% Pacific 65% Other 65% Total 65%	✗ Māori 33% ✗ Pacific 52% ✓ Other 66% ✗ Total 55%

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), and self-esteem.

Increasing the proportion of five-year-olds who have never experienced tooth decay 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 of preschool age.

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

The results presented are for the 2013 school year and are manually collected.

Disappointingly, the percentage of children caries free for the Other and Total population groups has dropped compared to 2012, the result for Māori tamariki and has decreased significantly by 8 percent, which means only one third of Māori children in this cohort group are caries free.

More children of this age group had x-rays during 2013, and this may have impacted on a higher yield of caries in children who, without x-rays, would have been classified as caries free.

These results have alarmed us and during the latter part of 2013/14 we developed a resolution plan. This includes the following actions or planned action which we expect to improve performance:

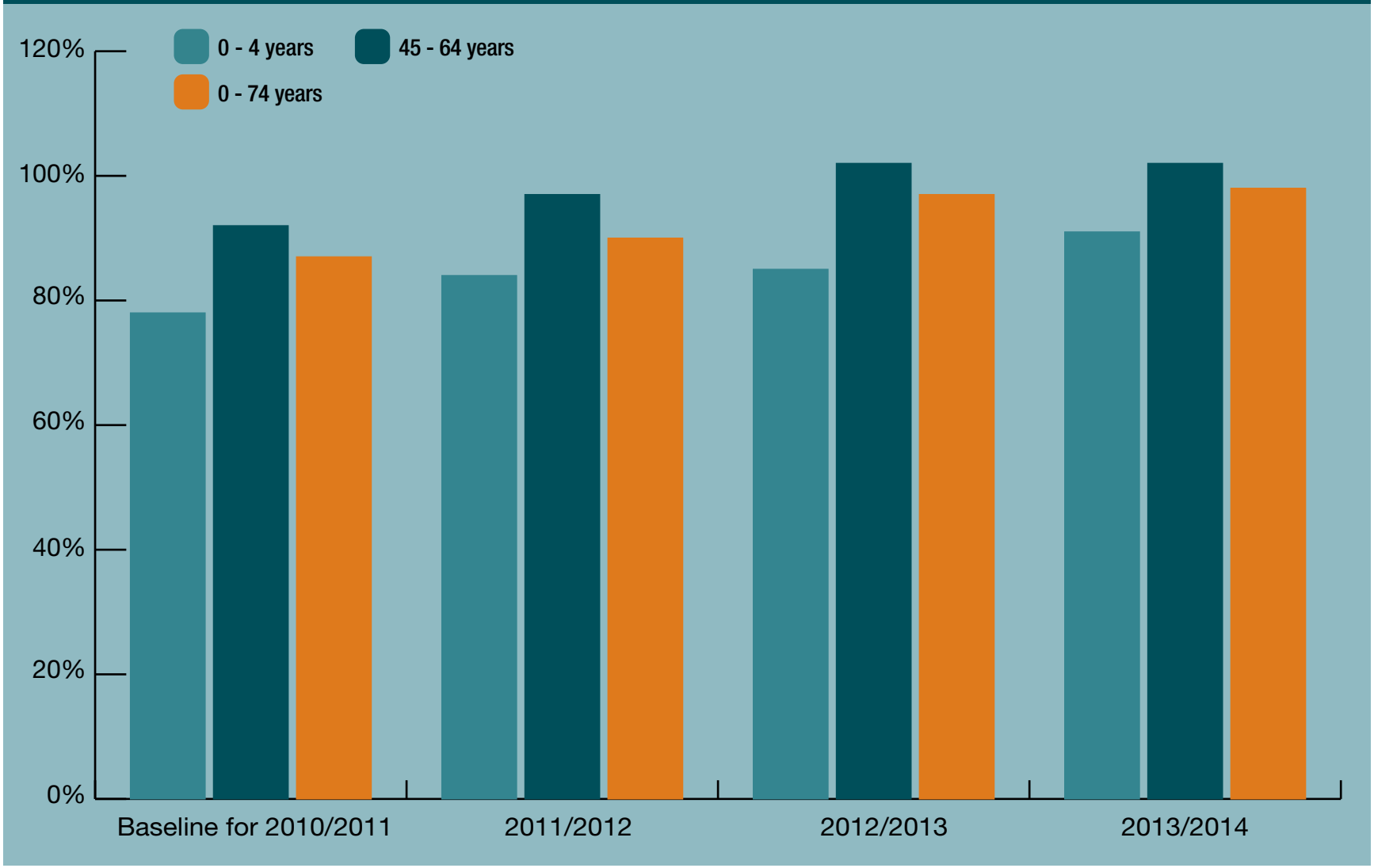
- preschool co-ordinator is spending more time proportionally with kohanga reo and groups in high deprivation areas
- Ongoing fluoride varnish will be applied as appropriate
- Automated text messaging, which we expect will assist in reducing did not attends for pre-schoolers, is planned to be introduced in 2014
- A Moodle training module to enable health care workers to apply topical fluoride dispensed from clinics for enrolled patients will be in place for 2014/2015
- A focus on increasing preschool enrolment with the Community Oral Health Service is being implemented as part of the Well Child / Tamariki Quality Framework initiatives
- Low risk patient groups are being seen on a 15 month rotation thereby enabling high risk patient groups to have 6 monthly fluoride applications

Impact measure

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable



People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Impact measure

Measures	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 0 – 4 years	78%	85%	<95%	✓ 91%
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 45 – 64 years	92%	102%	<100%	✗ 102%
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 0 – 74 years	87%	97%	<91%	✗ 98%

Significance of measure

Reducing the number of avoidable hospital admissions ensures that patients who need services that can be provided in community settings receive them there rather than in hospitals. This 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.

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
The DHB remains below both its target and the national rate for this age group overall. Rates for both Māori (127 percent) and Pacific People (154 percent) are both significantly higher than the national level.

Population aged between 45 and 64 years
The DHB is marginally above both its target and the national rate for this age group overall. Rates for both Māori and Pacific People are both higher than the national level, which is creating the variance to target. The key areas driving the higher rates appear to be areas which have had local focus and further work will occur to identify initiatives to reduce admissions.

Population aged between 0 and 74 years
The DHB is above its target but remains marginally below the national rate for this age group overall. There is a planned piece of work for 2014/15, we expect this work will have a positive impact on this measure

Patient, Alma Thurgood, with Julie Jay, Clinical Nurse Specialist for heart failure

People stay well in their homes and communities

Long-term conditions are detected early and managed well

Impact measure

Measures	September 2012	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Ambulatory sensitive hospitalisations per 100,000 for congestive heart failure (0 – 74 age group)	Māori 167 Pacific 154 Other 51 Total 80	Māori 190 Pacific 99 Other 51 Total 84	Māori <165 Pacific <150 Other <50 Total <80	✗ Māori 204 ✓ Pacific 101 ✓ Other 46 ✗ Total 81

Significance of measure

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

We did not formally identify a measure or set a target in our Statement of Intent. This approach was taken due to the pending implementation of the nationwide Integrated Performance and Incentive Framework. Implementation of the framework did not occur in the 2013/14 year as was expected, but is on track to occur in 2014/15.

To ensure we present a comprehensive performance story for this Annual Report we have chosen to include a measure around avoidable hospitalisations for congestive heart failure.

A number of measures were looked at as part of the framework and a proposed system measure around amendable mortality – cardiovascular disease and diabetes appeared to be an excellent measure for this part of our performance story.

Olive Small, resident, with Justine Litherland, Diversional Therapist at Atawhai Mercy Assisi Home & Hospital

People stay well in their homes and communities

People maintain functional independence

Impact measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Increase in the average age of entry to age related residential care (years) - **Rest home**	84.10	New Measure	≥83	✓ 84
Increase in the average age of entry to age related residential care (years) - **Dementia**	83.59	New Measure	≥83	✓ 83
Increase in the average age of entry to age related residential care (years) - **Hospital**	80.56	New Measure	≥83	✓ 85

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.

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

This measure, was included to provide an indication of the impacts from other services that have focused on providing home and community support to older people with the aim of prolonging (where appropriate) their time at home.

Aged Residential Care is a specialist, high cost, and scarce resource. We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible whilst ensuring the appropriate level of care is commited to older people.

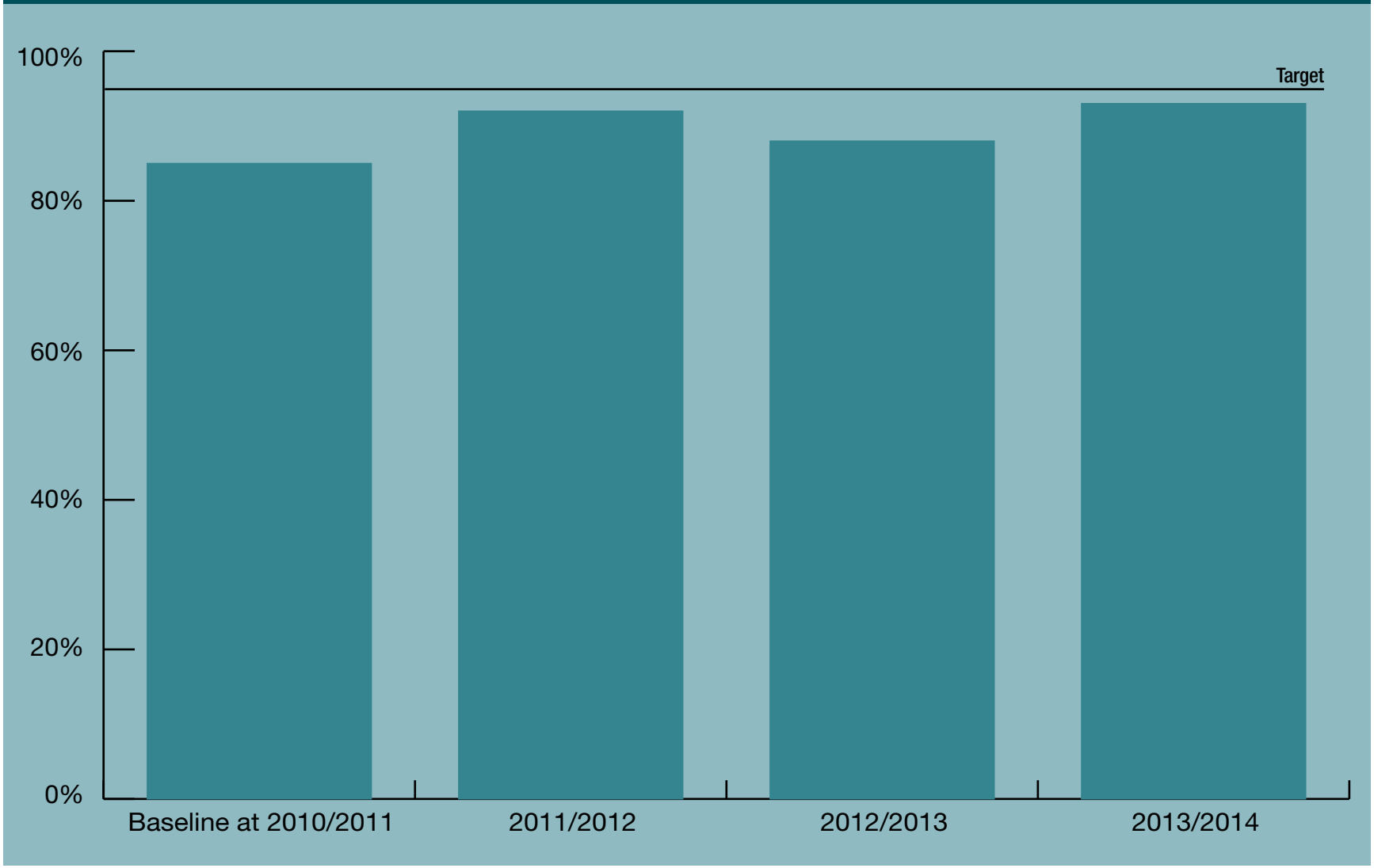
Long-term impact	People receive timely and appropriate specialist care			
Intermediate impacts	People receive prompt and appropriate acute care	People have appropriate access to elective services	Improved health status for people with a severe mental illness and addictions	More people with end stage 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	• Decrease in 28 day acute readmission rates	To Be Allocated

Impact measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Percentage of patients will be 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 2011 / 2012	Target 2013 / 2014	Result 2013 / 2014
Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours	85%	88%	95%	✗ 93%

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 ED with severe and life-threatening conditions receive immediate attention. ED'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.

This measure covers only emergency department facilities of level three and above. For Waikato DHB this is Waikato and Thames Hospital emergency departments only.

This is one of the National Health Targets.

Waikato DHB performance

The 2013/14 results have improved from the 2012/13 Annual report results, however the target for the 2013/14 year has not been met. A Waikato DHB Action Plan has been implemented with focus areas of work, these include: Primary options development, rollout of primary options to include ED referral, rollout of primary options to include referral from St John, acute care GP liaison, management of frequent presenters, front of house management, and clinical pathways to support patient flow.

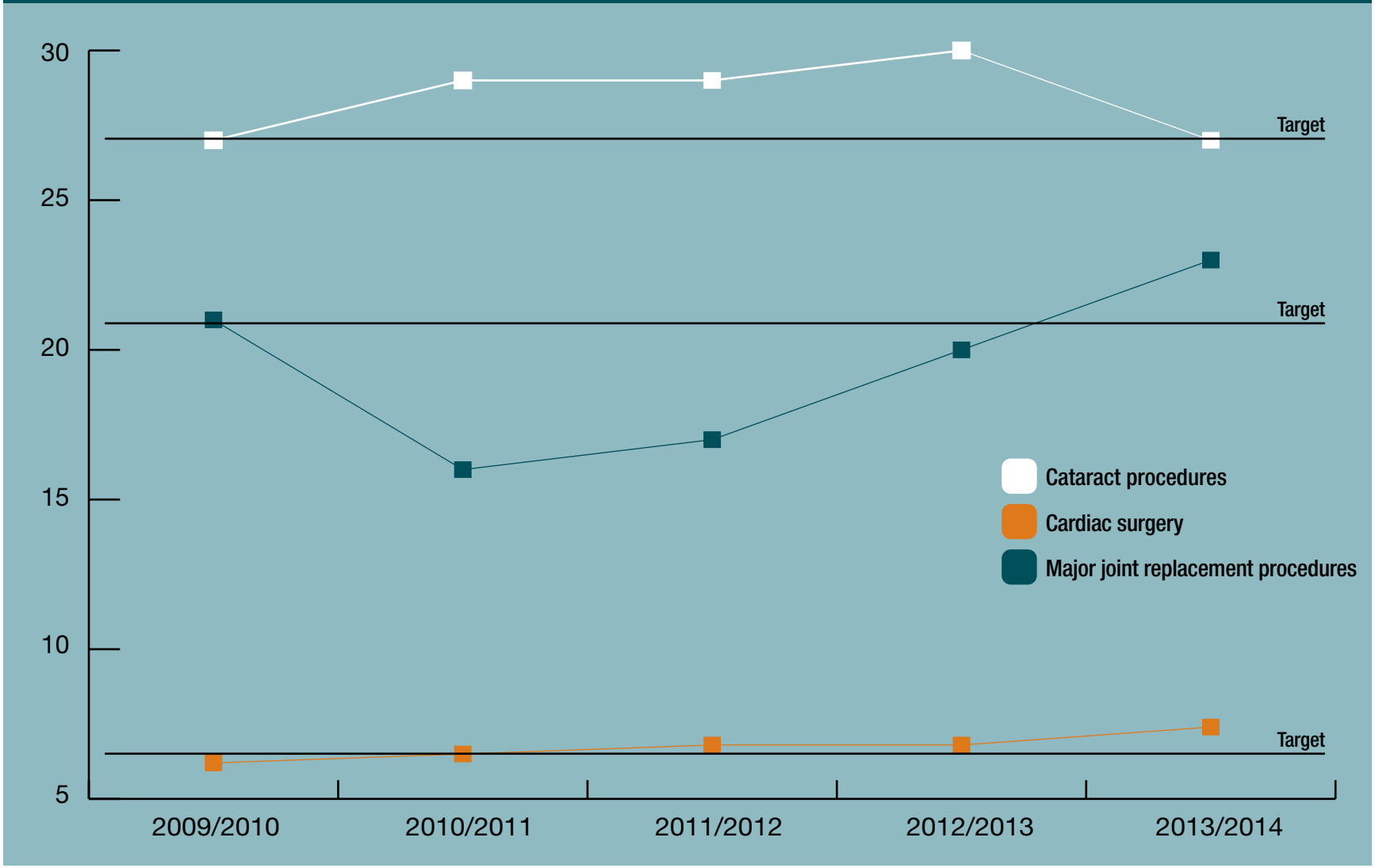
The percentages of patients admitted, discharged, or transferred from an emergency department within six hours for the Waikato DHB's hospitals are Waikato 91 percent; Thames 97 percent; Tokoroa 97 percent; Taumarunui 96 percent.

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 2009 / 2010	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Elective service standardised intervention rates (per 10,000) — **Major joint replacement procedures**	21	19.52	21	✓ 23
Elective service standardised intervention rates (per 10,000) — **Cataract procedures**	27	29.79	27	✓ 27
Elective service standardised intervention rates (per 10,000) — **Cardiac surgery**	6.23	6.78	6.5	✓ 7.4

Significance of Measure

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

Waikato DHB performance

Standard intervention ratios will continue to be a focus for Waikato DHB both locally and regionally. We will continue our regular monitoring and comparison processes.

Cardiac Services is one of the focused areas of work at a Midland DHB regional level in 2014/15. This work will involve monitoring performance against the relevant standardised intervention rates across the region for Māori and non-Māori.

Impact measure

People receive timely and appropriate specialist care

Improved health status for people with a severe mental illness and addictions

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Decrease in 28 day acute readmission rates (mental health and addictions)	13%	New Measure	≤ 15%	✓ 10%

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.

This is a new measure. 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

Performance against this measure remains a focus for the service. Work is routinely undertaken to analyse and interpret how acute readmission rates link to patient flow through services as referrals increase and length of stay and occupancy both demonstrate positive improvement.

People receive timely and appropriate specialist care

More people with end stage conditions are supported

Impact measure

Measure	Baseline	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
TBA - End stage conditions	TBA	TBA	TBA	TBA

Significance of measure

For people who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. The DHBs' 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

Work has been occurring to identify measures for the end stage conditions portion of our performance story. At this stage, while we have identified an output measure we have yet to determine the most appropriate impact measure.

As part of the midland annual planning process we investigated what measures would be appropriate but did not settle on a set of measures for end stage conditions.

During 2014/15 we will be undertaking a project to establish an agreed palliative care and end of life model of care across our district. It is expected that this will enable the identification of an agreed set of measures for our district.

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:

Continuum of care

Output Class 1: Prevention

Output Class 2: Early detection and management

Output Class 3: Intensive assessment and treatment

Output Class 4: Rehab and support

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 PHO enrolled smokers offered advice to quit • Percentage of hospitalised smokers offered advice to quit • Number of education sessions with tobacco retailers • Number of controlled purchase operations with tobacco retailers	• Percentage of the population >65 years who have received the seasonal influenza immunisation • Percentage of eight month olds fully immunised	• 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 fully or exclusively breastfed at 6 months • Percentage of Kura Kaupapa Māori primary schools participating in Project Energize • Percentage of total primary schools participating in Project Energize

Caroline Huntley, Registered Nurse, who is a smoking cessation representative for Ward M14 counselling a patient

People take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline March-June 2012	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of PHO enrolled smokers offered advice to quit	Māori 25.1% Total 28.4%	Māori - Data not available Total 61%	Māori 90% Total 90%	Māori - Data not available ✗ Total 84%*

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

Advice about quitting for this group of people is generally provided at a General Practice. Almost 39,000 PHO enrolled smokers were given advice and / or support to quit during 2013/14.

There has been increased scrutiny around this part of the better help for smokers to quit health target during 2013/14. Our primary care alliance partners have undertaken a number of initiatives to improve performance including:

- Development of practice level smoking cessation plans
- Workforce training
- Performance reporting to practices
- Identification of target groups

We are unable to report on the result for Māori as PHO's do not report on ethnicity for this measure. We are reviewing this at a National level.

Please Note: The baseline dates and figures published in the 2012/2013 Annual Report were incorrect, the baseline dates and figures published in the 2013/2014 Annual Plan and in this Annual Report are correct.

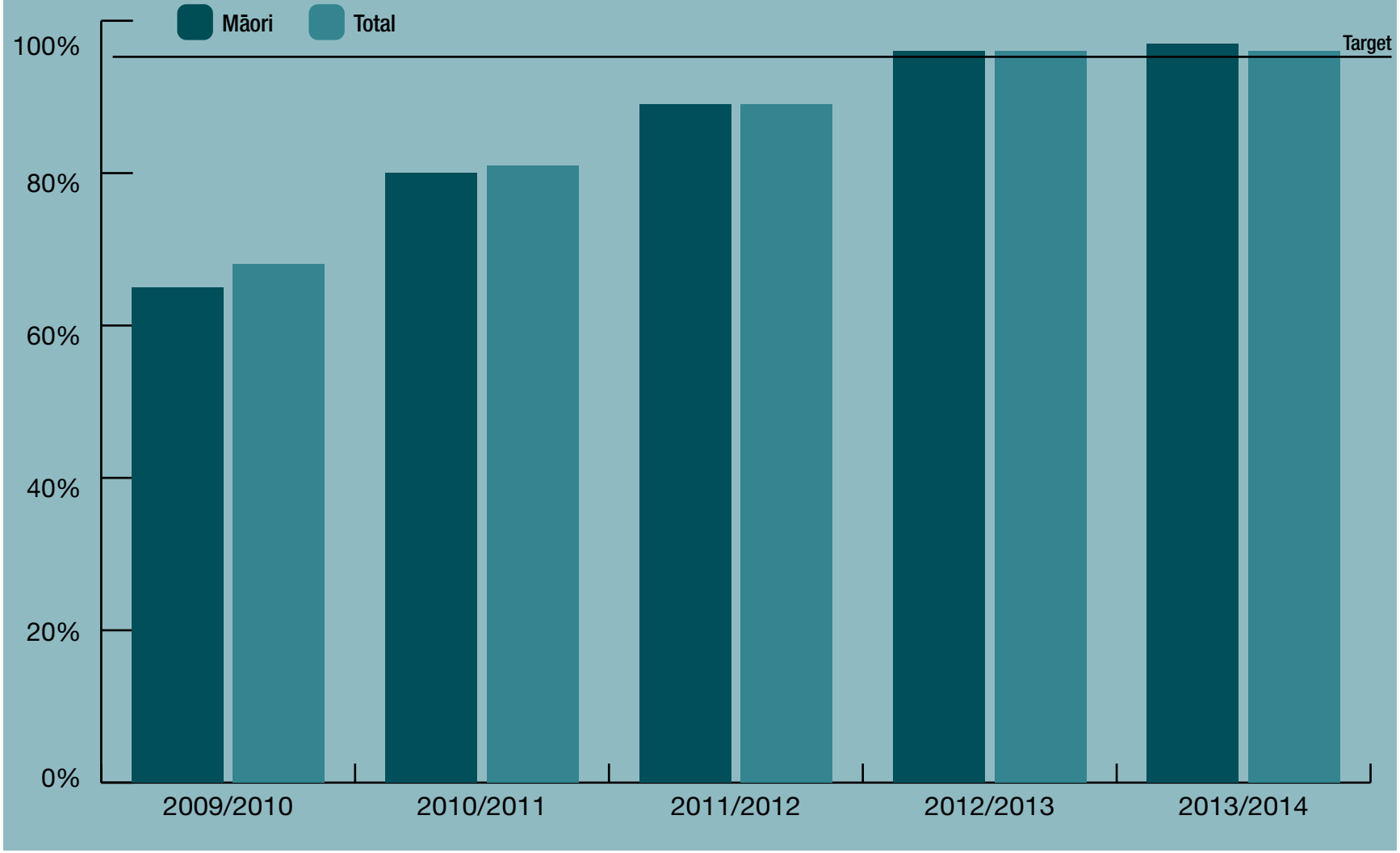
*Note: MoH preliminary result

Output measure

People take greater responsibility for their health

Fewer people smoke

Percentage of hospitalised smokers offered advice to quit



People take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of hospitalised smokers offered advice to quit	Māori 80% Total 81%	Māori 96% Total 96%	Māori 95% Total 95%	✓ Māori 97% ✓ Total 96%

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 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

We have achieved these targets for each quarter in 2013/14. Just over 4,866 Māori were given advice and / or support to quit; and overall 12,115 people were given advice and / or support to quit during 2013/14.

Education is essential to ensure new and existing frontline staff are knowledgeable about Waikato DHB systems to treat and refer patients who smoke.

The development of mandatory fields on the electronic discharge summary continues to be a focus as it viewed as the most effective strategy to sustain documented evidence of interventions being offered to people who smoke.

Waikato DHB Health Protection Advisor, Nick Young, works with Dairy owner, Sandip Patel, explaining tobacco placement within his shop

People take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Number of education sessions with tobacco retailers	80	287	200	✓ 790
Number of controlled purchase operations with tobacco retailers	80	191	200	✗ 85

Significance of measure

Education sessions cover the retailer's requirements under Smokefree legislation, relating to the display of tobacco products and sales to under-age customers. Advice is also provided to assist retailers to meet the requirements.

A controlled purchase operation is when under-age volunteers (under the supervision of a Smokefree enforcement officer) attempt to purchase cigarettes from tobacco retailers. Any sales result in the initiation of legal proceedings being taken against the retailer.

Waikato DHB performance

During 2013/14 we significantly over achieved against the target for the number of education sessions measure. The result is also a significant increase on our reported performance for 2012/13.

The 2013/14 result reflects a change in definition of the measure to include education sessions via mailout as well as face to face education sessions. There are almost 370 retailers in our district who sell tobacco. In the 2013/14 year there were 58 personal education sessions and two mailout education sessions to 366 retailers.

There were a number of factors why the target for the number of controlled purchase operations was not achieved in 2013/14. These factors are:

- Prioritised focus for staff on psychoactive substances management
- Staff vacancies
- Limited 'control purchase operation training courses' offered by the Ministry of Health over the past 24 months (staff need to complete this course before they can carry out controlled purchase operations).

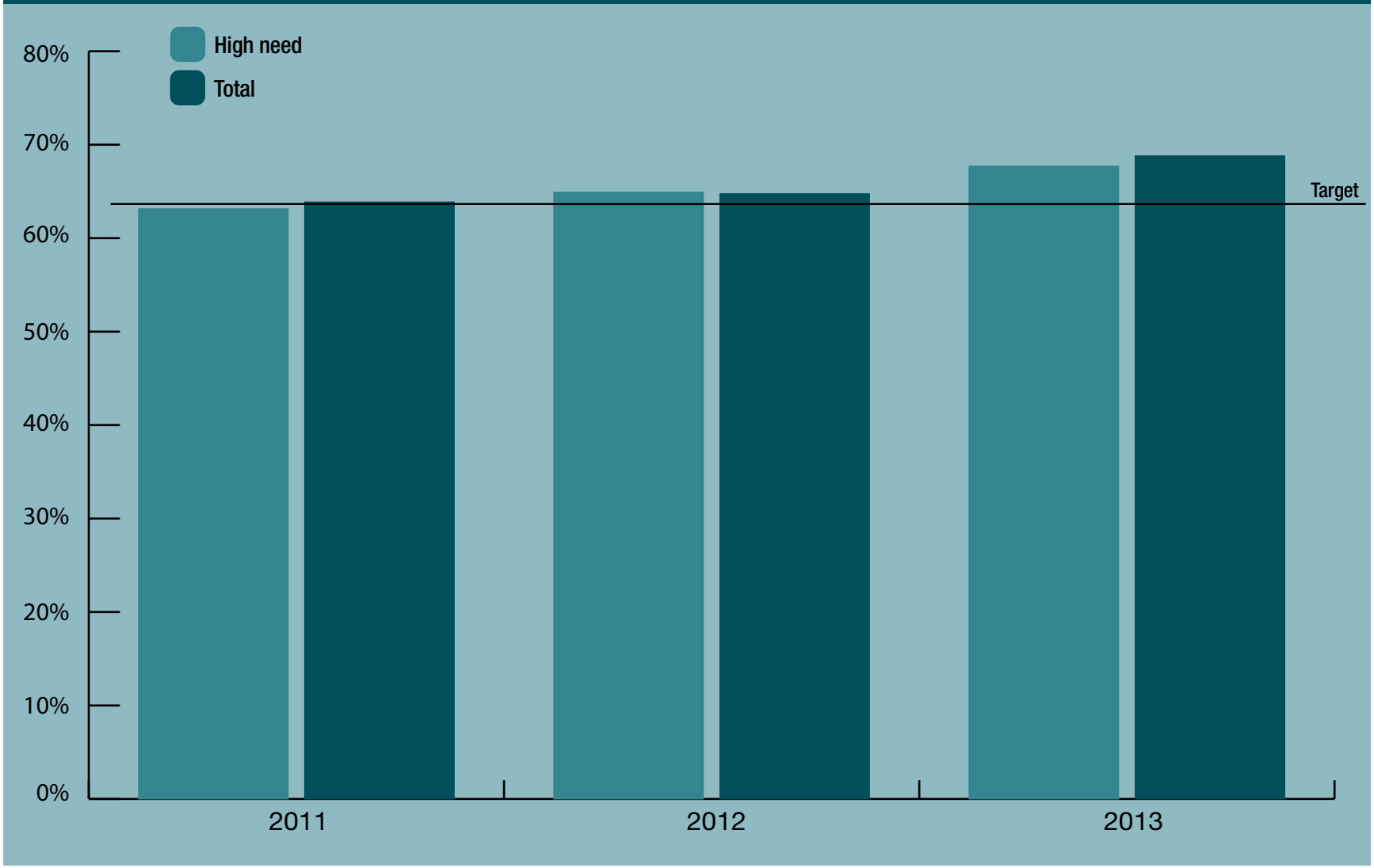
Following the 85 controlled purchase operations, there were nine retailers reported to Ministry of Health for enforcement follow up. This was an improvement from the 20 retailers reported for follow up in 2012/13.

Output measure

People take greater responsibility for their health

Reduction in vaccine preventable diseases

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



People take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measures	Baseline 2010 / 2011	Previous year 2012	Target 2013	Result 2013
Percentage of the population >65 years who have received the seasonal influenza immunisation — **High Need**	62.50%	64.92%	63.50%	✓ 67.7%
Percentage of the population >65 years who have received the seasonal influenza immunisation — **Total**	63.00%	64.92%	63.50%	✓ 68.8%

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

Results presented are for the 2013 calendar year which covers one 'flu season'. There are a number of social marketing campaigns at a national and local level that promote the benefits getting immunised against influenza.

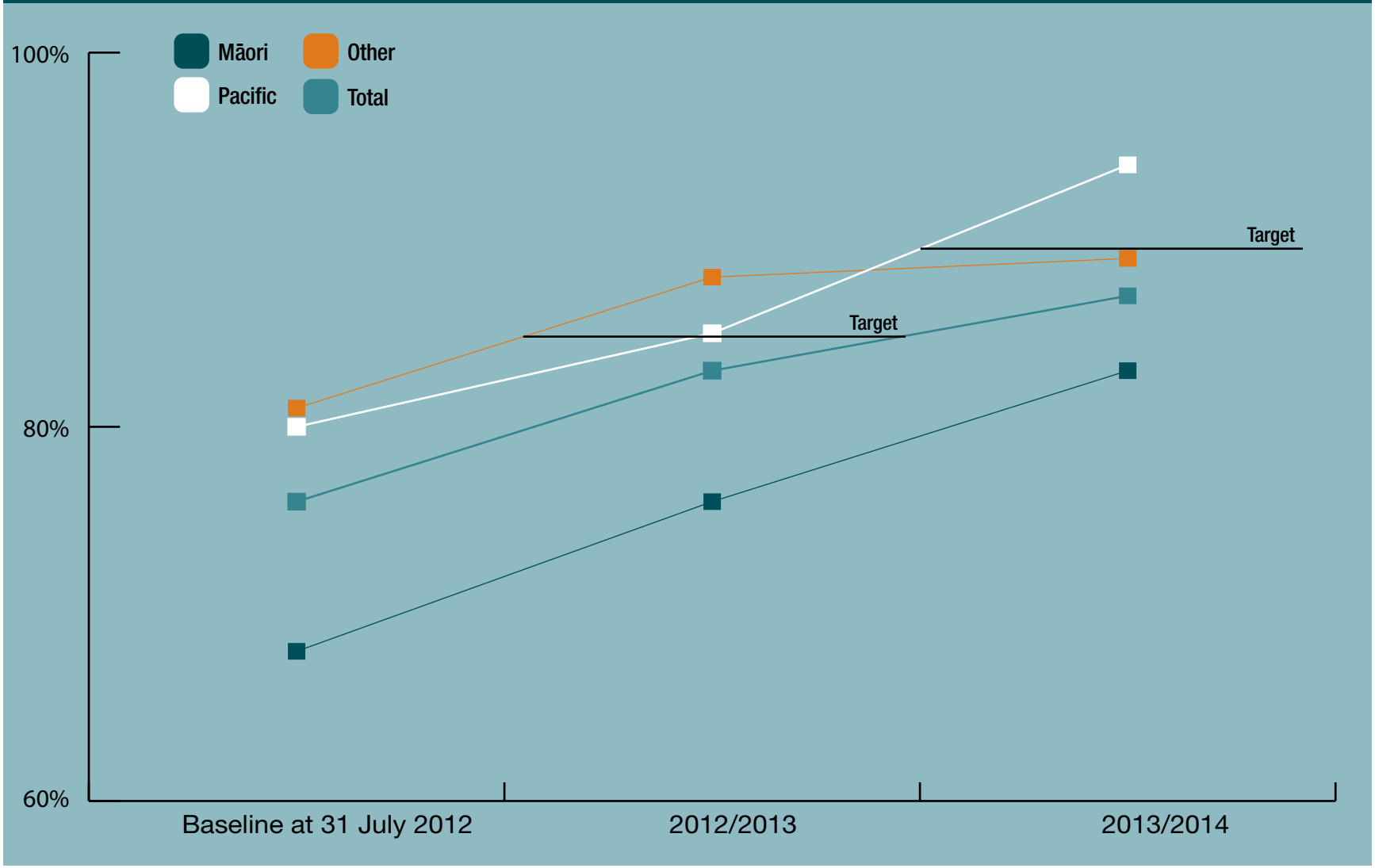
The majority of immunisations are delivered in a primary care setting. Influenza cases traditionally begin to rise sharply in winter and if people aren't immunised, especially those at high risk of complications this can put unnecessary pressure on the hospital system. The admissions to hospital due to influenza in the flu season being measured was relatively low when compared to the indicative information about the 2014 flu season to the end of June 2014.

Output measure

People take greater responsibility for their health

Reduction in vaccine preventable diseases

Percentage of eight month olds fully immunised



People take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measures	Baseline 31 July 2012	Previous year 2012/2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of eight month olds fully immunised	Māori 68% Pacific 80% Other 81% Total 76%	Māori 79.9% Pacific 85.1% Other 88.2% Total 83.2%	Māori 90% Pacific 90% Other 90% Total 90%	✗ Māori 83% ✓ Pacific 94% ✗ Other 89% ✗ Total 87%

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.

This is one of the National Health Targets.

Waikato DHB performance

Achieving this target has been challenging during the 2013/14 year. In late 2013/14 a 'Waikato 8 month Target Operation Group' was established and our immunisation action plan was updated. The plan outlines the actions we are planning to take to reach 90 percent for this target by the end of December 2014. One of the objectives of the operation group is to coordinate activity across our three primary care alliance partners around newborn enrolment. This has been identified as a priority which we expect to significantly contribute to achieving the increased immunisation health target in 2014/15.

Experience has shown that improving the six month immunisation coverage is vitally important as it would free up our mobile immunisation services to increase their focus on following up the most difficult to reach babies, and those who are not enrolled in a PHO. A focus area in 2014/15 will be improving the immunisation rate for babies not enrolled in with a primary health organisation.

Of the 5,365 eligible eight month olds, 4,685 were fully immunised on time during 2013/14, with 1,703 of those being Māori, 195 Pacific and 2,787 classified as Other.

Output measure

People take greater responsibility for their health

Improving health behaviours

Measures	Baseline 2010 / 2011	Previous year 2012	Target 2013 / 2014	Result 2013/2014
Percentage of infants fully and exclusively breastfeed — **6 weeks**	Māori 62% Pacific 56% Other 72% Total 68%	Māori 61% Pacific 63% Other 73% Total 69%	Māori 74% Pacific 74% Other 74% Total 74%	✗ Māori 63% ✗ Pacific 70% ✗ Other 73% ✗ Total 70%
Percentage of infants fully and exclusively breastfeed — **3 months**	Māori 49% Pacific 53% Other 60% Total 56%	Māori 45% Pacific 52% Other 58% Total 54%	Māori 57% Pacific 57% Other 57% Total 57%	✗ Māori 45% ✗ Pacific 47% ✓ Other 66% ✗ Total 54%
Percentage of infants fully and exclusively breastfeed — **6 months**	Māori 23% Pacific 25% Other 31% Total 28%	Māori 15% Pacific 25% Other 27% Total 23%	Māori 26% Pacific 26% Other 26% Total 26%	✗ Māori 15% ✗ Pacific 21% ✓ Other 26% ✗ Total 23%

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 2013/14 we incorporated 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.

Breastfeeding mum, Jaimie Brougham, at the Big Latch on in Te Awa foodcourt, The Base

Output measure

People take greater responsibility for their health

Improving health behaviours

Measures	Baseline 2009	Previous year 2012	Target 2013	Result 2013
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 focused on improving children's physical activity and nutrition.

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

These results are for the calender year.

Results for Project Energize continue to be outstanding with the international Cochrane Collaboration review of the World Health Organisation health promoting school framework demonstrating evidence Project Energize is improving the health and welling of children

Project Energize is also being delivered in County Cork Ireland, and the model is being piloted in the Northland and Counties Manukau districts.

Please Note: The baseline and target for Percentage of Kura Kaupapa Māori primary schools participating in Project Energize published in the 2012/2013 Annual Report was incorrect, the baseline published in the 2013/2014 Annual Plan and in this Annual Report is the correct baseline

Long-term impact	People stay well in their homes and communities			
Intermediate 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 children (0-4) enrolled in DHB funded dental services • Percentage of adolescent utilisation of DHB funded dental services • Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	• Percentage of eligible women (20-69) have a cervical cancer screen every 3 years • Percentage of eligible women (50-69) have a breast screen in the last 2 years • Percent of the eligible population will have had their cardiovascular risk assessed in the last five years • Percentage of population enrolled with a PHO • Number of clients on caseload (primary mental health and addictions) • Number of primary mental health and addictions packages of care	• Percentage of all Emergency Department presentations who are triaged at levels four and five • Percentage of Rest Home residents receiving vitamin D supplement from their GP • Percentage of eligible population who have had their B4 school checks completed • Reduction in hospitalisations for acute rheumatic fever	• Proportion of people with dementia who have been assessed as having a MAPIe score ≥3 who have a completed care plan • 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 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

Measure	Baseline 2009	Previous year 2012	Target 2013	Result 2013
Percentage of children (0-4) enrolled in DHB funded dental services	43%	70%	72%	✗ 68%

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 and reducing the number who are overdue for their scheduled examination, the DHB will show that it has made an impact on the outcome of protecting and promoting good health and independence. The measures 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.

The community oral health service is continuing to work collaboratively with other health providers to enrol pre-schoolers in the service. The new work as part of the Well Child / Tamariki Quality Framework suite of initiatives will enable enrolment from birth and this is expected to greatly assist with performance against this measure.

Please Note: The baseline published in the 2012/13 Annual Report was incorrect, the baseline published in the 2013/14 Annual Plan and in this Annual Report is the correct baseline

People stay well in their homes and communities

An improvement in childhood oral health

Output measure

Measure	Baseline 2009	Previous year 2012	Target 2013	Result 2013
Percentage of adolescent utilisation of DHB funded dental services	66.0%	72.5%	75.0%	✗ 71.3%

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

Almost 17,000 adolescents were seen in 2013 out of a projected population of 23,830. To achieve the target almost 880 more adolescents were needed to be seen.

A Safety Net Service, run by Community Oral Health Service, will be put in place for school holiday periods (from July 2014) in Waihi and Paeroa to address gaps in service coverage in this area. It is expected that this will assist in improving results for 2014.

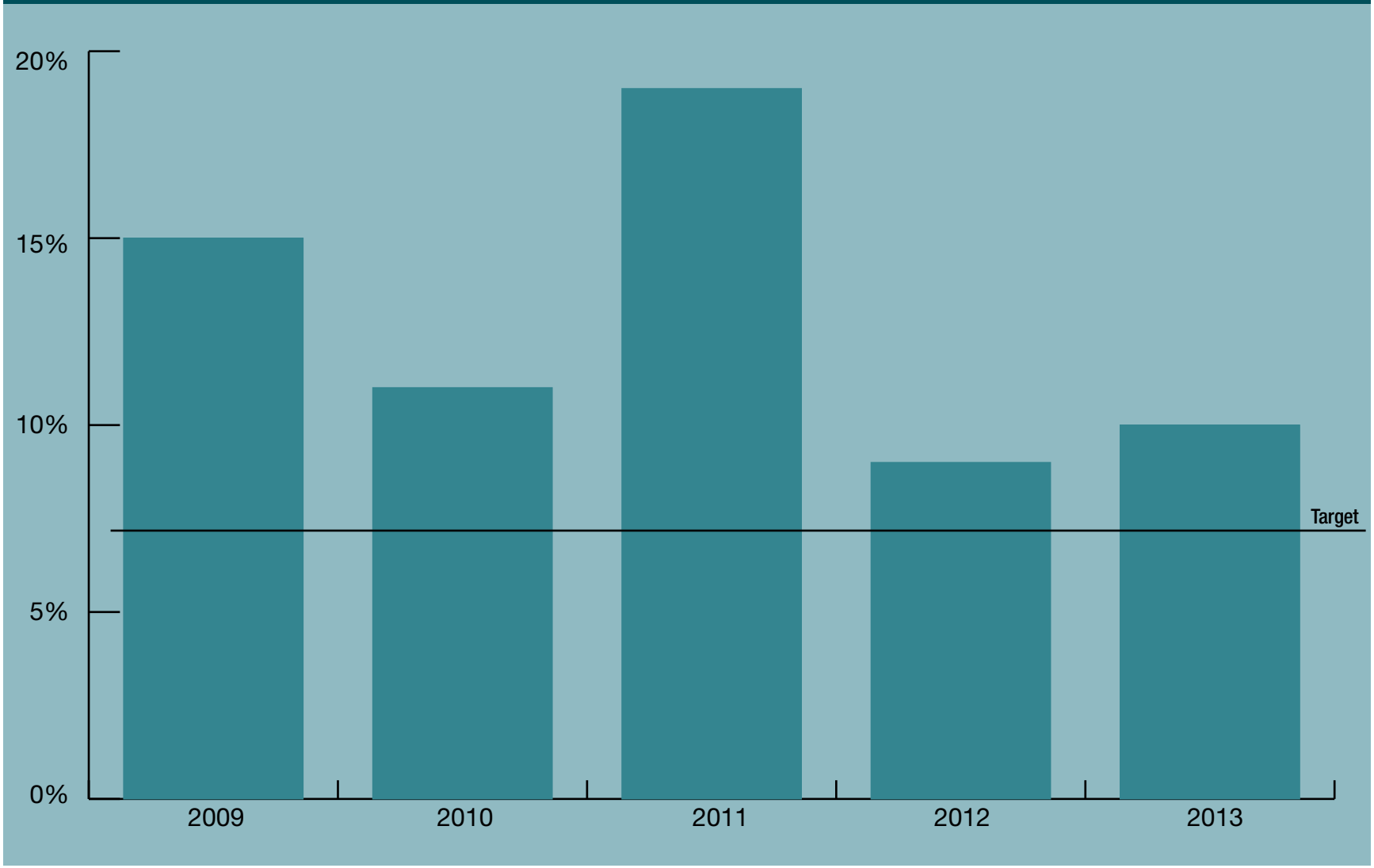
Data quality is an issue and a quality improvement initiative undertaken around mandatory National Health Index reporting has assisted in making improvements over 2013/14 by the adolescent enrolment function. This will enhance the utility of the combined dental agreement claims dataset and allow for more robust evidence when comparing service utilisation against school rolls in order to target specific activities.

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 2012/2013	Target 2013/2014	Result 2013/2014
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	11%	9%	<7%	✗ 10%

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

Less than optimal dental therapist staffing numbers reduced capacity to achieve our arrears target. This appears likely to be an ongoing issue for the service as vacancies across the sector exceed the supply of new graduates. The Community Oral Health Service will continue to provide opportunities for undergraduates to gain work experience at Waikato DHB in an effort to attract them back as graduates.

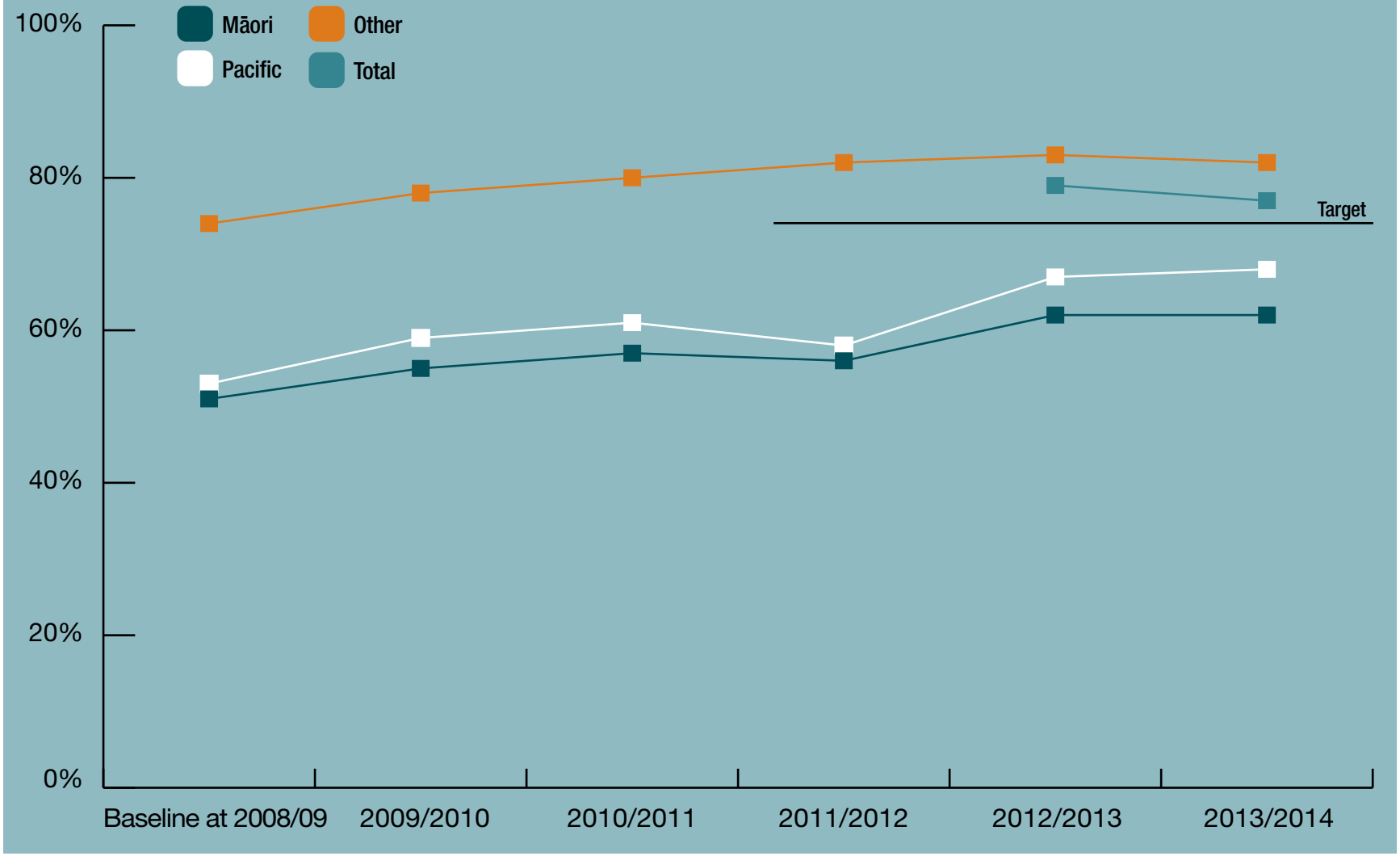
Please Note: The baseline published in the 2012/13 Annual Report was incorrect, the baseline published in the 2013/14 Annual Plan and in this Annual Report is the correct baseline

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



Measure	Baseline 2008 / 2009	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Māori 51.1% Pacific 52.5% Other 73.6% Total - new measure	Māori 62.4% Pacific 67.2% Other 82.7% Total 78.5%	Māori 75% Pacific 75% Other 75% Total 75%	✗ Māori 62% ✗ Pacific 68% ✓ Other 82% ✓ Total 77%

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

There has been no change in coverage rates.

Cervical screening has remained a focus for all PHOs and most priority women (Māori, Pacific Island, women over the age of 30 of any ethnicity who have never or not had a smear in more than five years) were eligible for a free cervical smear. In 2014/15 all priority women will be eligible once we have a contract in place with Hauraki PHO.

It is possible that Māori are under-represented on the National Cervical Screening Register and information has been provided to smear takers asking them to ensure all ethnicities are captured on a cervical smear referral form to mitigate this gap.

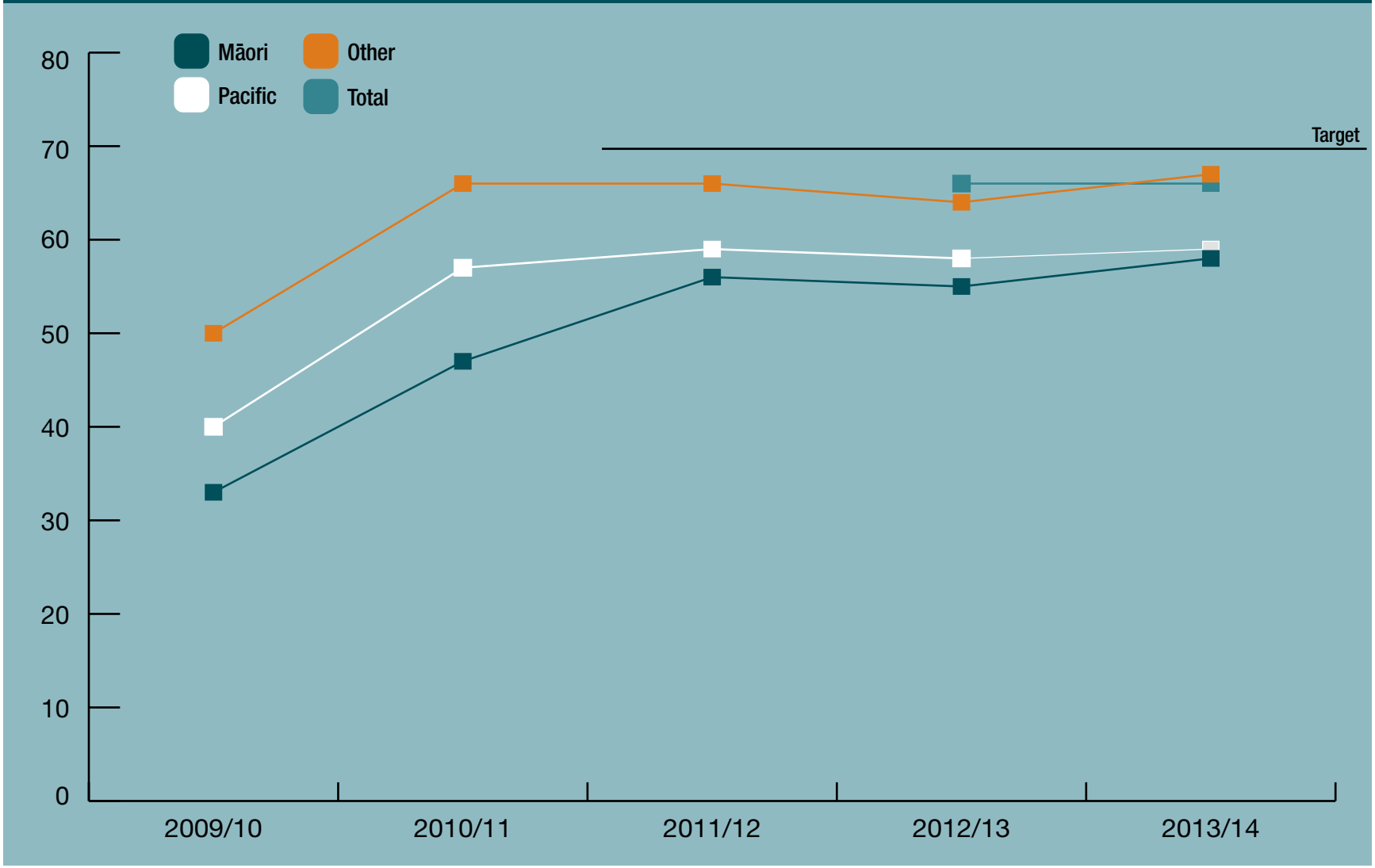
Please Note: The dates for the baseline published in the 2012/13 Annual Report was incorrect, the dates for the baseline published in the 2013/14 Annual Plan and in this Annual Report are correct.

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 2 years



People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure

Measure	Baseline March 2012	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori 55.7% Pacific 57.9% Other 81.7% Total - new measure	Māori 54.7% Pacific 57.7% Other 63.9% Total 66.1%	Māori 70% Pacific 70% Other 70% Total 70%	✗ Māori 58% ✗ Pacific 59% ✗ Other 67% ✗ 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).

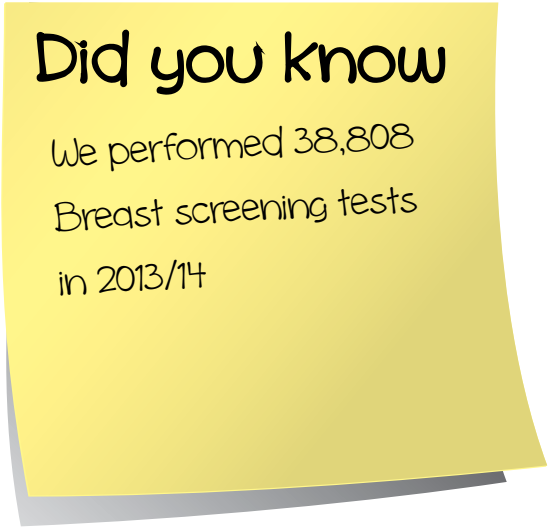
Breast screening is provided to reduce women's morbidity and mortality from breast cancer by identifying cancers at an early stage, allowing treatment to be commenced sooner than might otherwise have been possible.

The eligible population for this measure is women aged 50-69.

Waikato DHB performance

Breast Screen Midlands has converted to a digital environment, which has significantly increased productivity to a point where the volume to achieve 70 percent coverage is expected to be achieved.

Please Note: The baseline in the 2013/14 Annual Plan was updated to figures from March 2012. Also, the 2013/14 Annual Plan measure stated a 3 year period for measurement, this was an error, the measure remains as it has been; a 2 year period.

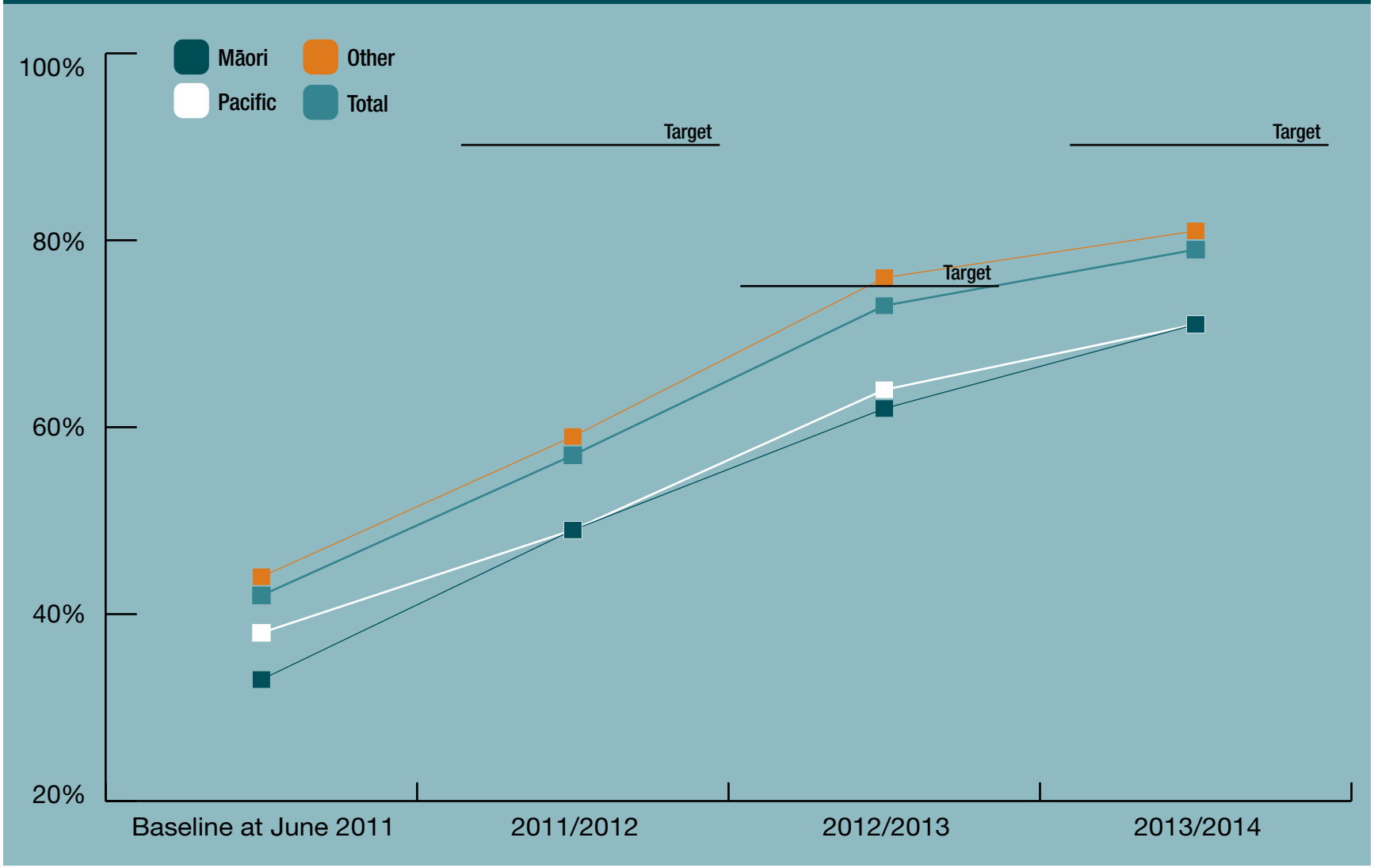


Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percent 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 as at June 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percent of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori 33.4% Pacific 38.1% Other 44.4% Total 42.1%	Māori 62% Pacific 64% Other 76% Total 73%	Māori 90% Pacific 90% Other 90% Total 90%	✗ Māori 71% ✗ Pacific 71% ✗ Other 81% ✗ Total 79%

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 Tagets.

Waikato DHB performance

We have not met the target for any of the populations, however there is improvement between the 2012/13 and the 2013/14 results.

Some key intitiatives that have and will be put in place to ensure we met the 2014/15 target:

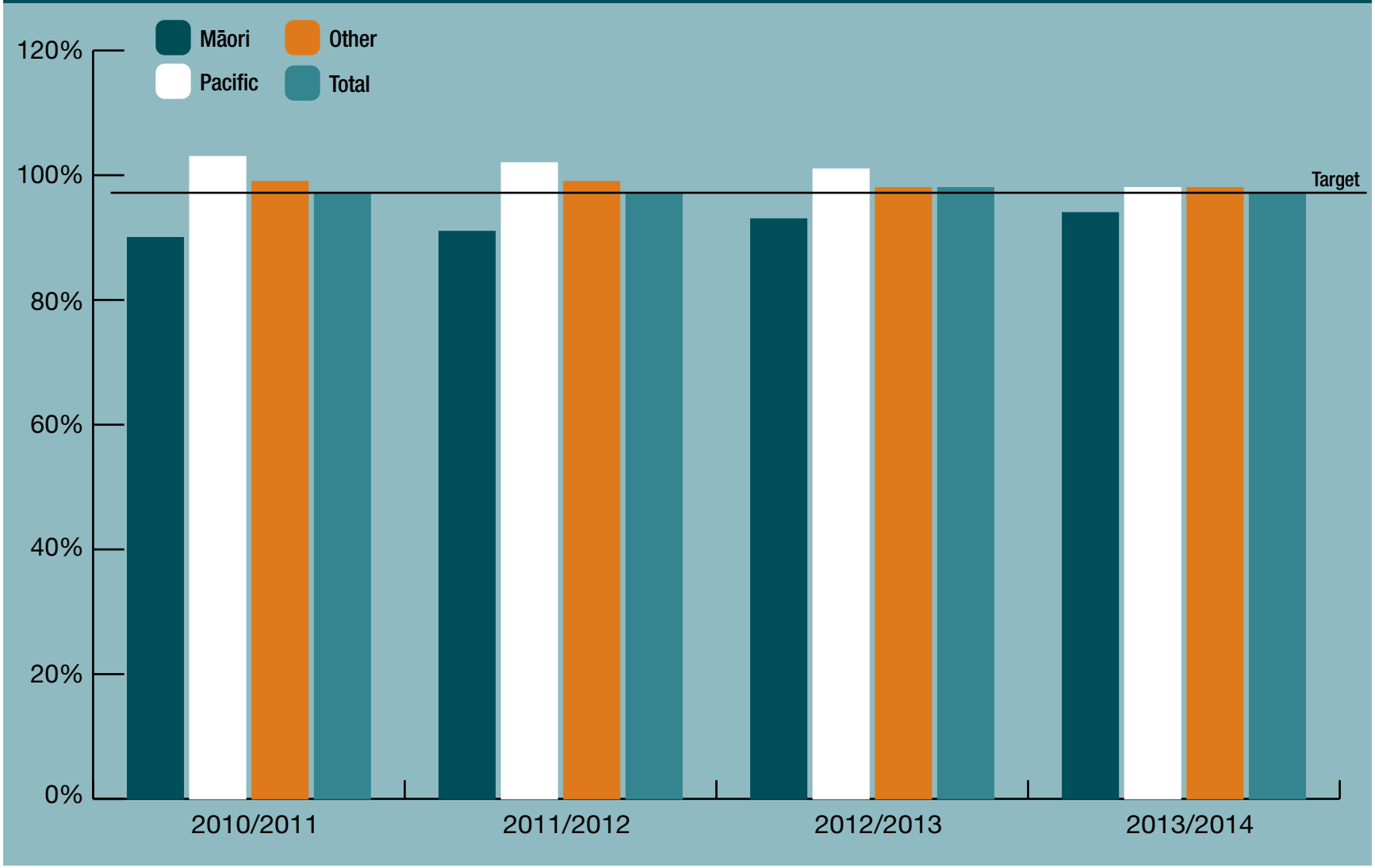
- Regular meetings occur between Primary Health Organisations and DHB to track progress
- Monthly Board reports to include individual Primary Health Organisation progress against the Health targets
- Primary Health Organisation resourced to provide a dedicated clinical full-time equivalent to work with the Primary Health Organisation practices to achieve the health targets with a focus on the following:
  - Best Practice quality guidelines for cardiovascular disease/diabetes management programmes are understood and followed by all Hauraki Primary Health Organisation practice teams;
  - 100 percent achievement of cardiovascular disease/diabetes management targets

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of population enrolled with a primary health organisation



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 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of population enrolled with a primary health organisation	Māori 89.5% Pacific 102.6% Other 98.8% Total 97.0%	Māori 93.4% Pacific 100.6% Other 98.3% Total 97.6%	Māori 97% Pacific 97% Other 97% Total 97%	✗ Māori 94% ✓ Pacific 98% ✓ Other 98% ✓ Total 97%

Significance of measure

Each GP or medical centre in the Waikato is a member of a Primary Health Organisation (PHO). The Waikato has three PHOs: Midlands Health Network, Hauraki Primary Health Organisation, and the National Hauora Coalition. The government provides funding to PHOs to subsidise visiting fees and prescriptions. It is voluntary for people to join a PHO, however subsidies are only available to those who have joined.

People are encouraged to join a PHO 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 enrolment rates with PHOs than other ethnicities. This is an issue Waikato DHB and the PHOs in the Waikato are focusing on by ensuring there are PHO's whose GPs provide kaupapa Māori health services and that these are promoted in Waikato's communities.

Waikato DHB performance

Our overall performance against this target represents a small drop in performance compared to last year. We have however achieved the target for all the ethnic groupings we monitor except for Māori.

Performance against the Māori portion of this measure has been the subject of discussion at Iwi Māori Council and a plan is in place to increase the percentage of Māori enrolled with a PHO in 2014/15.

Work in this area includes:

- an initiative to ensure that all newborns born at Waikato Hospital are enrolled before discharge.
- The promotion of enrolment also occurs via the Waikato Safe Sleep Programme (Pepi-Pods).

In 2014/15 we plan to increase our target for this measure to 100%.

Output measure

People stay well in their homes and communities

Long-term conditions are detected early and managed well

Measure	Baseline Jun-Dec 2011	Previous year 2012 /2013	Target 2013 / 2014	Result 2013 / 2014
Number of clients on caseload (primary mental health and addictions)	218	2,832	230	✓ 4,321
Number of primary mental health and addiction packages of care	318	192	540	✓ 2,004

Significance of measure

Untreated mental health and addiction issues impact not only the individual but their family/whānau, friends, and communities. Waikato DHB supports and funds many services for the identification, intervention, and/or specialist referral for people with mild to moderate mental health and addiction issues.

Packages of care provide consumers with a holistic and wrap around service that is targeted to the individuals need, whilst also taking into consideration the needs of the family/whānau.

Targeted services for people with mild to moderate mental health and addictions issues reduces the likelihood that people's concerns will become more severe, and thereby reducing the need for more expensive services and reducing the impacts to the individual, families/whānau, and communities.

Waikato DHB performance

The targets for both of these measures were determined when the service was being established. The results over the past two years indicate these target levels are low. Updated targets for these measures are expected to be put forward for 2014/15.

Since 2011/12, allowances have been made to enable the providers to carry unused packages of care through to the next financial year.

One of the providers, Midlands Health Network, allocated $721,000 from its Flexible Funding Pool for Counselling services for patients with mild to moderate mental health and addiction issues. Their reporting included the volumes provided through this funding in addition to the specific primary mental health care contracts we have with them.

There has been dialogue with the Ministry of Health to try and capture more accurate data. They are currently developing a national reporting template and the indicators and targets for primary mental health will be reviewed. This work is expected to be completed in 2014/15.

Please Note: The dates for the baseline published in the 2012/2013 Annual Report was incorrect, the dates for the baseline published in the 2013/2014 Annual Plan and in this Annual Report are correct

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Output measure

Measure	Baseline 2009 / 2010	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of all Emergency Department presentations who are triaged at levels four and five	49.70%	45.00%	<45.00%	✗ 46.90%

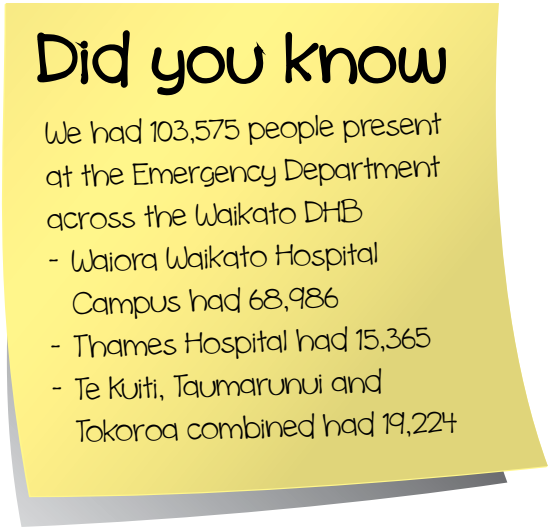
Significance of measure

Emergency departments (EDs) 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 ED with severe and life-threatening conditions receive immediate attention. EDs must have an effective triage system to ensure those requiring immediate attention receive this as fast as possible. Overcrowding of EDs is a common occurrence world-wide and can lead to patients not receiving timely care. Triaging involves assessing which patients require immediate care and which patients conditions are not as urgent.

Emergency department services utilise a scale of one to five triage, with one being the most urgent. Triage category four and five may more appropriately be seen in primary care.

Waikato DHB performance

The 2013/14 result shows we have not met the target and that there has been a slight decrease in performance compared to last years results. We will continue monitoring this measure to ensure we meet the target and improve where necessary.

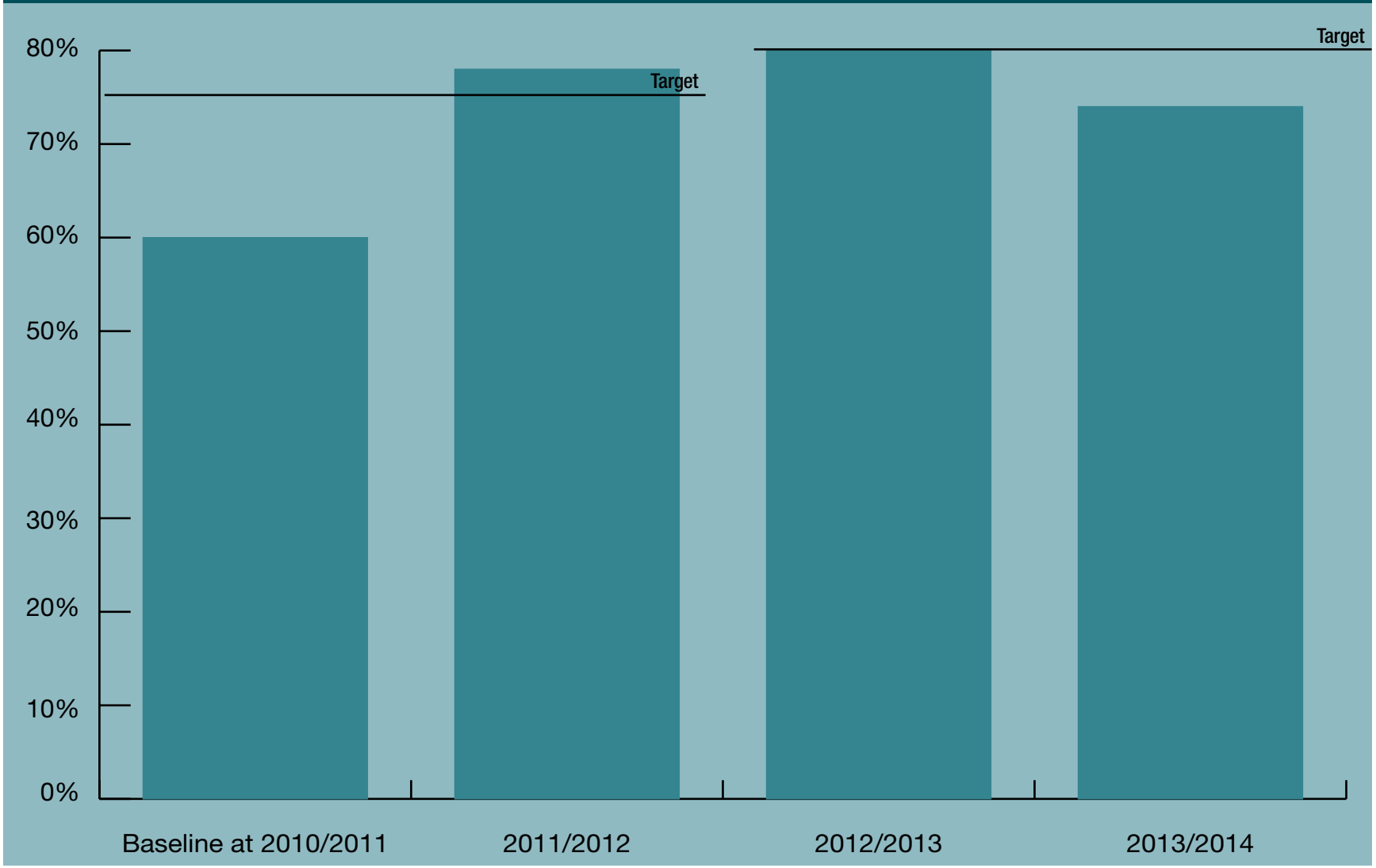


Output measure

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 at Dec 2010	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of Rest Home residents receiving vitamin D supplement from their GP	60%	80%	80%	✗ 74%

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 did not achieve the 2013/14 target, the following processes are in place to improve the performance.

If individual facilities achieved results of less than 80 percent they were sent their specific result and asked to explain why it had dropped; and requested to outline proposed actions to reach the required target. In addition the data was forwarded to the Clinical Director of Midlands Health Network to inform communications with General Practitioners and further their education. The DHB Clinical Nurse Specialist (Gerontology) was advised so that facility clinical staff were reminded to discuss vitamin D prescriptions with the resident's General Practitioners.

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 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of eligible population who have had their B4 school checks completed – High Needs	95%	80%	90%	✓ 90%
Percentage of eligible population who have had their B4 school checks completed – Total	81%	80%	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.

Waikato DHB performance

We are very pleased we have achieved the coverage targets and particularly achieved the target for high needs children thereby reducing inequalities.

We believe our contracting approach, which includes the B4 school coordinator being located in primary care with effective links to our three primary health organisations has assisted all providers to locate and undertake checks for “lost’ children

The targets for the past two years have been met, even with an increase in target.

Please Note: The dates and results for the baselines published in the 2013/14 Annual Plan were updated from the 2012/13 Annual Report. The 2013/14 Annual Plan and this Annual Report are the baselines being used going forward.

Hannah Luccock with Mum, Ellen Luccock having her B4 school checks

Output measure

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Reduction in hospitalisation for acute rheumatic fever - **Number of people**	New Measure	New Measure	12	✗ 18
Reduction in hospitalisation for acute rheumatic fever - **Rate per 100,000**	New Measure	New Measure	3.3	✗ 4.8

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.

This is a new measure. 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

We have been proactive in working to reduce the incidence and impact of Rheumatic Fever. Following an audit of Rheumatic Fever cases and services in 2004, recommendations were made to: standardise care and align management to national guidelines; form the Waikato Rheumatic Fever stakeholders group and design and manage the Waikato Rheumatic Fever register.

The Waikato DHB's work-plan covers the years July 2013-2017, with a particular focus on 2013 to 2014. The plan includes sections on:

- Overarching actions to reduce the incidence of Rheumatic Fever
- Investment in reducing Rheumatic Fever
- Actions preventing the transmission of Group A Streptococcal throat infections
- Actions to treat Group A Streptococcal throat infections quickly and effectively
- Actions facilitating the effective follow-up of identified Rheumatic Fever cases

Consultant ear, nose and throat surgeon Francoise Jean-Louis, examins the throat of four year old patient Angellee Weir

Output measure

People stay well in their homes and communities

More people maintain their functional independence

Measure	Baseline 2011 / 2012	Previous year 2012 /2013	Target 2013 / 2014	Result 2013 / 2014
Proportion of people with dementia who have been assessed as having a MAPIe score ≥3 who have a completed care plan	100%	100%	90%	✓ 100%

Significance of measure

MAPIe stands for Method of Assigning Priority for level of service. This measure allows for service allocation that is based on clinical need.

Care plans for people with dementia who have a MAPIe score of 3 or greater are prioritised due to their higher need for assistance. This does not mean those with a score below 3 are not a priority, rather that there is a form of triaging where the DHB can ensure those with a higher need for service receive a completed care plan.

Waikato DHB performance

We have exceeded the target again, with all people in the Waikato District who have dementia were assessed as having a MAPIe score of 3 or greater had a completed care plan.

We will continue to work to exceed this target.

People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure	Baseline Jun-Dec 2012	Previous year 2012 /2013	Target 2013 / 2014	Result 2013 / 2014
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%	New Measure	100%	✗ 94%

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 long-term 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

From 1 July 2013 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 as indicated.

Existing Health of Older People funded clients, whose need for a review or reassessment occurs within the 2013-14 year, receive a comprehensive clinical assessment. (93.9 percent)

100 percent of all clients receiving a comprehensive clinical assessment have an individual care plan.

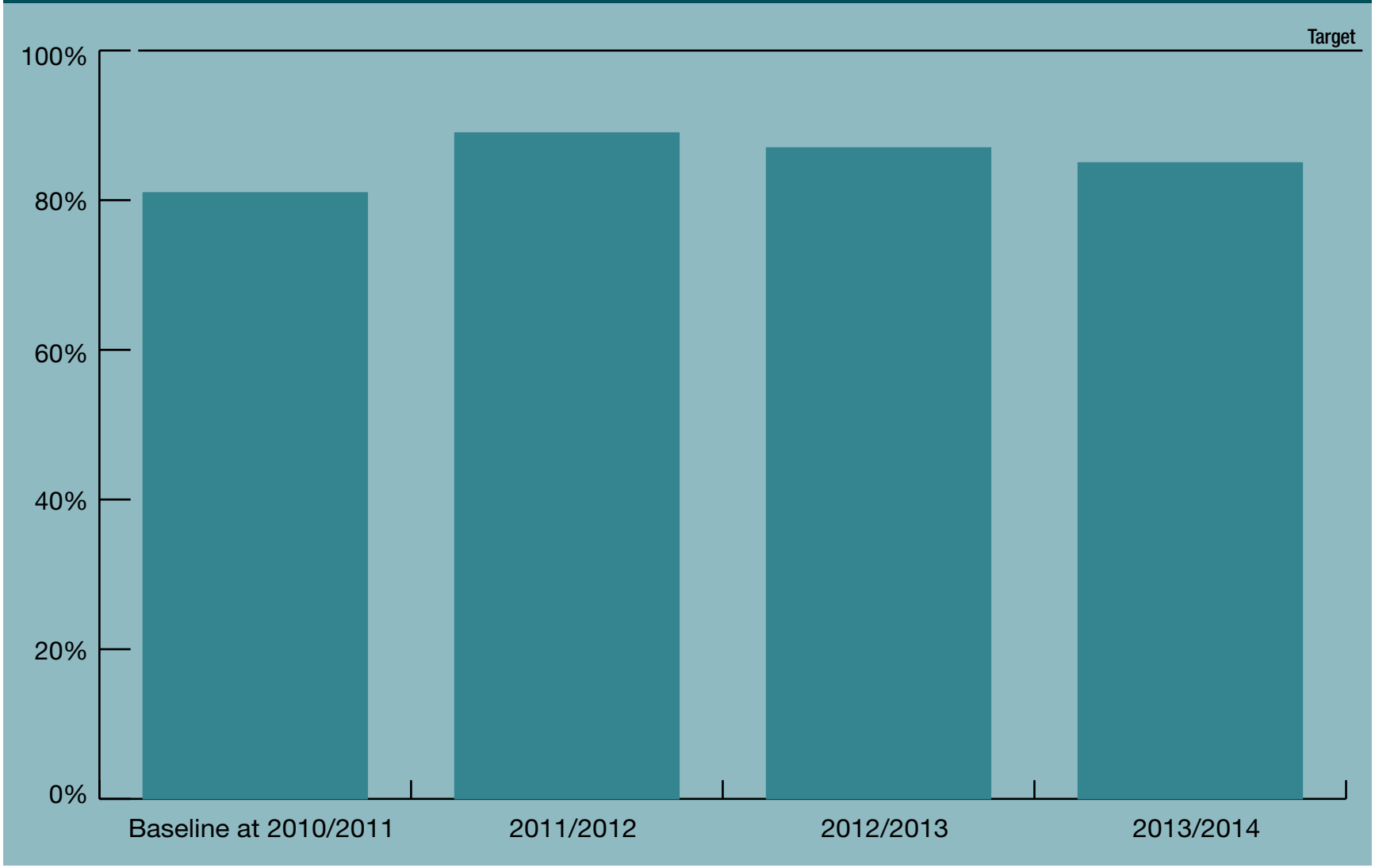
Those clients who are not yet due a review or reassessment and who have not previously had a comprehensive clinical assessment account for the 6.1 percent outstanding. All eligible clients allocated DHB funded services have a completed care plan

Output measure

People stay well in their homes and communities

People maintain functional independence

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



People stay well in their homes and communities

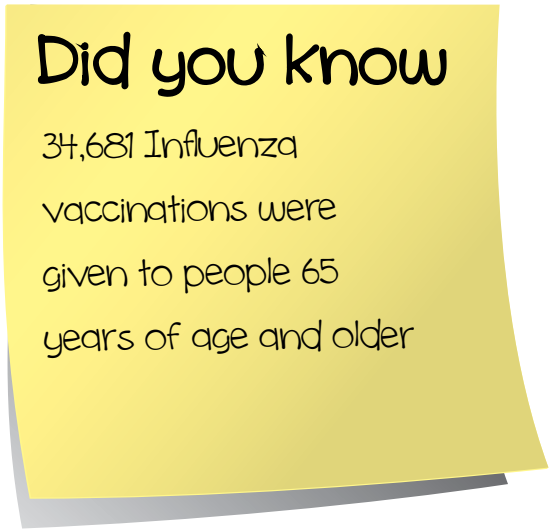
More people maintain their functional independence

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 /2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of needs assessment and service co-ordination (NASC) waiting times for new assessments within 20 working days	81%	87%	100%	✗ 85%

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.

There were 1,570 new assessments in 2013/14 of which 240 (or 15 percent) took longer than 20 days.

Work is occurring in this area both regionally and locally. At a regional level the work is around home and community support services should deliver new approaches to assist with meeting demand. Locally an internal review is being undertaken of the NASC service covering both funding levels and the overall service model for client assessment and service allocation.

This work is expected to start to improve waiting times by the end of 2014, with further improvements in January – March 2015.

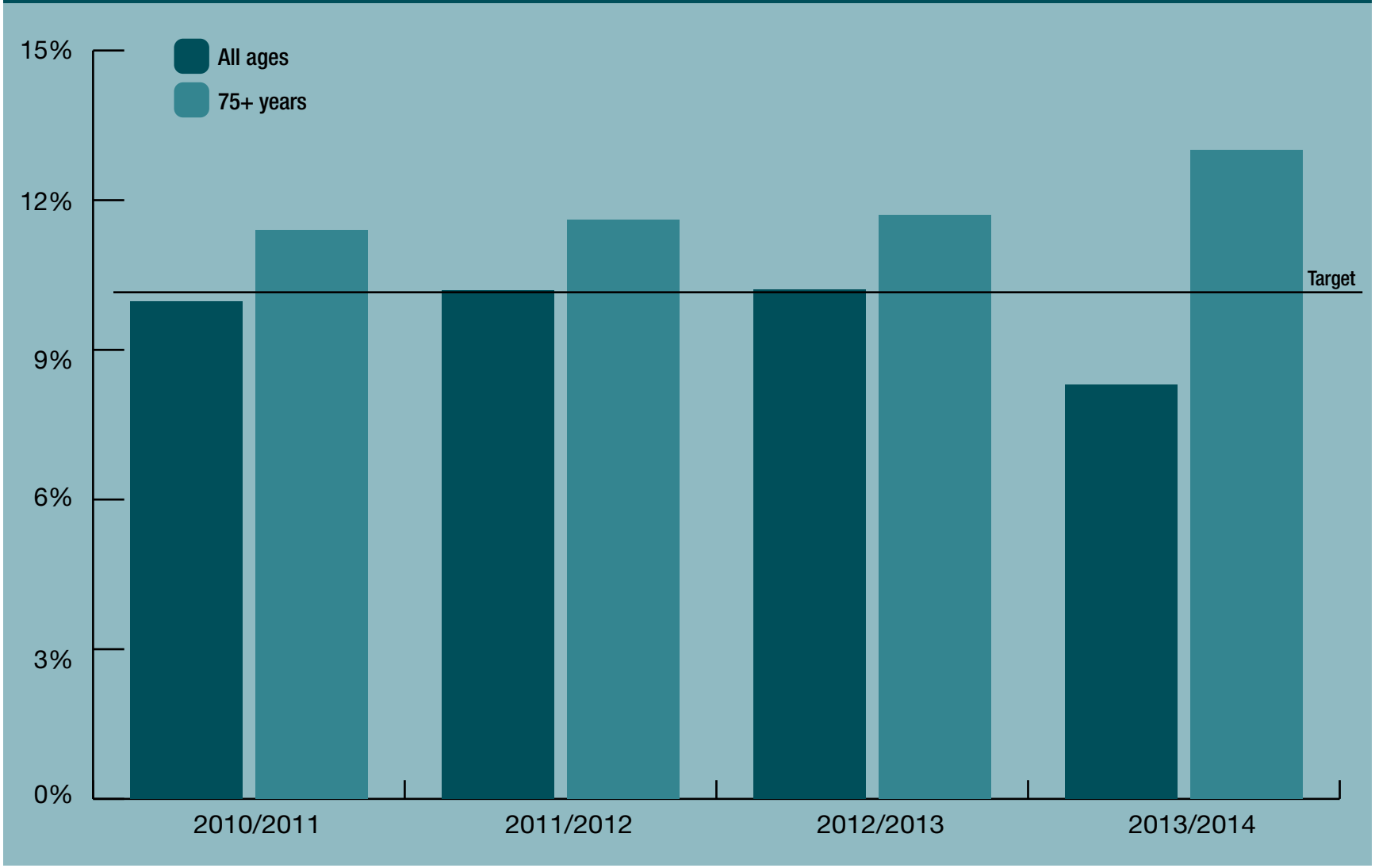
Long-term impact	People receive timely and appropriate specialist care				
Intermediate impacts	People receive prompt and appropriate acute care	People have appropriate access to elective services	Improved health status for people with a severe mental illness and addictions	More people with end stage conditions are supported	Support Services
Output Performance Measures	• Acute re-admission rate (all ages) • Acute readmission rate (75 +years old) • Acute inpatient average length of stay • Elective surgical inpatient average length of stay • Percentage of patients who require radiation or chemotherapy are treated with 4 weeks • Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	• Did-not-attend percentage for outpatient services • Number of surgical discharges under the elective initiative • Percentage of patients waiting longer than five months for their first specialist assessment	• Improving the percentage of long-term clients with up to date relapse prevention / treatment plans • Percentage of people referred for non-urgent mental health or addiction services are seen within three weeks • Average length of acute inpatient stay in an adult mental health and addiction inpatient unit • Rates of post-discharge community care	• Number of first attendances at the Waikato DHB hospital palliative care outpatient service	**Diagnostic colonoscopy** • Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks • Percentage of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks **Surveillance colonoscopy** • Percentage of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks beyond the planned date **Improved wait times for diagnostic services** • Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months • Percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within than 6 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 care

Acute re-admission rate



People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Output measure

Measure	Baseline Jun 2010-Mar 2011	Previous year 2012 /2013	Target 2013 / 2014	Result 2013 / 2014
Acute re-admission rate (all ages)	6.70%	10.60%	≤8.06%	✗ 8.30%
Acute re-admission rate (75+ years old)	10.30%	11.70%	≤12.30%	✗ 13.00%

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

Amongst the tertiary DHBs (relevant comparators) Waikato is performing in the mid-range but is slightly behind its target for on-going improvement for both age ranges (all ages and 75+ years old). The changes to palliative care signalled at the end of the 2012/13 year have been implemented successfully.

The focus of the quality improvement work has now shifted to colorectal surgery. A service quality project looking at acute readmissions in colorectal surgery is underway. This is an area of particular incidence.

The General Surgical service conducted a preliminary audit of acute re-admission rates clustered by condition type and the specialist team are now conducting a more comprehensive audit of a larger cohort of cases to identify common causation.

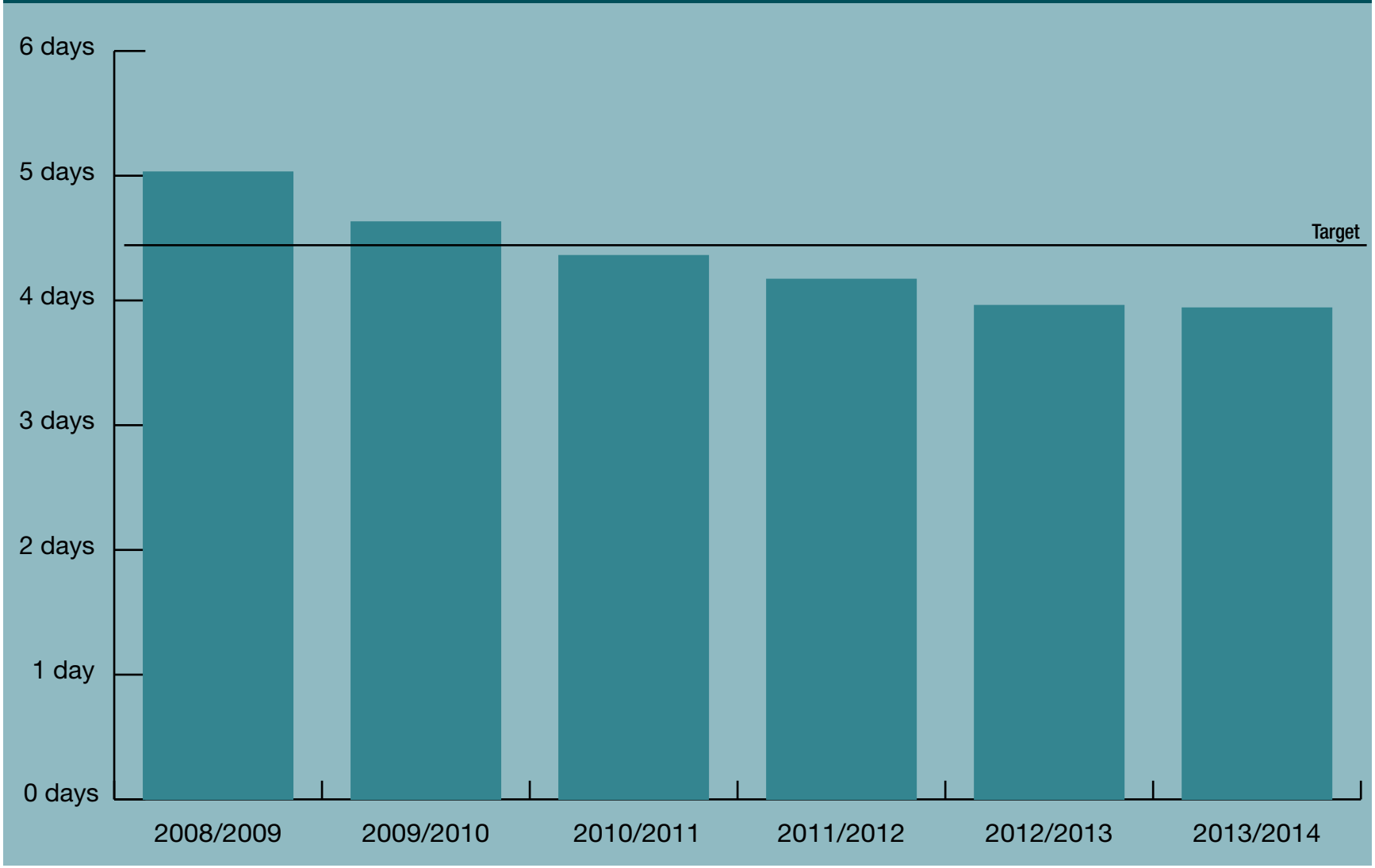
Please Note: The baseline published in the 2012/13 Annual Report is for a different period of time than the baseline published in this Annual Report and the 2013/14 annual plan.

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Acute inpatient average length of stay



People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Output measure

Measure	Baseline 2012	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Acute inpatient average length of stay	4.51 days	3.96 days	≤4.47 days	✓ 3.94 days

Significance of measure

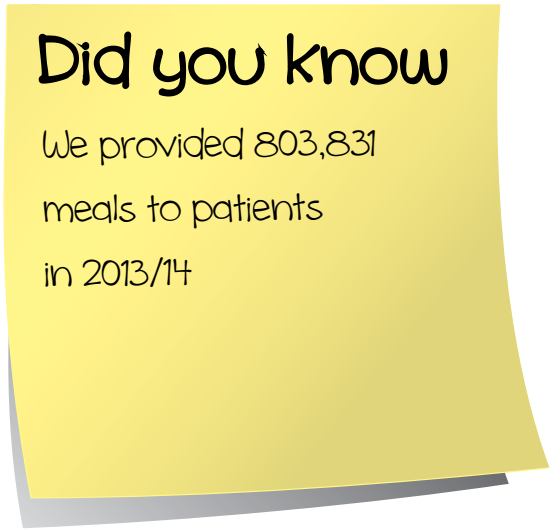
Acute care is a branch of secondary health care where a patient turns up at hospital unexpectedly, and needs to be admitted (for investigation or treatment) there and then. This measure relates to physical health issues.

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

Over a number of years we have undertaken a plethora of initiatives within the hospital setting to increase productivity and make efficiency gains. These combined efforts are the achievement of our acute inpatient average length of stay target.

This is a new measure. Previously average length of stay in a hospital included both elective and acute patients. For the 2013/14 year and going forward we are measuring acute seperate to elective.

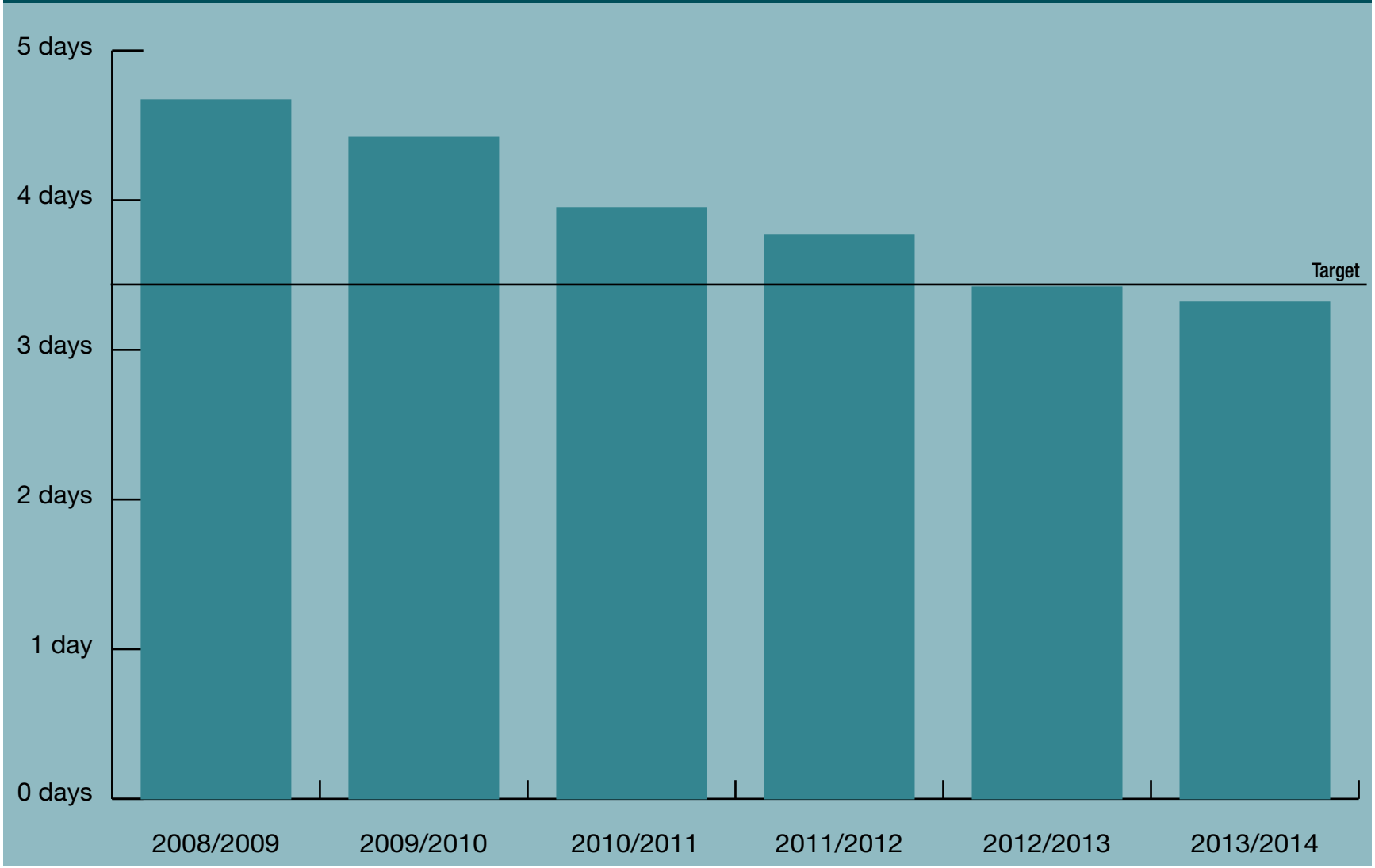


Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Elective surgical inpatient average length of stay



People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Elective surgical inpatient average length of stay	4.26 days	3.42 days	≤3.43days	✓ 3.32 days

Significance of measure

By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, the DHB will improve hospital productivity through freeing up beds and other resources so it can provide more elective surgery and other services.

Addressing the factors that influence a patient's length of stay in hospital requires the DHB to consider its performance on other measures, such as reducing readmissions, and increasing its integration activities that strengthen the ability of primary care to treat people more appropriately in the community.

Waikato DHB performance

Over a number of years we have undertaken a plethora of initiatives within the hospital setting to increase productivity and make efficiency gains. This trend continued in 2013/14 an impact of these combined efforts is the achievement of our elective average length of stay target.

The kind of initiatives include:

- End to end reviews of process at Waikato hospital (covering triaging, threshold management, booking administration, patient flow management and preadmission)
- Supported Transfer and Accelerated Rehabilitation Team
- Elective Short Stay Surgical Unit Project
- Focus on long stay patients
- Medihotel

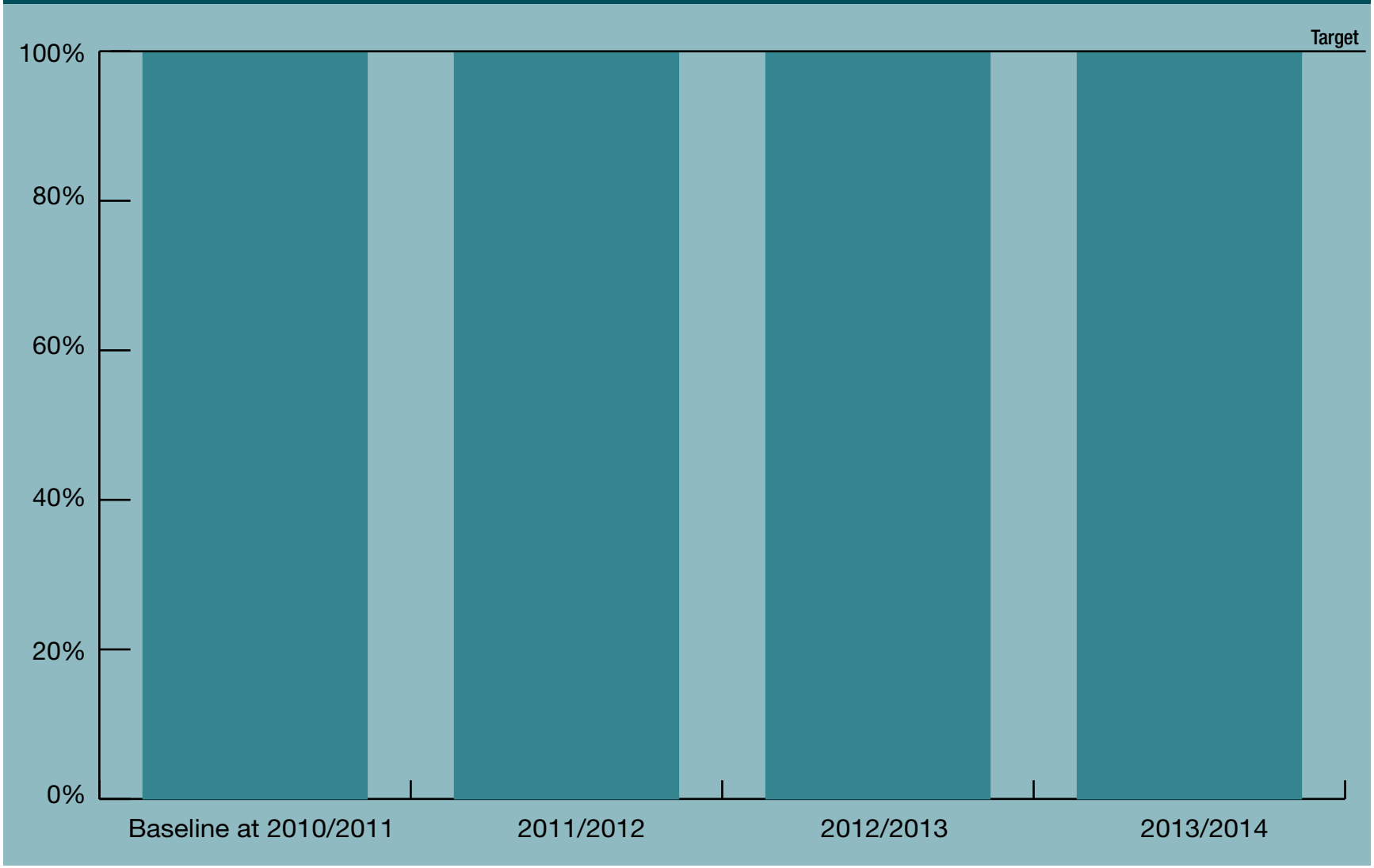
This is a new measure. Previously average length of stay in a hospital included both elective and acute patients. For the 2013/14 year and going forward we are measuring elective seperate to acute.

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

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



People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
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

This is a national health target and our quarterly results are presented under the quality improvement priority in part one. Initiatives to maintain our performance included:

- Participation in the Waikato medical oncology service change transition project with Bay of Plenty DHB
- Contribution to the implementation of the Midland medical oncology plan
- Linac technology upgrade

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.

This service was delivered to 1,501 patients from Waikato DHB, Bay of Plenty DHB, Lakes DHB, Tairawhiti District Health and other DHBs.

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute care

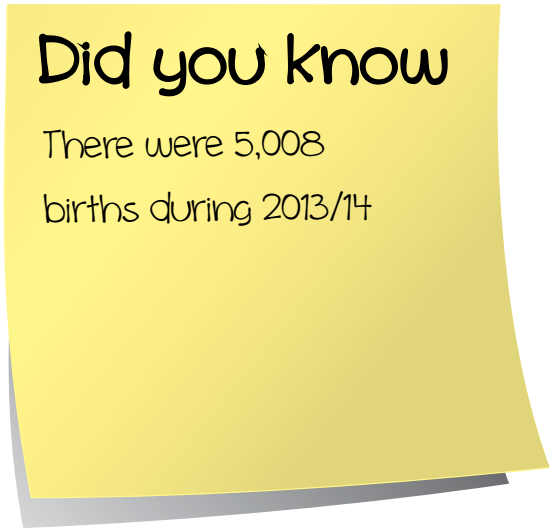
Measure	Baseline 2011 / 2012	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	13%	New Measure	≤16%	✓ 12%

Significance of measure

Caesarean deliveries have a higher risk of operative complications (infections, haemorraghia, visceral injury, thromboembolism).

Waikato DHB performance

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.



People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measure	Baseline 2011/2012	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Did-not-attend percentage for outpatient services	Māori 17% Pacific 16% Other 18.4% Total 10%	Māori - new measure Pacific - new measure Other - new measure Total 10%	Māori <8% Pacific <8% Other <8% Total <8%	✗ Māori 22% ✗ 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.

Did you know

The number of outpatients who did not attend appointments rose to 22,137, compared to 20,672 during 2012/13

Waikato DHB performance

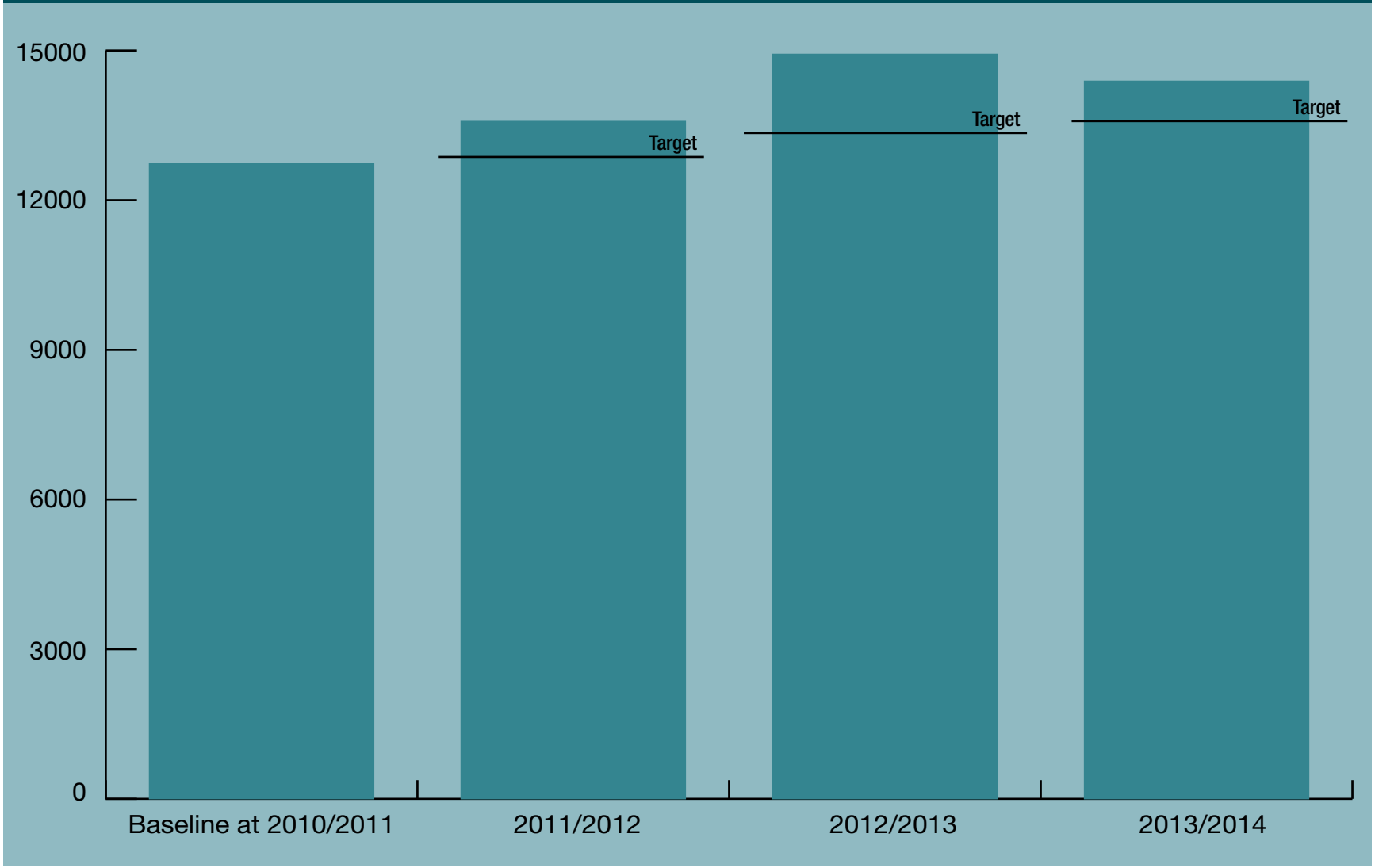
There are a number of initiatives underway targeted at reducing the number of people who do not attend their scheduled outpatient appointment. These include text reminders, proactively updating patient information, provision of grants to community transport providers and our Kaitiaki service and public health nurses working with high-needs and Māori families.

Output measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

Number of surgical discharges under the elective initiative



People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Number of surgical discharges under the elective initiative	12,737	14,925	13,231	✓ 14,385

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

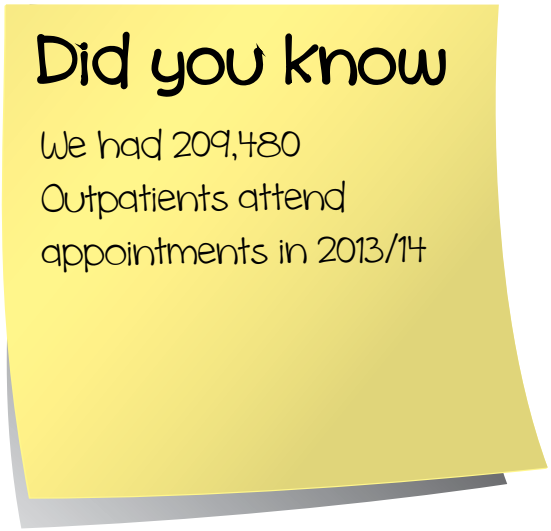
Increasing delivery should improve access and reduce waiting times, which should increase public confidence that the health system will meet their needs.

This measure is one of the National Health Targets.

Waikato DHB performance

We have over achieved against this target in 2013/14. This is partly a reflection of the higher levels of surgery currently required to meet elective waiting times, for example the percentage of patients waiting longer than five months for their first specialist assessment.

Please note the figure for the 2010/11 baseline presented in the 2013/14 Annual Plan is an error (Printed as 12,373). The accurate baseline for 2010/11 is 12,737.



Output measure

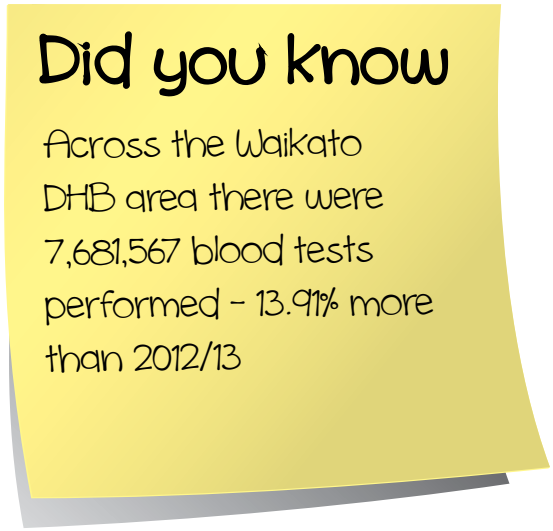
People receive timely and appropriate specialist care

People have appropriate access to elective services

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of patients waiting longer than five months for their first specialist assessment (FSA)	5.6%	1%	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 five months for outpatient first specialist attendances and inpatient elective surgical procedures (including day cases) by 30 June 2014. The improvement in performance over the past few years reflects an enormous amount of exceptionally hard work from many staff.

This waiting time target decreases to four months by the end of December 2014.

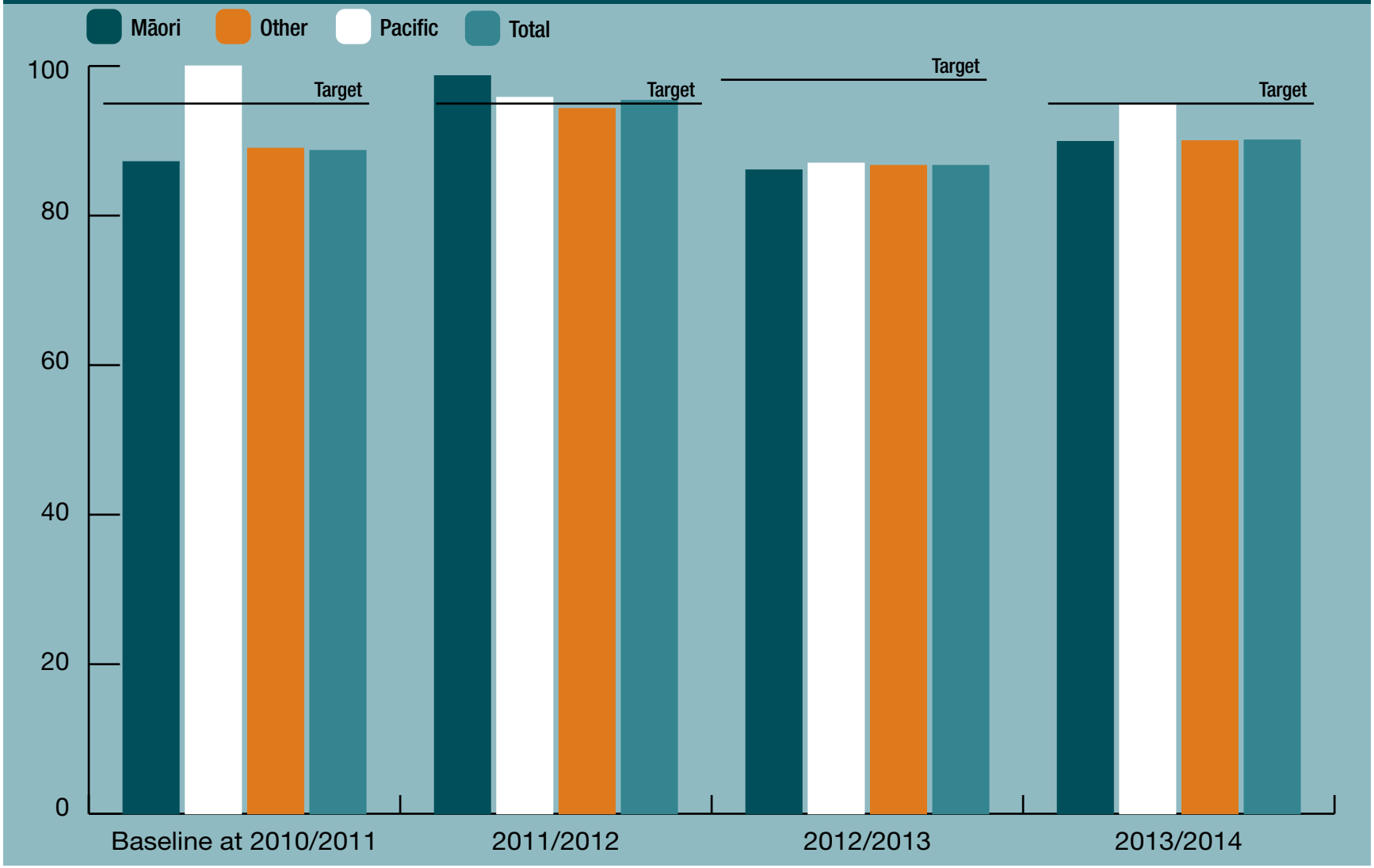
Emergency services heading to a call out

Output measure

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Improving the percentage of long-term clients with up-to-date relapse prevention/treatment plans (20+ year olds)



People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Improving the percentage of long-term clients with up-to-date relapse prevention / treatment plans (20+ year olds)	Māori 87.17% Pacific 100% Other 88.98% Total 88.74%	Māori 86.09% Pacific 86.96% Other 86.67% Total 88.66%	Māori 95% Pacific 95% Other 95% Total 95%	✗ Māori 90% ✓ Pacific 95% ✗ Other 90% ✗ Total 90%

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-centred 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.

The measure relates to long-term (two years or more) clients of Mental Health and Addiction Services.

Waikato DHB performance

Performance against this measure has been below target for each grouping except for the Pacific ethnic group. Overall 2,468 people out of 2,715 had relapse prevention plans.

Work occurred during 2013/14 on the quality and consistency of plan content which impacted on volume compliance. A number of activities to improve performance are now being implemented and we expect this will mean we will achieve the target by December 2014. These activities include:

- Reseating of accountability against this target
- Monthly monitoring of progress
- Reporting progress to the relevant leadership group

Please Note: The figures for the baseline and the2012/23 results published in the 2012/13 Annual Report and the 2013/14 Annual Plan were incorrect, the figures in this report are accurate and in-line with the Ministry of Health reports.

Output measure

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of people referred for non-urgent **mental health** services are seen within three weeks – 0-19 year olds	43%	66.20%	75%	✗ 74.10%
Percentage of people referred for non-urgent **mental health** services are seen within three weeks – 20-64 year olds	47%	87.70%	82%	✓ 85.90%
Percentage of people referred for non-urgent **mental health** services are seen within three weeks – 65+ year olds	57%	82.20%	80%	✓ 83.30%
Percentage of people referred for non-urgent **addiction services** are seen within three weeks – 0-19 year olds	70%	68.40%	80%	✗ 78.30%
Percentage of people referred for non-urgent **addiction services** are seen within three weeks – 20-64 year olds	46%	61.20%	75%	✗ 70.10%
Percentage of people referred for non-urgent **addiction services** are seen within three weeks – 65+ year olds	63%	66.70%	80%	✓ 83.30%

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure

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.

The age groups for this target are: child and youth covers 0 – 19 years of age, adult covers 20 – 64 years of age and older persons covers 65 years plus.

Waikato DHB performance

One of the areas where it has traditionally been a challenge to meet wait time targets is Ministry of Justice referred clients. During 2013/14 a multi-agency project to enhance the process for community based offenders requiring alcohol and other drug services was undertaken. While a pilot was undertaken during 2013/14 district wide rollout will occur in 2014/15. This project is expected to improve performance against these targets through the creation of a single point of entry for referrals.

There continue to be data issues which impact our reported performance against these waiting times targets. Work has been ongoing to try to understand the indicator's parameters and how the Programme for the Integration of Mental Health Data (PRIMHD) underlying data has been collected. The detailed report received from the Ministry of Health (wait times by addiction service providers in particular) has raised a number of questions about the validity of provider level information received.

Further work is required to understand the extent to which the validity of the waiting times report is affected by provider coding and/or PRIMHD extraction issues.

Output measure

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Measure	Baseline 2012 / 2013	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Average length of acute inpatient stay in an adult mental health and addiction inpatient unit	13.89 days	13.89 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

The result for 2013/14 is within the target range. Average length of stay performance is regularly monitored against referral and discharge information as a component of the patient pathway.

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure

Measure	Baseline	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Rates of post-discharge community care (mental health and addictions)	New Meausre	New Meausre	90-100%	✗ 82%

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 occurred in the last 12 months to improve discharge planning and clearly define what constitutes follow up within seven days, as many patients were seen on the day of discharge. We are now in a position where our teams and clinicians in the community clearly understand the requirements and where exceptions occur there is a clearly documented rationale. It is expected this information will be used to inform planning in this area to improve performance to the target levels in 2014/15.

Dr Lara Hoskins member of the Palliative care team based at Waikato hospital

People receive timely and appropriate specialist care

More people with end stage conditions are supported

Output measure

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Number of first attendances at the Waikato DHB hospital palliative care outpatient service	408	260	<52	✓ 34

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

Late in 2012/13 Waikato DHB and Hospice Waikato agreed to share resources and work more collaboratively in the future.

This increased collaboration has enabled improvements to be made to palliative care services, which resulted in some changes to the way services are provided.

One change was significantly strengthening the specialist support at the Hospice Waikato inpatient service. While specialist palliative care is still available at Waikato Hospital for hospital in-patients with palliative care needs, a higher level of service for patients and their families is available at Hospice Waikato including the majority of outpatient palliative care services.

These changes only affect adult specialist palliative care services. There is no change to services for children and young people.

This is a new measure.

Output measure

People receive timely and appropriate specialist care

Support Services

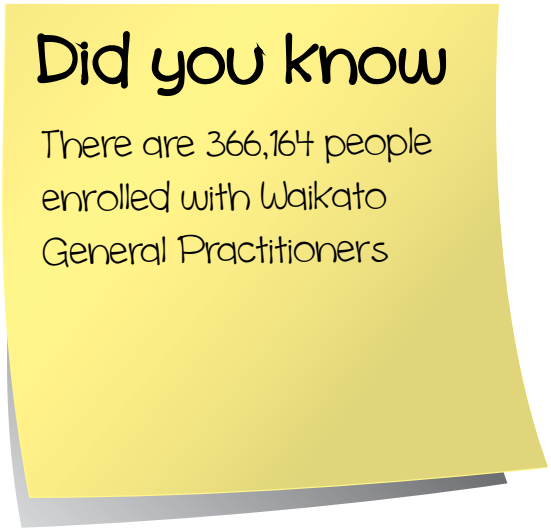
Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Diagnostic colonoscopy - percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days)	New Measure	New Measure	50%	✗ 21%
Diagnostic colonoscopy - percentage of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)	New Measure	New Measure	50%	✗ 41%
Surveillance colonoscopy - percentage of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	New Measure	New Measure	50%	New Meausre

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

These are developmental measures and are part of the nationally driven multiyear programme to improve waiting times for diagnostics. This has required collection of data outside normal systems. These measures will be shifting from developmental status to full accountability measures in 2014/15 for all DHBs.

During 2013/14 we focused on wait time data recording and the establishment of a wait time improvement plan. In 2014/15 as part of the improvement plan we will continue to identify and implement improvements to colonoscopy services. We will ensure compliance against the national referral guidelines for colonoscopy.

Improving the processes to enable collection of data for this measure continues to progress. We expect we will be able to report against this measure in 2014/15.

These are new measures.

Output measure

People receive timely and appropriate specialist care

Support Services

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Improved wait times for diagnostic services- percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	New Measure	New Measure	85%	✗ 81%
Improved wait times for diagnostic services- percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within than six weeks (42 days)	New Measure	New Measure	CT scans 85% MRI scans 75%	✗ CT scans 66% ✗ MRI scans 30%

Did you know

Waikato DHB approved $1.6 million to purchase an advanced CT Scanner for improved internal imagery of the human body

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

While we did not achieve the target level for these measures, there has been steady improvement during the year from 65.8 percent as at 31 July 2013.

A suite of actions to improve performance have been identified and we expect implementation of these will improve performance in 2014/15. These actions include:

- Review of production plan to verify demand and capacity alignment
- Business process review of patient flow to increase productivity

We plan to complete the following actions to deliver improved performance by the end of the 2014 calendar year:

- Undertake detailed process analysis of CT, MRI and ultrasound and implement identified opportunities for improvements to service processes
- Operationalise the new CT and MRI facilities being implemented in late 2013/14 as part of the MRI tender and Meade Clinical Centre programme
- Implement greater contract controls with the MRI outsourced provider to ensure waitlist management is enhanced

These are new measures.

Output measure

People receive timely and appropriate specialist care

Support Services

Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	99.6%	100%	99.6%	✓ 100%

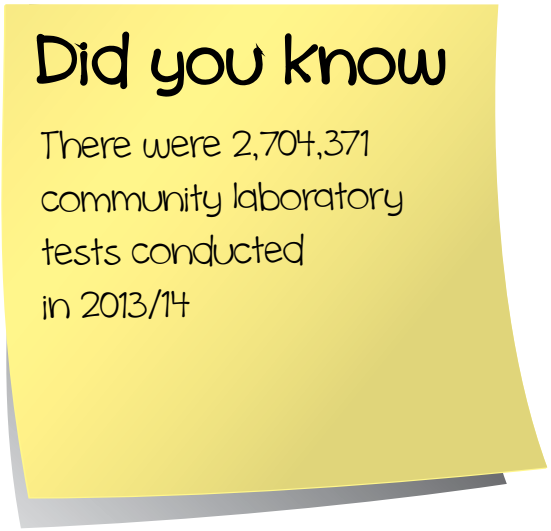
Significance of measure

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

This measure relates to a service that requires timly responses so that diagnosis, intervention and treatment can occur. The results for this measure have exceeded the target for the 2012/13 year and for the 2013/14 year. We are pleased with the efforts being made to continue to deliver on the services required to meet this measure.



People receive timely and appropriate specialist care

Support Services

Output measure

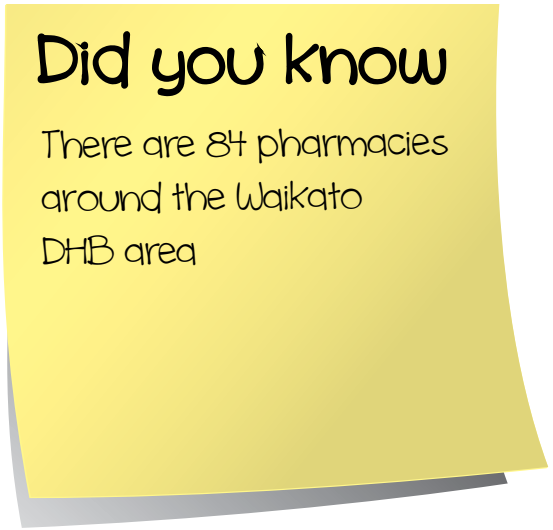
Measure	Baseline 2010 / 2011	Previous year 2012 / 2013	Target 2013 / 2014	Result 2013 / 2014
Total number of pharmaceutical items dispensed in the community	5,339,890	5,015,669	>5,500,000	✗ 5,475,980

Significance of measure

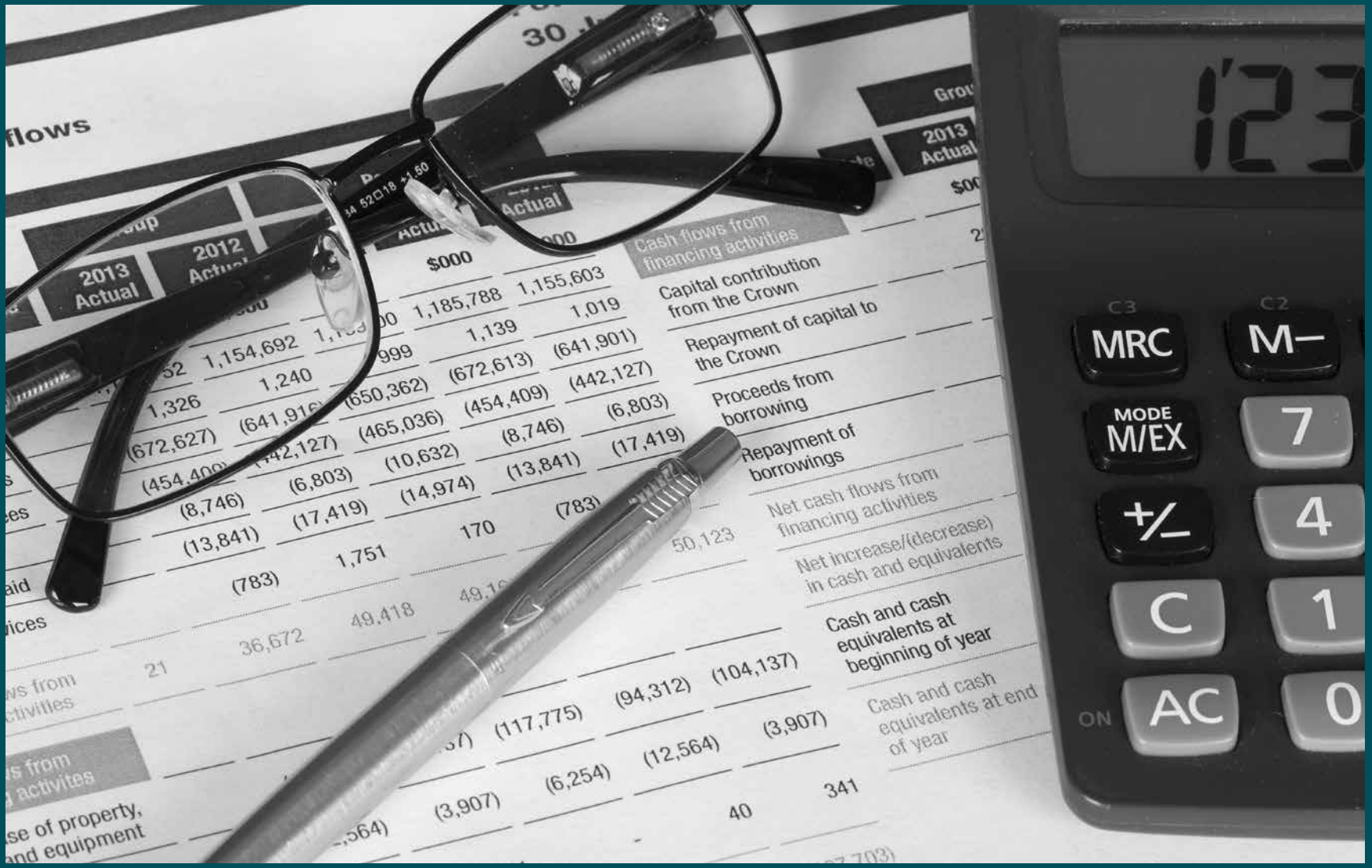
Pharmaceuticals are an important resource in improving health outcomes. Subsidised pharmaceuticals are dispensed by 76 pharmacies across the Waikato district.

Waikato DHB performance

There has been a significant increase in the number of pharmaceutical items dispensed in the community compared to 2012/13. This increase has occurred despite the impact of the national increase in pharmacy co-payments from $3.00 per item to $5.00 per item in January 2013.



Part 3 Financial Statements



Statement of comprehensive income

For the year ended 30 June 2014

	Note	Group 2014 Actual	Group 2013 Actual	Parent 2014 Budget	Parent 2014 Actual	Parent 2013 Actual
Income		$000	$000	$000	$000	$000
Patient care revenue	1	1,206,336	1,168,616	1,195,779	1,206,336	1,168,616
Other operating income	2	15,427	14,898	14,880	16,069	15,222
Finance income	3	1,505	1,342	900	1,338	1,139
Total income		1,223,268	1,184,856	1,211,559	1,223,743	1,184,977
Expenses						
Personnel costs	4	482,822	458,948	476,731	482,822	458,948
Depreciation	5	34,425	29,254	37,662	34,425	29,254
Amortisation	6	4,006	4,412	4,361	4,006	4,412
Outsourced services		52,966	61,015	40,602	52,966	61,015
Clinical supplies		127,367	118,598	124,943	127,367	118,598
Infrastructure and non-clinical expenses		62,896	65,664	66,875	62,896	65,664
Other district health boards		48,895	47,568	54,042	48,895	47,568
Non-health board providers		373,285	366,854	371,508	373,285	366,854
Other operating expenses	7	7,017	7,628	7,362	7,002	7,613
Finance costs	8	10,248	8,818	9,209	10,248	8,818
Capital charge	9	16,015	14,202	16,464	16,015	14,202
Total expenses		1,219,942	1,182,961	1,209,759	1,219,927	1,182,946
Share of associate surplus/(deficit)	10	5	1	-	5	1
Share of joint venture surplus/(deficit)	11	26	156	-	26	156
Surplus/(deficit)		3,357	2,052	1,800	3,847	2,188
Other comprehensive income						
Increase/(decrease) in revaluation reserve	12	30,681	-	-	30,681	-
Other comprehensive income for the year		-	-	-	-	-
Total comprehensive income for the year		34,038	2,052	1,800	34,528	2,188

The accompanying notes form part of the financial statements.

Explanations of major variances to budget are provided in note 32.

Statement of changes in equity

For the year ended 30 June 2014

	Note	Group		Parent		
		2014 Actual	2013 Actual	2014 Budget	2014 Actual	2013 Actual
		$000	$000	$000	$000	$000
Balance at 1 July		212,928	186,927	206,246	207,313	181,177
Comprehensive income						
Surplus/(deficit) for the year		3,357	2,052	1,800	3,847	2,188
Other comprehensive income/(expense)		30,681	-	-	30,681	-
Total comprehensive income for the year		34,038	2,052	1,800	34,528	2,188
Owner transactions						
Capital contributions from the Crown		10	26,139	-	10	26,139
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement		-	4	-	-	3
Balance at 30 June	12	244,782	212,928	205,852	239,657	207,313

The accompanying notes form part of these financial statements.

Did you know

The estimated cost of outpatients who did not attend appointments cost $3,320,550

Statement of financial position

As at 30 June 2014

Assets	Note	Group 2014 Actual $000	Group 2013 Actual $000	Parent 2014 Budget $000	Parent 2014 Actual $000	Parent 2013 Actual $000
Current assets						
Cash and cash equivalents	13	5,029	5,694	17	-	-
Receivables and prepayments	14	27,670	24,496	30,665	27,650	24,479
Inventories	15	9,063	7,883	7,659	9,063	7,883
Assets held for sale	16	40	40	-	40	40
Total current assets		41,802	38,113	38,341	36,753	32,402
Non-current assets						
Property, plant and equipment	5	583,311	544,596	580,373	583,311	544,596
Intangible assets	6	20,842	16,090	16,435	20,842	16,090
Investment in associate	10	6	31	30	6	31
Investment in joint venture	11	220	194	38	220	194
Total non-current assets		604,409	560,911	596,876	604,409	560,911
Total assets		646,211	599,024	635,217	641,162	593,313

Liabilities	Note	Group 2014 Actual $000	Group 2013 Actual $000	Parent 2014 Budget $000	Parent 2014 Actual $000	Parent 2013 Actual $000
Current liabilities						
Cash and cash equivalents	13	-	-	-	91	207
Borrowings	17	17,210	40,373	41,744	17,210	40,373
Employee entitlements	18	88,208	81,741	81,668	88,208	81,741
Trade and other payables	19	68,967	57,281	58,051	68,952	56,978
Provisions	20	631	680	78	631	680
Total current liabilities		175,016	180,075	181,541	175,092	179,979
Non-current liabilities						
Borrowings	17	212,355	191,880	234,123	212,355	191,880
Employee entitlements	18	13,566	13,805	13,701	13,566	13,805
Provisions	20	492	336	-	492	336
Total non-current liabilities		226,413	206,021	247,824	226,413	206,021
Total liabilities		401,429	386,096	429,365	401,505	386,000
Net assets		244,782	212,928	205,852	239,657	207,313
Equity						
Crown equity	12	81,662	83,846	81,652	81,662	83,846
Revaluation reserve	12	83,411	52,730	52,730	83,411	52,730
Retained earnings	12	74,584	70,737	71,470	74,584	70,737
Trust funds	12	5,125	5,615	-	-	-
Total equity		244,782	212,928	205,852	239,657	207,313

The accompanying notes form part of these financial statements.

For and on behalf of the board

Bob Simcock, Chair
Waikato DHB, 22 October 2014

Sally Christie, Deputy Chair
Waikato DHB, 22 October 2014

Statement of cash flows

For the year ended 30 June 2014

	Note	Group 2014 Actual	Group 2013 Actual	Parent 2014 Budget	Parent 2014 Actual	Parent 2013 Actual
Cash flows from operating activities		$000	$000	$000	$000	$000
Operating receipts		1,219,587	1,185,752	1,210,436	1,220,229	1,185,788
Interest receipts		1,539	1,326	900	1,338	1,139
Payments to suppliers		(665,826)	(672,627)	(714,268)	(665,826)	(672,613)
Payments to employees		(475,930)	(454,409)	(475,747)	(475,930)	(454,409)
Interest payments		(10,097)	(8,746)	(9,210)	(10,097)	(8,746)
Capital charge paid		(15,960)	(13,841)	(16,464)	(15,960)	(13,841)
Goods and services tax (net)		1,905	(783)	119	1,905	(783)
Net cash flows from operating activities	21	55,218	36,672	(4,234)	55,659	36,535
Cash flows from investing activities						
Purchase of property, plant and equipment		(48,925)	(94,312)	(66,859)	(48,925)	(94,312)
Purchase of intangible assets		(1,742)	(12,564)	(1,838)	(1,742)	(12,564)
Receipts from sale of property, plant and equipment		6	40	-	6	40
Net cash flows from investing activities		(50,661)	(106,836)	(68,697)	(50,661)	(106,836)

	Note	Group 2014 Actual	Group 2013 Actual	Parent 2014 Budget	Parent 2014 Actual	Parent 2013 Actual
Cash flows from financing activities		$000	$000	$000	$000	$000
Capital contribution from the Crown		-	26,139	-	-	26,139
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowing		-	42,943	43,077	-	42,943
Repayment of borrowings		(2,688)	-	-	(2,688)	-
Net cash flows from financing activities		(4,882)	66,888	40,883	(4,882)	66,888
Net increase/(decrease) in cash and equivalents		(325)	(3,276)	(32,048)	116	(3,413)
Cash and cash equivalents at beginning of year		5,354	8,970	(9,240)	(207)	3,206
Cash and cash equivalents at end of year	13	5,029	5,694	(41,289)	(91)	(207)

The accompanying notes form part of these financial statements.

Notes to the financial statements

Significant 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 in New Zealand.

Waikato DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, the Public Finance Act 1989 and the Crown Entities Act 2004.

The financial statements of Waikato DHB for the year ended 30 June 2014 comprise Waikato DHB as parent and Waikato DHB's interest in an associate (Urology Services Limited) and jointly controlled entity (HealthShare Limited). Waikato DHB's interest in its associate and joint venture are equity accounted. These companies are incorporated and domiciled in New Zealand. The group financial statements of Waikato DHB include full consolidation of the Waikato Health Trust.

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 is a Public Benefit Entity, as defined under New Zealand International Accounting Standard (NZ IAS) 1.

The financial statements were authorised for issue by the board on 22 October 2014.

Statement of compliance

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

The financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards (FRS), as appropriate for Public Benefit Entities.

Basis of preparation

The financial statements have been presented in New Zealand Dollars (NZD), rounded to the nearest thousand dollars ($000). The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, and forward foreign exchange contracts at fair value.

Non-current assets held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The preparation of financial statements under NZ IFRS requires management and the Board to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors including expectation of future events that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the subsequent actual results.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

There have been no revisions to accounting standards during the financial year which have had an effect on Waikato DHB's financial statements.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

NZ IFRS standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to Waikato DHB, are:

NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 *Financial Instruments: Recognition and Measurement* is being replaced through the following main phases: Phase 1 Classification and Management, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in NZ IFRS 9 Financial Instruments. NZ IFRS 9 *Financial Instruments* uses a single

approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39 *Financial Instruments: Recognition and Measurement.* The approach in NZ IFRS 9 *Financial Instruments* is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39 *Financial Instruments: Recognition and Measurement*, except for when an entity elects to designate a financial liability at fair value through the statement of comprehensive income. The new standard is required to be adopted for the year end 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 *Financial Instruments* will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Waikato DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Waikato DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Waikato DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Subsidiaries

Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the group 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 and fair value 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 an associate, 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 an associate.

Budget figures

The budget figures are made up of the Parent's Annual Plan which was tabled in Parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable financial reporting standards as appropriate for Public Benefit Entities. Those standards are consistent with the accounting policies adopted by Waikato DHB for the preparation of these financial statements.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

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 its objectives. Revenue from MoH is recognised as revenue when earned.

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. The Ministry of Health pays Waikato DHB with a 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 income
Interest income is recognised using the effective interest method.

Rental income
Rental lease income is recognised in the statement of comprehensive income on a straight-line basis over the term of the lease.

Provision of services
Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at balance date, based on the actual service provided as a percentage of the total services to be provided.

Donations and bequests
Donations and bequests to Waikato DHB and Waikato Health Trust (consolidated into Group accounts) are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are recognised in the Trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive income and an equivalent amount is transferred from the Trust component of equity to the statement of comprehensive income.

Capital charge

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

Borrowing costs

Waikato DHB has elected to defer adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions within this standard that are applicable to public benefit entities. Consequently, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases 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 statement of comprehensive income 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 statement of comprehensive income 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 using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses are recognised in the statement of comprehensive income.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, and bank overdrafts.

Trade and other 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.

Inventories

Inventories held for distribution or consumption are stated at the lower of cost and adjusted where applicable for any loss of service potential. The loss of service potential of inventory held for distribution or consumption is determined on the basis of obsolescence. The amount of any write-down for the loss of service potential is recognised in the statement of comprehensive income.

Non-current assets held for sale and discontinued operations

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 the statement of comprehensive income. 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:

- land
- buildings
- plant, equipment and vehicles
- work in progress.

Land and buildings
Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amounts are not materially different to fair value, and at least every five years. The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

The net revaluation results are credited or debited to other comprehensive income 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 income but is recognised in the expense section of the statement of comprehensive income. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the statement of comprehensive income will be recognised first in the expenses section of the statement of comprehensive income up to the amount previously expensed with the remainder then recognised as a movement in the revaluation reserve in the statement of comprehensive income.

Additions
The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that 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 at no cost, or for a nominal cost, 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 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 statement of comprehensive income 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 statement of comprehensive income. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to retained earnings.

Depreciation
Depreciation is charged to the statement of comprehensive income 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
Building structure including curtilage	15 - 75 years	1.3 - 6.7%
Building fit out including all other building services	3 - 50 years	2.0 - 33.3%
Plant and equipment	2 - 40 years	2.5 - 50.0%

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

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
Amortisation is charged to the statement of comprehensive income on a straight-line basis over the estimated useful lives. 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 statement of comprehensive income. The estimated useful lives and associated amortisation rates of the major classes of intangible assets are:

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

Impairment of property, plant, equipment and intangible assets

Property, plant, equipment and intangible assets 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. If any such indication exists, the entity shall estimate the recoverable amount of the asset. The recoverable 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 based on depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows, and where Waikato DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in the movement of revaluation reserve in the statement of comprehensive income to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised as an expense in the statement of comprehensive income. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the statement of comprehensive income.

The reversal of an impairment loss on a revalued asset is credited to movement in the revaluation reserve in the statement of comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised as an expense in the statement of comprehensive income, a reversal of the impairment loss is recognised as revenue in the statement of comprehensive income. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised as an expense in the statement of comprehensive income.

Trade and other payables

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

Borrowings

Borrowings are initially recognised at their fair value less transaction costs. 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. Borrowings where Waikato DHB has an unconditional right to defer settlement of the liability for at least twelve months after balance date are classified as current liabilities if Waikato DHB expects to settle the liability within twelve months of the balance date.

Employee benefits

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 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.

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.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution plans are recognised as an expense in the statement of comprehensive income 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 settlement payment will be required, and a reliable estimate can be made of the amount of the obligation. Provisions are not recognised for future operating losses.

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.

Equity

Equity is classified into the following components:

- Crown equity
- retained earnings
- revaluation reserves
- 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

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.

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 and long service leave
Note 18 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service liabilities.

Agency relationship
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 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Health and disability services (MoH contracted revenue)	1,049,215	1,011,634	1,049,215	1,011,634
ACC contract revenue	10,741	8,783	10,741	8,783
Revenue from other district health boards	121,982	124,887	121,982	124,887
Clinical Training Agency revenue	10,712	10,048	10,712	10,048
Other patient care related revenue	13,686	13,264	13,686	13,264
	1,206,336	1,168,616	1,206,336	1,168,616

2: Other operating income	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Donations and bequests received	541	446	1,183	770
Rental income	1,061	980	1,061	980
Net gain on sale of property, plant and equipment	23	12	23	12
Other income	13,802	13,460	13,802	13,460
	15,427	14,898	16,069	15,222

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

3: Finance income	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Interest income	1,505	1,342	1,338	1,139
	1,505	1,342	1,338	1,139

4: Personnel costs	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Salaries and wages	463,838	444,210	463,838	444,210
Increase/(decrease) in liability for employee entitlements	6,228	4,759	6,228	4,759
Contributions to superannuation schemes	12,756	9,979	12,756	9,979
	482,822	458,948	482,822	458,948

5: Property, plant and equipment	Group 2014 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2012	28,450	275,862	165,860	141,555	611,727
Additions	-	-	2,595	87,875	90,470
Transfers	-	121,616	15,919	(129,623)	7,912
Disposals	-	(577)	(2,069)	-	(2,646)
Reclassifications	30	70	(59)	-	41
Balance at 30 June 2013	28,480	396,971	182,246	99,807	707,504
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

5: Property, plant and equipment (continued)	Group 2014 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2012	-	27,934	108,341	-	136,275
Depreciation charge for the year	-	15,944	13,310	-	29,254
Disposals	-	(577)	(2,038)	-	(2,615)
Reclassifications	-	-	(6)	-	(6)
Balance at 30 June 2013	-	43,301	119,607	-	162,908
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
Carrying amounts					
At 1 July 2012	28,450	247,928	57,519	147,672	481,569
At 30 June 2013	28,480	353,670	62,639	99,807	544,596
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

5: Property, plant and equipment (continued)	Parent 2014 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2012	28,450	275,862	165,860	141,555	611,727
Additions	-	-	2,595	87,875	90,470
Transfers	-	121,616	15,919	(129,623)	7,912
Disposals	-	(577)	(2,069)	-	(2,646)
Reclassifications	30	70	(59)	-	41
Balance at 30 June 2013	28,480	396,971	182,246	99,807	707,504
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

5: Property, plant and equipment (continued)	Parent 2014 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2012	-	27,934	108,341	-	136,275
Depreciation charge for the year	-	15,944	13,310	-	29,254
Disposals	-	(577)	(2,038)	-	(2,615)
Reclassifications	-	-	(6)	-	(6)
Balance at 30 June 2013	-	43,301	119,607	-	162,908
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
Carrying amounts					
At 1 July 2012	28,450	247,928	57,519	141,555	475,452
At 30 June 2013	28,480	353,670	62,639	99,807	544,596
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

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 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.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.
- Buildings available for use and capitalised but awaiting final charges have not been revalued as the book value is assumed to be representative of the depreciated replacement cost.

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
Outstanding commitments for the acquisition of property, plant and equipment at 30 June 2014 total $14.5 million (2013:$33.2 million).

6: Intangible assets

Group 2014 Actual	Internally Generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2012	320	31,382	6,117	37,819
Additions	50	7,863	7,612	15,525
Disposals	-	-	(7,912)	(7,912)
Reclassifications	16	43	-	59
Balance at 30 June 2013	386	39,288	5,817	45,491
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)
Reclassifications	-	-	-	-
Balance at 30 June 2014	386	42,393	10,044	52,823
Amortisation and impairment losses				
Balance at 1 July 2012	50	24,933	-	24,983
Amortisation charge for the year	35	4,377	-	4,412
Disposals	-	-	-	-
Reclassifications	3	3	-	6
Balance at 30 June 2013	88	29,313	-	29,401
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)
Reclassifications	-	-	-	-
Balance at 30 June 2014	136	31,845	-	31,981
Carrying amounts				
At 1 July 2012	270	6,449	6,117	12,836
At 30 June 2013	298	9,975	5,817	16,090
At 1 July 2013	298	9,975	5,817	16,090
At 30 June 2014	250	10,548	10,044	20,842

6: Intangible assets (continued)

Parent 2014 Actual	Internally Generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2012	320	31,382	6,117	37,819
Additions	50	7,863	7,612	15,525
Disposals	-	-	(7,912)	(7,912)
Reclassifications	16	43	-	59
Balance at 30 June 2013	386	39,288	5,817	45,491
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)
Reclassifications	-	-	-	-
Balance at 30 June 2014	386	42,393	10,044	52,823
Amortisation and impairment losses				
Balance at 1 July 2012	50	24,933	-	24,983
Amortisation charge for the year	35	4,377	-	4,412
Disposals	-	-	-	-
Reclassifications	3	3	-	6
Balance at 30 June 2013	88	29,313	-	29,401
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)
Reclassifications	-	-	-	-
Balance at 30 June 2014	136	31,845	-	31,981
Carrying amounts				
At 1 July 2012	270	6,449	6,117	12,836
At 30 June 2013	298	9,975	5,817	16,090
At 1 July 2013	298	9,975	5,817	16,090
At 30 June 2014	250	10,548	10,044	20,842

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 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Net Impairment of trade receivables	89	318	89	318
Audit fees for the audit of the financial statements	205	201	190	186
Audit related fees for assurance and internal audits	-	15	-	15
Board members' remuneration and expenses	369	356	369	356
Operating lease expenses	5,999	6,727	5,999	6,727
Koha and donations	17	11	17	11
Loss on disposal of intangible assets	338	-	338	-
	7,017	7,628	7,002	7,613

8: Finance costs

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Interest and financing expenses	10,248	8,818	10,248	8,818
	10,248	8,818	10,248	8,818

9: Capital charge

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Capital charge	16,015	14,202	16,015	14,202
	16,015	14,202	16,015	14,202

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 2014 was 8% (2013:8%).

10: Investment in associate

a: General information

Name of entity	Principal activities	Interest held at 30 June 2014	Balance date
Urology Services Limited	Provision of urology services	50%	30 June

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

2014 Actual	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
Urology Services Limited	1,087	1,016	71	5,910	10
	1,087	1,016	71	5,910	10
2013 Actual					
Urology Services Limited	1,108	1,047	61	6,017	1
	1,108	1,047	61	6,017	1

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
c: Share of profit of associate (50%)	$000	$000	$000	$000
Share of profit before tax	5	1	5	1
Less: Tax expense	-	-	-	-
Share of profit after tax	5	1	5	1
d: Investment in associate (50%)				
Carrying amount at beginning of year	31	30	31	30
Share of associate surplus/(deficit)	5	1	5	1
Carrying amount at end of year	36	31	36	31

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 2014	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
b: Carrying amount of investment	$000	$000	$000	$000
Opening Balance	194	38	194	38
Share of joint venture surplus/(deficit)	26	156	26	156
Closing Balance	220	194	220	194
c: Summary of Waikato DHB's interests in HealthShare Limited (20%)				
Current assets	527	500	527	500
Non-current assets	581	133	581	133
Current liabilities	(738)	(439)	(738)	(439)
Non-current liabilities	(150)	-	(150)	-
Net assets	220	194	220	194
Revenue	1,538	1,529	1,538	1,529
Expenses	(1,512)	(1,373)	(1,512)	(1,373)
Share of surplus of joint venture	26	156	26	156

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 2012	5,750	59,901	52,730	68,546	186,927
Total comprehensive income/(expense)	(136)	-	-	2,188	2,052
Capital contributions from the Crown	-	26,139	-	-	26,139
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Other movement	1	-	-	3	4
Balance at 30 June 2013	5,615	83,846	52,730	70,737	212,928
Balance at 1 July 2013	5,615	83,846	52,730	70,737	212,928
Total comprehensive income/(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

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 2012	59,901	52,730	68,546	181,177
Total comprehensive income/(expense)	-	-	2,188	2,188
Capital contributions from the Crown	26,139	-	-	26,139
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	-	-	3	3
Balance at 30 June 2013	83,846	52,730	70,737	207,313
Balance at 1 July 2013	83,846	52,730	70,737	207,313
Total comprehensive income/(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

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 27.

13: Cash and cash equivalents	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Bank balances	(91)	(207)	(91)	(207)
Trust funds	5,120	5,901	-	-
	5,029	5,694	(91)	(207)

14: Receivables and prepayments	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Ministry of Health trade receivables	2,958	2,339	2,958	2,339
Other trade receivables	3,479	4,537	3,459	4,520
Total trade receivables	6,437	6,876	6,417	6,859
Ministry of Health accrued income	13,329	10,195	13,329	10,195
Other accrued income	3,099	3,927	3,099	3,927
Prepayments	4,805	3,498	4,805	3,498
	27,670	24,496	27,650	24,479

Receivables and accrued income are shown net of impairment losses (provision for doubtful debts) amounting to $0.94 million (2013:$1.15 million). The carrying value of debtors and other receivables approximates their fair value.

14: Receivables and prepayments (continued)	Group 2014 Actual		Group 2013 Actual	
Trade receivables	Gross Receivable	Impairment	Gross Receivable	Impairment
The ageing profile of trade receivables and their impairment is:				
	$000	$000	$000	$000
Not past due	2,955	-	3,841	-
Past due 0-30 days	2,910	-	2,322	-
Past due 31-120 days	750	164	648	223
Past due 121-360 days	404	215	324	231
Past due more than 1 year	363	566	891	696
	7,382	945	8,026	1,150

	Parent 2014 Actual		Parent 2013 Actual	
Trade receivables	Gross Receivable	Impairment	Gross Receivable	Impairment
	$000	$000	$000	$000
Not past due	2,935	-	3,824	-
Past due 0-30 days	2,910	-	2,322	-
Past due 31-120 days	750	164	648	223
Past due 121-360 days	404	215	324	231
Past due more than 1 year	363	566	891	696
	7,362	945	8,009	1,150

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 and prepayments (continued)	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Movements in provision for impairment of trade receivables are as follows:	$000	$000	$000	$000
At 1 July	1,150	1,322	1,150	1,322
Provisions made/(reversed) during the year	69	318	69	318
Bad debts written off during the year	(291)	(502)	(291)	(502)
Bad debts recovered during the year	17	12	17	12
At 30 June	945	1,150	945	1,150

15: Inventories	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Pharmaceuticals	454	452	454	452
Surgical and medical supplies	7,791	6,669	7,791	6,669
Other supplies	818	762	818	762
	9,063	7,883	9,063	7,883

The amount of inventories recognised as revenue due to change in stock value during the year was $307,000 (2013: $274,000), which is included in the clinical supplies line item in the statement of comprehensive income.

Write-down of inventories amounted to $316,000 for 2014 (2013:$363,000). The provision for obsolete inventories adjustment recognised as expenses during the year ended 30 June 2014 was $Nil (2013:$Nil). No inventories are pledged as security for liabilities.

16: 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.

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Land	40	40	40	40
	40	40	40	40

17: Borrowings	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Current	$000	$000	$000	$000
Loan from Health Benefits Limited	15,677	39,285	15,677	39,285
Loan from HealthShare Limited	1,303	977	1,303	977
Loan from Energy Efficiency and Conservation Authority	154	111	154	111
Finance leases	76	-	76	-
	17,210	40,373	17,210	40,373
Non-current				
Crown loans	211,659	191,659	211,659	191,659
Loan from Energy Efficiency and Conservation Authority	274	221	274	221
Finance leases	422	-	422	-
	212,355	191,880	212,355	191,880
Loan facility limits				
Crown loans	211,659	211,659	211,659	211,659
Loan from Health Benefits Limited	63,432	62,038	63,432	62,038

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.

17:Borrowings (continued)

The fair value of Crown loan borrowings is $214.3 million (2013:$199.4 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.

Finance leases	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Minimum lease payments payable	$000	$000	$000	$000
No later than one year	76	-	76	-
Later than one year and not later than five years	422	-	422	-
Later than five years	-	-	-	-
Total minimum lease payments	498	-	498	-
Future finance charges	(49)	-	(49)	-
Present value of minimum lease payments	449	-	449	-
Present value of minimum lease payments payable:				
No later than one year	74	-	74	-
Later than one year and not later than five years	375	-	375	-
Later than five years	-	-	-	-
Total present value of minimum lease payments	449	-	449	-

17: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 $449,000 (2013: $Nil). 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 have been classed as to be finance leases.

18: Employee entitlements	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Current	$000	$000	$000	$000
Liability for long service leave	2,722	2,524	2,722	2,524
Liability for retirement gratuities	2,844	2,495	2,844	2,495
Liability for annual leave	50,150	48,565	50,150	48,565
Liability for sick leave	786	823	786	823
Liability for continuing medical education leave and expenses	11,222	10,820	11,222	10,820
PAYE payable	6,008	5,736	6,008	5,736
Salary and wages accrual	14,476	10,778	14,476	10,778
	88,208	81,741	88,208	81,741
Non-current				
Liability for long service leave	966	1,456	966	1,456
Liability for sabbatical leave	3,394	2,543	3,394	2,543
Liability for retirement gratuities	9,206	9,806	9,206	9,806
	13,566	13,805	13,566	13,805

18: Employee entitlements (continued)

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 4.5% (2013:4.0%) and a salary inflation factor of 3.5% (2013:3.5%) was used.

19: Trade and other payables

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	$000	$000	$000
Trade payables and accruals to non-related parties	57,624	48,190	57,609	47,887
ACC levy payable	2,393	1,657	2,393	1,657
GST payable	7,992	6,087	7,992	6,087
Income in advance	453	897	453	897
Capital charge to the Crown	505	450	505	450
	68,967	57,281	68,952	56,978

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.

20: Provisions

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	576	648	576	648
Motor vehicle repairs on disposal	55	32	55	32
	631	680	631	680
Non-current				
Motor vehicle repairs on disposal	492	336	492	336
	492	336	492	336

Movements for each class of provision	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2012	744	221	965
Additional provisions made	253	249	502
Amounts used	(349)	(102)	(451)
Balance at 30 June 2013	648	368	1,016
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

20: Provisions (continued)

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 2014. The actuary 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 actuary's report.

A prudent margin of 11% (2013:11%) 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 2.5% per annum (2013: 2.4%); and
- a discount factor of 2.95% for 30 June 2014 (2013:3.5%).

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

	Note	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
		$000	$000	$000	$000
Net surplus/(deficit)		3,357	2,052	3,847	2,188
Add/(less) non-cash items:					
Depreciation	5	34,425	29,254	34,425	29,254
Amortisation	6	4,006	4,412	4,006	4,412
Impairment of intangible asset		1,191	1,191	1,191	1,191
Bad and doubtful debts	14	89	318	89	318
Share of associate (surplus)/deficit	10	(5)	1	(5)	1
Share of joint venture (surplus)/deficit	11	(26)	(156)	(26)	(156)
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	2	(23)	(12)	(23)	(12)
Net loss/(gain) on disposal of intangible assets	3	338	-	338	-
(Increase)/decrease in fixed asset creditor		(1,643)	(627)	(1,643)	(627)
Add/(less) movements in statement of financial position items:					
(Increase)/decrease in inventories	15	(1,180)	(262)	(1,180)	(262)
(Increase)/decrease in receivables and prepayments	14	(3,174)	1,820	(3,171)	1,836
Increase/(decrease) in employee entitlements	18	6,228	4,759	6,228	4,759
Increase/(decrease) in trade and other payables	19	12,026	(6,129)	11,974	(6,418)
Increase/(decrease) in other provisions	20	107	51	107	51
Increase/(decrease) in finance leases	17	(498)	-	(498)	-
Net cash inflow from operating activities		55,218	36,672	55,659	36,535

22: Capital commitments and operating leases

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Capital commitments	**$000**	**$000**	**$000**	**$000**
Property, plant and equipment	13,761	33,249	13,761	33,249
Intangible assets	706	2,552	706	2,552
	14,467	35,801	14,467	35,801

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 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
	$000	**$000**	**$000**	**$000**
Not more than one year	4,622	4,507	4,622	4,507
One to two years	4,247	3,557	4,247	3,557
Two to three years	2,575	3,093	2,575	3,093
Three to four years	587	2,354	587	2,354
Four to five years	109	539	109	539
Over five years	15	81	15	81
	12,155	14,131	12,155	14,131

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.

23: Contingencies

	Group 2014 Actual	Group 2013 Actual	Parent 2014 Actual	Parent 2013 Actual
Contingent liabilities	**$000**	**$000**	**$000**	**$000**
Personal grievances	210	260	210	260
Legal proceedings and disputes by third parties	10	30	10	30
	220	290	220	290

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 2014 (2013:$Nil).

24: 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 Income, Statement of Financial Position or Statement of Cash Flows.

	2014 Actual	2013 Actual
	$000	**$000**
Balance at 1 July	19	38
Receipts	77	127
Payments	(76)	(146)
Balance at 30 June	20	19

25: Financial instruments

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

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 (32% at 30 June 2014). 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 contractual maturity date. The amounts disclosed are contractual undiscounted cash flows.

	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
Loan from Energy Efficiency and Conservation Authority	428	428	52	52	104	220	-
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	85,999	52	104	220	211,659

	Group 2013 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	191,659	191,659	-	-	-	-	191,659
Loans from Energy Efficiency and Conservation Authority	332	332	52	52	104	124	-
Loan from HealthShare Limited	39,285	39,285	39,285	-	-	-	-
Unsecured bank facility	977	977	977	-	-	-	-
Trade and other payables	57,281	57,281	57,281	-	-	-	-
	289,534	289,534	97,595	52	104	124	191,659

25: Financial instruments (continued)

	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
Loan from Energy Efficiency and Conservation Authority	428	428	52	52	104	220	-
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	85,984	52	104	220	211,659

	Parent 2013 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	191,659	191,659	-	-	-	-	191,659
Loan from Energy Efficiency and Conservation Authority	332	332	52	52	104	124	-
Loan from HealthShare Limited	39,285	39,285	39,285	-	-	-	-
Unsecured bank facility	977	977	977	-	-	-	-
Trade and other payables	56,978	56,978	56,978	-	-	-	-
	289,231	289,231	97,292	52	104	124	191,659

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.

Interest rate risk
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 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.

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

At 30 June 2014, it is estimated that a general increase of one percentage point in interest rates would decrease the surplus by approximately $200,000 (2013:$400,000).

Foreign currency risk
Foreign exchange 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 foreign 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 2014 Waikato DHB had no forward foreign currency agreements outstanding (2013:$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.

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

27: 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.

	2014 Actual	2013 Actual
Loans from related parties	**$000**	**$000**
HealthShare Limited	1,303	977
	1,303	977

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 $1.049 billion (2013:$1.012 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2014 was $2.641 million (2013:$2.3 million). Waikato DHB incurred a capital charge of $16.0 million (2013:$14.2 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 2014 of $10.7 million (2013:$8.8 million) to provide health services.

27: 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 2014 was $122.0 million (2013:$124.9 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2014 was $48.9 million (2013:$47.6 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 2014 totalled $17.6 million (2013:$20.5 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. The Group's share of the retained earnings of HealthShare Limited for the 12 months ending 30 June 2014 amounted to $25,669 (2013:$156,380).

During the year Waikato DHB received $611,906 (2013: $392,390) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $4,619,833 (2013:$4,722,088) for services provided.

As at 30 June 2014 Waikato DHB owed HealthShare Limited $311,517 (2013:$443,146), and HealthShare Limited owed Waikato DHB $13,184 (2013:$525,648).

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.

As at 30 June 2014, HealthShare Limited had total assets of $5.542 million (2013:$3.285 million) and total liabilities of $4.441 million (2013:$2.314 million).

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

This investment in associate for Waikato DHB comprises 500 shares of $1 each and its share of undistributed post-acquisition surpluses as at 30 June 2014 amounting to $35,772 (2013:$30,615).

No dividends have been received from Urology Services Limited. During the period Waikato DHB received inpatient urological services from Urology Services Limited of $5.75 million (2013: $5.7 million). Waikato DHB received facility and management service fees of $2.8 million (2013: $3.0 million) from Urology Services Limited. During the period Waikato DHB's share of revenue amounted to $2.95 million (2013:$2.7 million) from Urology Services Limited.

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 2014 are Pippa Mahood, Maureen Chrystall and Mary Anne Gill. 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. As at 30 June 2014 the Waikato Health Trust had total assets of $5.14 million (2013:$5.92 million) and total liabilities of $15,000 (2013:$306,000).

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $1,089,320 (2013:$737,508). There was $Nil owing to Waikato District Health Board at 30 June 2014 (2013:$287,615).

27: Related parties (continued)

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 , Genesis Energy for gas and electricity, 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, Waikato Heart Trust for professional 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 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 and Brett Paradine are directors, Health Benefits Limited where Craig Climo is a director, Waikato Health Trust where Mary Anne Gill, Maureen Chrystall and Pippa Mahood are Trustees, Wolstencroft & Associates where Ian Wolstencroft is a shareholder and director, and Urology Services Limited where Maureen Chrystall is a director.

27: Related parties (continued)

The aggregate value of transactions and outstanding balances relating to Board members and executives and the entities which they have control or significant influence were as follows:

		Transaction value year ended 30 June		Balance outstanding as at 30 June	
Board members	**Transaction**	**2014 Actual**	**2013 Actual**	**2014 Actual**	**2013 Actual**
		$000	**$000**	**$000**	**$000**
Bob Simcock*	Waikato Regional Council (supplier)	4	-	-	-
Chairman	*Facilities*				
Bob Simcock*	Life Unlimited (supplier)	10	-	-	-
Wife is a Trustee of Life Unlimited	*Private Hospitals & Resthomes*				
Clyde Wade	Midland Cardio Vascular (supplier)	1,351	3,991	3	-
	Midland Cardio Vascular (client)	2	3	-	-
Shareholder	*Clinical Services*				
Martin Gallagher	Hamilton City Council (supplier)	1,002	2,842	32	-
Chairman					
Ewan Wilson					
Councillors	*Facilities*				
Gay Shirley	Braemar Hospital (supplier)	3,776	3,114	329	86
	Braemar Hospital (client)	2	7	-	-
Husband is a Trustee of Braemar Charitable Trust**	*Clinical services*				
Sharon Marui	National Health Committee (client)	-	9	-	2
Member	*Professional Services*				
Grame Milne***	Genesis Energy (supplier)	2,220	2,344	-	-
Director	*Facilities*				

* New board member from December 2013
** Braemar Charitable Trust (the Trust owns all the shares in Braemar Hospital Limited).
*** No longer a member of the Board but had influence for a significant portion of the year so included for related parties purposes.

27: Related parties (continued)

Board members	Transaction	Transaction value year ended 30 June 2014 Actual	Transaction value year ended 30 June 2013 Actual	Balance outstanding as at 30 June 2014 Actual	Balance outstanding as at 30 June 2013 Actual
		$000	$000	$000	$000
Grame Milne* **	Massey university (client)	-	2	-	-
	Massey university (supplier)	19	-	-	-
Member of Advanced Engineering & Technolgy Advisory Board	*Staff Development*				
Deryck Shaw* **	Lakes District Health Board (supplier)	254	249	(619)	2
	Lakes District Health Board (client)	1,545	1,954	46	279
Chairman	*Clinical Services*				
Deryck Shaw*	Central Regions Technical Advisory Services (supplier)	2,109	-	-	-
Director	*Non-clinical Professional Services*				
Harry Mikaere* **	Te Korowai Hauora O Hauraki (supplier)	129	156	11	7
Chairman	*General Practitioner Clinical Services*				
Harry Mikaere* **	Hauraki PHO (client)	-	5	-	-
Chairman	*Staff Development*				
Harry Mikaere* **	Coromandel Marine Farmers Limited (client)	24	30	-	12
Shareholder	*Marine Farming*				
Pippa Mahood	Waikato Health Trust (supplier)	50	-	-	-
	Waikato Health Trust (client)	1,089	738	-	288
Trustee	*Health funding*				

*** No longer a member of the Board but had influence for a significant portion of the year so included for related parties purposes.

27: Related parties (continued)

Executives	Transaction	Transaction value year ended 30 June 2014 Actual	Transaction value year ended 30 June 2013 Actual	Balance outstanding as at 30 June 2014 Actual	Balance outstanding as at 30 June 2013 Actual
		$000	$000	$000	$000
Craig Climo	National Health Committee (client)	-	9	-	2
Member	*Professional Services*				
Craig Climo	Health Benefits Limited (supplier)	2,499	858	139	44
	Health Benefits Limited (client)	245	64	-	63
Director	*Professional services*				
Craig Climo	HealthShare Limited (supplier)	4,620	4,722	436	365
Director	HealthShare Limited (client)	638	482	13	49
Brett Paradine					
Alternate Director	*Professional services*				
Neville Hablous	Hamilton Residential Trust (supplier)	-	2	-	-
Trustee	*Disability Support Services*				
Darrin Hackett*	HIQ Ltd (supplier)	-	419	-	-
	HIQ Ltd (client)	-	183	-	-
General Manager	*Project Director services*				
Ian Wolstencroft	Wolstencroft and Associates (supplier)	289	449	-	32
Shareholder and Director	*Project Director Services*				
Maureen Chrystall	Urology Services Limited (client)	3,666	3,133	261	483
Director	*Clinical Services*				
Maureen Chrystall	Waikato Health Trust (supplier)	50	-	-	-
Trustee	Waikato Health Trust (client)	1,089	738	-	288
Mary Anne Gill					
Trustee	*Health funding*				

* No longer associated with HIQ Ltd

28: Key management personnel remuneration

Compensations

There were no loans to board members during the year ended 30 June 2014 (2013:$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 2014 (2013:$Nil).

Remuneration

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

	2014 Actual	2013 Actual
	$000	$000
Salaries and other short-term benefits	3,072	3,161
Contributions to superannuation schemes	77	56
	3,149	3,217

Board members	No. of meetings elligible to attend 2014	No. of meetings actually attended 2014	Remuneration 2014 Actual	Remuneration 2013 Actual
			$	$
Bob Simcock	15	15	31,355	-
Sally Christie	27	25	36,875	35,813
Crystal Beavis	10	8	14,758	-
Andrew Buckley	23	23	29,250	28,250
Martin Gallagher	21	21	27,750	28,000
Tania Hodges	8	7	14,758	-
Pippa Mahood	16	14	27,063	26,250
Sharon Mariu	21	19	27,688	28,563
Harry Mikaere	6	6	13,500	25,750
Graeme Milne	13	12	28,875	54,750
Deryck Shaw	4	4	12,750	25,000
Gay Shirley	23	21	29,000	29,188
Clyde Wade	24	22	28,250	29,500
Ewan Wilson	19	19	28,000	27,250
			349,872	338,314

28: Key management personnel remuneration (continued)

Non-board members who attended committee meetings	No. of meetings elligible to attend 2014	No. of meetings actually attended 2014	Remuneration 2014 Actual	Remuneration 2013 Actual
			$	$
Paul Malpass	4	4	1,250	1,250
Robyn Klos	4	4	1,250	1,000
Ross Lawrenson	6	4	1,000	1,250
John Macaskill-Smith	6	3	1,000	500
John McIntosh	6	1	250	1,000
Fungai Mhlanga	6	5	1,500	1,250
Tureiti Moxon	4	-	-	250
Ken Price	4	1	500	1,000
David Slone	6	5	1,250	1,250
Tipa Mahuta	6	-	-	250
Piki Taiaroa	6	-	250	250
Mary Burdon	1	1	250	-
David Stewart	1	1	250	-
Yvonne Boyes	1	1	-	-
Rob Vigor-Brown	1	1	-	-
Alisa Gathergood	1	1	-	-
Ron Scott	1	1	-	-
			8,750	9,250

June 2014 meeting attendances will be paid in the next financial year.

29: Employee remuneration

Employee remuneration over $100,000 ($10,000 bands)	2014 Actual	2013 Actual
100,001 - 110,000	113	125
110,001 - 120,000	75	91
120,001 - 130,000	63	59
130,001 - 140,000	45	53
140,001 - 150,000	27	33
150,001 - 160,000	13	28
160,001 - 170,000	24	21
170,001 - 180,000	20	23
180,001 - 190,000	25	21
190,001 - 200,000	24	24
200,001 - 210,000	21	17
210,001 - 220,000	17	17
220,001 - 230,000	23	17
230,001 - 240,000	23	18
240,001 - 250,000	10	27
250,001 - 260,000	22	21
260,001 - 270,000	18	14
270,001 - 280,000	16	13
280,001 - 290,000	8	15
290,001 - 300,000	19	14
300,001 - 310,000	18	11
310,001 - 320,000	13	10
320,001 - 330,000	4	10
330,001 - 340,000	6	5
340,001 - 350,000	10	4

29: Employee remuneration (continued)

Employee remuneration over $100,000 ($10,000 bands)	2014 Actual	2013 Actual
350,001 - 360,000	2	2
360,001 - 370,000	3	4
370,001- 380,000	5	1
380,001 - 390,000	1	3
390,001 - 400,000	1	1
400,001 - 410,000	1	3
410,001 - 420,000	1	-
430,001 - 440,000	-	-
460,001 - 470,000	-	-
480,001 - 490,000	-	1
490,001 - 500,000	1	-
530,001 - 540,000	-	1
540,001 - 550,000	1	-
630,001 - 640,000	-	-
680,001 - 690,000	1	1
	674	708

Of the 674 (2013:708) employees shown above, 85% or 574 (2013:603) are or were clinical employees. If the remuneration of part time employees were grossed up to full time equivalent basis, the total number of employees with remuneration of $100,000 or more would be 717 (2013:752).

The 2013 actual includes 27 fortnightly pay runs for some employees, compared to the standard 26 fortnightly pay runs in 2014.

The remuneration of the Chief Executive for the year ended 30 June 2014 was in the $490,001 to $500,000 band (2013:$480,001 - $490,000). Unlike the other employees shown above, the remuneration of the Chief Executive is calculated on a total remuneration basis and includes non-monetary benefits.

29: Employee remuneration (continued)

Termination payments
During the year the Board made payments to eight employees (2013:31) in respect of the termination of employment with the Waikato DHB.

	2014 Actual	2013 Actual
	$000	$000
Amount paid	328	595

30: Subsequent event

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

31: Comparative information

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

32: Explanation of financial variances from budget

Waikato DHB recorded a net surplus of $3.8 million against its annual plan budget of $1.8 million. Explanations of major variances are:

Variances in comprehensive income:
Waikato DHB recorded a $2.0 million favourable variance to budget. This includes:

- revenue is $12.2 million favourable due to additional funding for extra health services delivered
- interest, depreciation and capital charge costs are $3.0 million favourable due to slower than planned capital expenditure
- personnel costs are $6.1 million unfavourable with some offset in outsourced services due to use of contractors
- outsourced services are $12.4 million unfavourable due to later than planned

32: Explanation of financial variances from budget (continued)

commissioning of the theaters resulting in higher outsourcing of clinical services to meet elective targets.

- clinical supplies are $2.4 million unfavourable due to higher than planned use of disposable supplies in theaters and radiology
- other expenses are $7.3 million favourable due to less health services provided to other district health boards than planned

Variances in statement of changes in equity:
- The surplus was $2.0 million favourable to budget due to the statement of comprehensive income explanations provided above.

Variances in financial position:
Current assets are $1.6 million lower than budgeted due to:

- inventories $1.4 million higher than budgeted due to conversion of consignment stock to owned stock
- receivables and prepayments $3.0 million lower than budgeted due to improvements in credit controls and timing of revenue accruals

Current liabilities are $6.4 million lower than planned due lower than planned capital spend resulting in lower borrowings, partly offset by trade and other payables being higher than budgeted.

Non-current assets are $23.2 million lower than budget due to lower than planned capital spending in the 2012/13 year after budgeting was completed resulting in the budgeted opening balance being high.

Non-current liabilities are $21.4 million lower than planned as draw downs on term loans were slower than planned due to slower than planned capital spend.

Variances in cash flows:
- Net cash flows from operating activities are $59.9 million higher than budgeted due to an increase in payments to suppliers partly offset by a decrease in payments to employees
- Net cash flows from investing activities are $18.0 million higher than budgeted due to acquisition of property, plant and equipment being lower than budgeted due to slower than planned capital spend
- Borrowings are lower than planned due slower than planned capital spend.

Part 4 Audit Report

Audit report

P.178

P.180