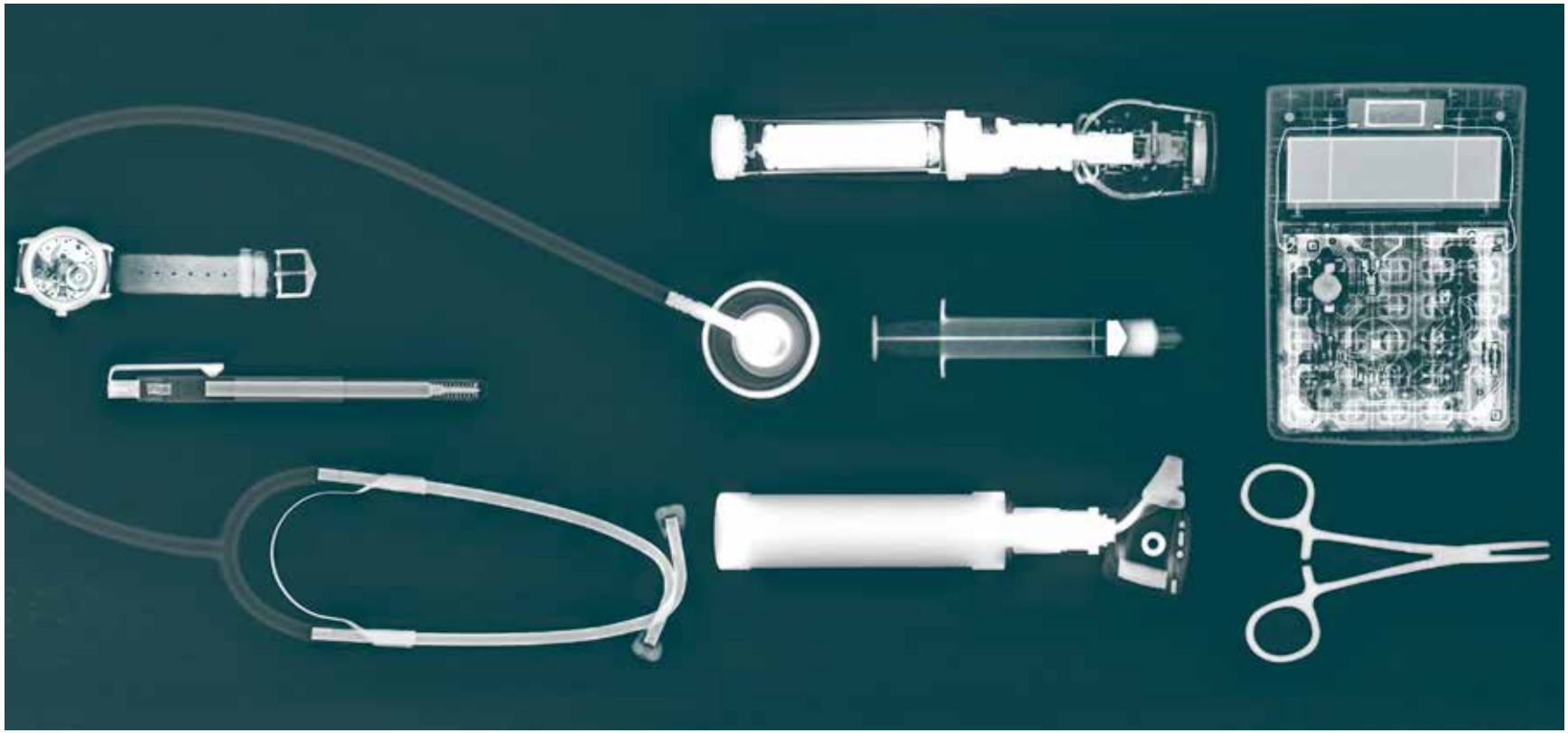
Waikato District Health Board
Annual Report

12/13

Te Hanga Whaioranga Mō Te Iwi

Building Healthy Communities



Waikato District Health Board

Our performance in summary

Emergency Department presentations
▲ 2.36%
2012 99,596
2013 101,944

Inpatient discharges
▲ 5.48%
2012 77,808
2013 82,068

All surgical operations
▲ 3.16%
2012 26,272
2013 27,102

Outpatient attendances
▼ 2.30%
2012 207,336
2013 202,558

Did not attend outpatient clinics
▼ 4.31%
2012 21,717
2013 20,781

Patient meals
▲ 2.71%
2012 759,511
2013 780,122

Meals on Wheels
▲ 3.29%
2012 50,699
2013 52,365

Elective operations (including those for other DHBs)
▲ 4.96%
2012 15,783
2013 16,566

Mental health admissions
▼ 7.6%
2012 1,593
2013 1,472

Mental health community visits
▲ 4.41%
2012 156,554
2013 163,458

Chemotherapy attendances
▲ 6.55%
2012 7,241
2013 7,715

Radiology examination attendances
▲ 30.6%
2012 102,878
2013 134,386

Radiotherapy attendances
▲ 5.65%
2012 25,793
2013 27,250

Births (3,577 at Waikato Hospital in 2013)
▲ 1.23%
2012 3,975
2013 4,024

Breast screen tests
▼ 1.36%
2012 34,975
2013 34,500

District nurse community visits
▼ 0.82%
2012 138,555
2013 137,414

Contents

P.04 Board statement

It is a pleasure to report on another year of progress towards improving the health of our population and reducing or eliminating health inequalities.

Total expenditure this year was $1.2 billion reflecting the size of our population, and its age, gender, ethnicity and socio-economic status.

Significant changes to healthcare funding emerged following the global financial crisis across Europe. It does have a plus side for Waikato DHB as we are seeing the return of our New Zealand trained medical professionals and we are now able to attract people into some specialist roles where we struggled in the past.

Our ageing population trends and the consequent higher percentage of chronic conditions means individuals have to be proactive about their personal health situation. The continuum of care between primary and secondary care takes on even greater significance and care in the community is just as important as care in hospital.

Over the next few pages, you can read the Waikato DHB performance story for the year starting 1 July 2012. There are some good successes and some areas where we need to continue to improve.

Highlights were that we came in $1 million ahead of budget, we delivered further major buildings and facilities on time and on budget and our work behind the scenes to get a rural health hub in Tokoroa got underway reinforcing an ever-strengthening relationship between primary and secondary care in the South Waikato.

There were other successes too.

After years of debate and tension about a sustainable model to deliver integrated rural health care in the north Ruapehu district, we worked in partnership with a number of community providers and have developed new models of care, which when implemented will result in primary and secondary providers working collaboratively so that patients get the best possible care.

The Waikato DHB funded and Sport Waikato delivered Project Energize, a health and fitness project covering 44,000 children in Waikato primary schools rolled out to pre-schoolers and their families.

Research shows that we are already seeing lower obesity rates in our children compared to the national average and that Waikato children are even running faster than the same age groups in other regions.

Our Supported Transfer and Accelerated Rehabilitation Team (START), which provides intensive rehabilitation in patients' homes is another example of Waikato DHB thinking outside of traditional care delivery for the good of the patient. Setting rehabilitation goals and then having multi disciplinary teams from the DHB going into their homes to help achieve them, has resulted in some excellent results for patients.

To further our partnership with primary care, the START service sits in an integrated family health centre.

Our elective surgery delivery performance, while in the midst of a huge campus rebuilding programme, is a credit to our clinicians, administrators and management. We completed 16,566 elective surgical procedures – a 5 percent increase on the year before.

We opened stage one of the Meade Clinical Centre, the High Dependency and Intensive Care units, Older Persons and Rehabilitation Building, the Regional Renal Centre, demolished the Smith Building floor by floor and refurbished several of the existing wards. All of these significant projects placed demands on the services and we continued to deliver services whilst planning and implementing significant change processes.

We also achieved extended three-year certification across all our hospitals, a first for Waikato DHB.

Information Technology is an area of great opportunity but immediate challenge for Waikato DHB as it is for the wider health sector. As it is a key enabler we prioritise our scarce health dollars to invest in this area.

A telemedicine trial between Taumarunui and Waikato hospitals' emergency departments is an example of how IT can help the DHB deliver in an area where clinical sustainability is a challenge. This offers opportunities for future development.

The PACS Extended Imaging solution enabled the Waikato DHB to achieve a number of key objectives through:

- reducing paper records
- centralisation of images
- providing greater access to digital images
- providing clinicians the ability to view digital images remotely to allow a clinical opinion to aid in the patient's treatment path.

The implementation of Vocera (a wearable wireless communication system) within Critical Care, Older Persons and Rehabilitation and the new theatres and interventional suites, delivered significant communication enhancements through:

- instant hands free communication
- reduction in time locating key staff
- increased time on patient care
- the ability during emergencies to communicate to a wide audience instantly.

Whilst we have done very well on most of the national health targets, we still struggle with two of them. Despite improvements on the previous year efficiencies, we did not achieve the six-hour shorter stays in emergency department target.

- Growth in attendances of 2.4 percent added to our challenge and this was on top of the 11 per cent growth in the previous year caused by a number of factors including chronic conditions, active lifestyles and our roading network, which results in more motor vehicle accidents in this region than any other DHB.

- The ongoing building reconstruction and moves by wards, clinics and services around Waikato Hospital has not helped either. The expectation is that once we complete the work, and have full utilisation of the new clinical services, this along with other improvements will get us much closer.

We achieved the smoking target of 95 percent of hospitalised smokers provided with advice and help to quit in the last quarter and this continues to be one we have to keep our eye on. Getting someone help to quit smoking is one of the biggest differences we can make on health outcomes in the DHB.

To reach a smoke free Aotearoa by 2025 our Māori health team placed Tupeka Kore kawenata (tobacco free covenants) across a variety of services and organisations including Te Puna Oranga, Midland Cancer Network, Population Health, Bright Stars (Bilingual early childhood centre) and Bernard Fergusson Kura Kaupapa.

We launched Project 270, an initiative that seeks to mitigate the effects of child/whānau poverty.

We completed the Warm our Whare initiative for the 2012-2013 year and we insulated 380 homes for high needs whānau and generated more than 1000 referrals.

Pepi/babies and tamariki/children with high needs, benefited from this and we will look to insulate a further 400 homes over the next 12 months.

As part of Project 270 we launched a Kai in Schools (KIS) initiative in conjunction with KidsCan to feed hungry children from low income families. Our funding extended KidsCan's Food in Schools initiative to 23 decile 1 and 2 schools across the greater Waikato.

Our Māori Health team leads the largest Pepi-Pod initiative in the country having established 25 Māori and mainstream hospital and community-based providers across the Waikato District to distribute 2000 Pepi-Pods to vulnerable whānau.

We can see the finish line to our building programme. We have spent approximately $500 million at mainly Thames and Waikato hospitals over the last five years and have done it in an envelope we can afford to finance.

The remaining big issue is the replacement of many of our wards at Waikato Hospital but we do need a break to repay debt so we have the financial capacity.

This is my last report as board chair. After five years in the role, I must say how impressed I am at the dedication of our health teams throughout the Waikato. Health is an area where everything we do affects peoples' lives. It takes a team who really care and are willing to go the extra mile. I see these qualities wherever I go in the organisation and therefore it has been a real privilege to be part of the Waikato DHB.

I have also enjoyed working with our skilled and dedicated executive team led by Craig Climo who collectively took health services in the Waikato to a significantly improved level over the last few years.

Lastly, many thanks to my fellow board members for their dedication and hard work during the year.

Graeme Milne

Our Board

Graeme Milne - Waikato DHB Chair from 18 May 2009

Reappointed: 6 December 2010

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 & J A Milne.

Sally Christie - Deputy chair

Re-elected: 6 December 2010

Partner, Mr Michael O'Donnell, works for Work Wise Trust which is in receipt of some funding from Waikato DHB.

Andrew Buckley

Elected: 6 December 2010

Company Director of "Crannog Ltd"
Trustee of "Golden 8" Family Trust
Primary Health Practice Principal – Osteopathic Medicine Clinic
Wife is an employee of Waikato DHB (nurse).

Gay Shirley

Reappointed: 20 December 2010

Owner, Chartered Accountant in Private Practice
Director, Waikato Regional Airport Limited
Director, Titanium Park Limited
Director, Alandale Lifecare Limited
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 Limited).

Pippa Mahood

Re-elected: 6 December 2010

Hamilton City Council Portfolio:

- Community Development Committee
- City Planning and Development Committee
- Civil Defence Emergency Management Committee
- District Plan Review
- Statutory Management Committee

Trustee, Waikato Health and Disability Expo Trust
Member, Opus Trust Board
Husband retired respiratory consultant from Waikato DHB.

Ewan Wilson

Elected: 6 December 2010

Hamilton City Councillor
Director/Shareholder MEW Developments Ltd
Director of Grand Journey by Wilson Tours Ltd
Director of Wilson Aviation Ltd
Daughter is an employee of Waikato DHB.

Sharon Mariu

Appointed: 6 December 2010

Director and Shareholder, THS & Associates Ltd
Director, P.O.W. Partnership Ltd
Director and Shareholder, Plus Potential Investments Ltd
Director and Shareholder, New Zealand Sports Academy International Ltd
Chair, Oraukura 3 Incorporation
Shareholder, New Zealand Sports Academy Ltd
Member, National Health Committee.

Clyde Wade

Elected: 6 December 2010

Employee of Waikato District Health Board (cardiologist)
Shareholder, Midland Cardiovascular Services, which holds a contract with Waikato DHB (until 2012)
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.

Deryck Shaw

Appointed: 28 May 2012

Director/Owner of APR Consultants Limited
Director/Shareholder:
- APR Group
- Principal Holdings Rotorua Limited
- Partner, Shaw Property Partnership

Chair:
- Lakes District Health Board
- Rotorua United AFC – Not for profit Soccer/ Football Club
- New Zealand Walking Association (Inc) Organiser of walking events in Rotorua Walking Festival

Board Member:
- NZ Maori Arts and Crafts Institute – Te Puia
- 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).

Martin Gallagher

Elected: 6 December 2010

Member of Hamilton City Council
Hamilton City Council Portfolio:
- Chair, Operations & Activity Performance Committee
- Chair, Civic Subcommittee
- Member, Strategy & Policy Committee
- Member, Finance & Monitoring Committee
- Member, District Plan Review Steering Group

Board Member, 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.

Harry Mikaere

Reappointed: 6 December 2010

Part owner of Phoenix House Resthome and Hospital with wife, which is leased to daughter and son-in-law, Riana and John Manuel, who holds contracts with Waikato DHB to provide aged care, primary care and transitional care.
Chair of Iwi/Maori Council
Chair of Te Korowai Hauora O Hauraki
Chair of Hauraki PHO
Chair of the Tainui Waka Alliance
Director of Hauraki Fishing Group and Taimoana Marine Farms Limited
Director of New Zealand Aquaculture Limited
Chair of Waikato Whanau Ora Regional Leadership Forum
Shareholder of Coromandel Marine Farmers Limited.

Statement of responsibility

For the year ended 30 June 2013

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 2013 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 2013 fairly reflect the financial position and operations of Waikato District Health Board.

Signed on behalf of the Board

Graeme Milne, Chair
23 October 2013

Sally Christie, Deputy Chair
23 October 2013

P.10 Audit report

Part 1 Overview

Kara Disher Dental Nurse at Frankton primary school treating Katie Jeffcoat

Introduction

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2013. 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.

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

We have both funded and provided health services this year. We received approximately $1.1 billion in funding from Government to undertake our role. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. The National Health Board also has a role in the planning and funding of some health services, for example breast and cervical screening and the provision of disability support services for people aged less than 65 years services are funded and contracted nationally.

During 2012/13 we funded a number of different healthcare providers including Health Waikato, our provider arm, which received approximately 66 percent of the funding. The remaining 34 percent was utilised to fund healthcare delivery by other providers including primary care, pharmacy, laboratories, aged residential care, Māori providers, Pacific providers and other DHBs. We monitored and evaluated service delivery, including audits of a range of providers.

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).

Waikato hospital campus, September 2013

P.16 Diagram: Our Performance Framework

1. National

Health and disability system outcomes	New Zealanders lead longer, healthier and more independent lives		New Zealand's economic growth is supported	
Ministry of Health intermediate outcomes	Good health and independence are protected and promoted	A more unified and improved health and disability system	People receive better health and disability services	The health and disability system and services are trusted and can be used with confidence
Overarching health sector goal	Better, sooner, more convenient health services for all New Zealanders			
Policy drivers	Regional collaboration	Integrated care		Value for money

2. Regional

Midland vision	All residents of Midlands DHBs lead longer, healthier and more independent lives				
Midland outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Midland strategic objectives	To build the workforce	Systems integration across the continuum of care	To improve quality across 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. Local

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	• 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 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	Output measures		

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

5. Stewardship

Stewardship	People	Performance	Collaboration	Information

P.18 Our Organisational Profile

Waikato DHB

Employs around 6,000 people

Plans, funds and provides hospital and health services to around 372,865 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

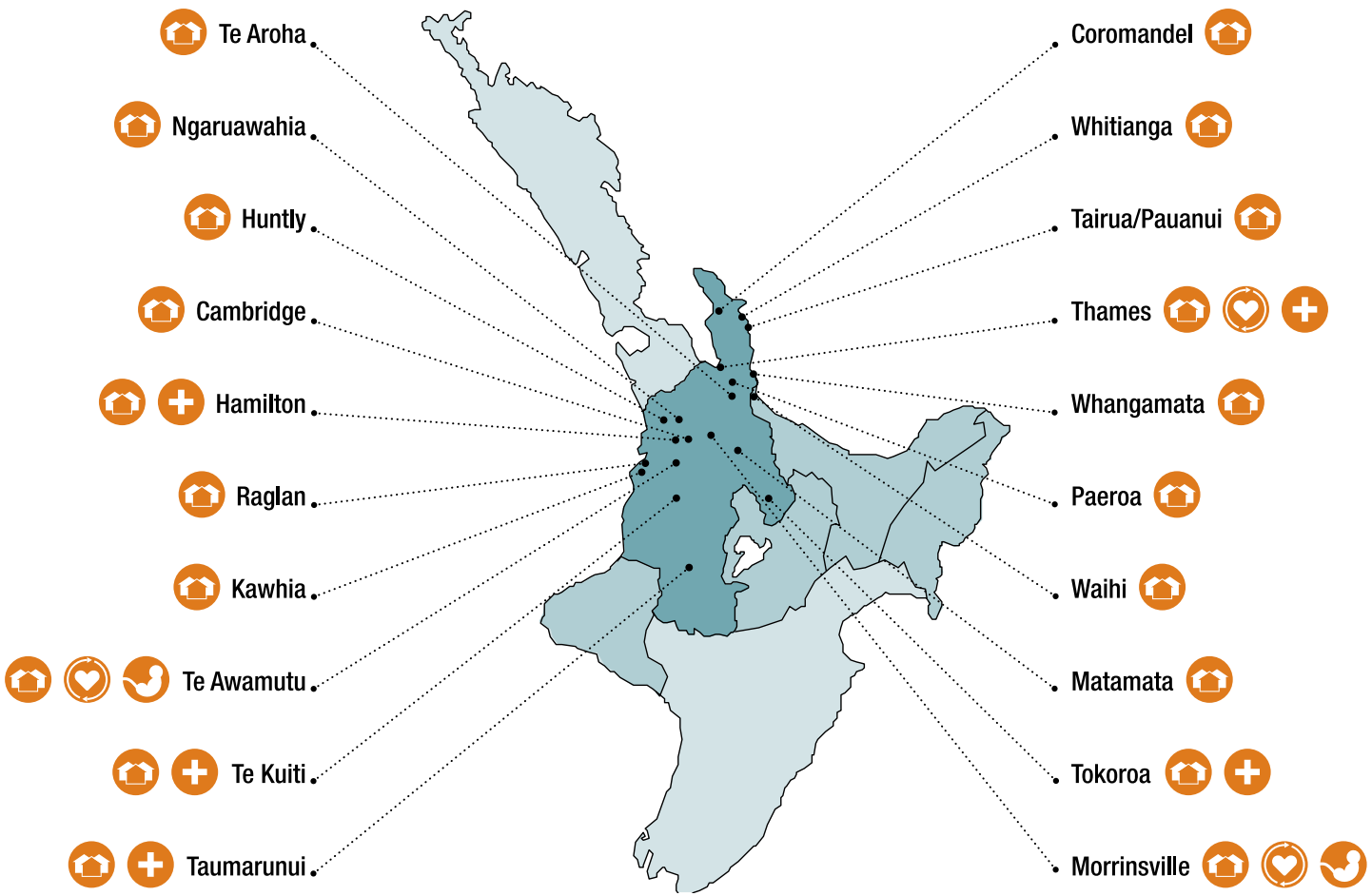
Agendas and minutes of all Board meetings, as well as key planning and reporting documents, are on the Waikato DHB website: www.waikatodhb.health.nz

Community Bases

Continuining Care Facilities

Hospitals

Primary Birthing Units



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 comprises 11 members of which six are elected and five are appointed by the Minister of Health, and are responsible to the Minister of Health. Our Board has three statutory committees which are made up of Board members and elected members from the community. The Board has two Māori members.

The current chair of the Board is Graeme Milne; the chief executive is Craig Climo. 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.

To continue to maintain a high quality of clinical standards a Board of Clinical Governance supports the chief executive.

Our board and executive offices are located in Hamilton at the Waiora Waikato hospital campus.

Location and population

Waikato DHB covers almost eight p ercent of New Zealand, 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 2012/13 our projected population was 372,865. 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 of 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 more than 78 percent by 2026). This, and the increase in chronic and complex health conditions, defines many of the strategies we are putting in place to meet future health needs.

The Māori population (estimated to be 22 percent of our population in 2012/13) 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 include and engage Māori in health service decision making; and to deliver health information and health services in a culturally appropriate way.

Pacific people represent an estimated 2.5 percent of our population and are a group which 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 the need for people to travel 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 an in-depth analysis of our populations, their health status and the significance for strategic health planning and for prioritisation of programmes at an operational level.

We retain strong links with neighbouring 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.

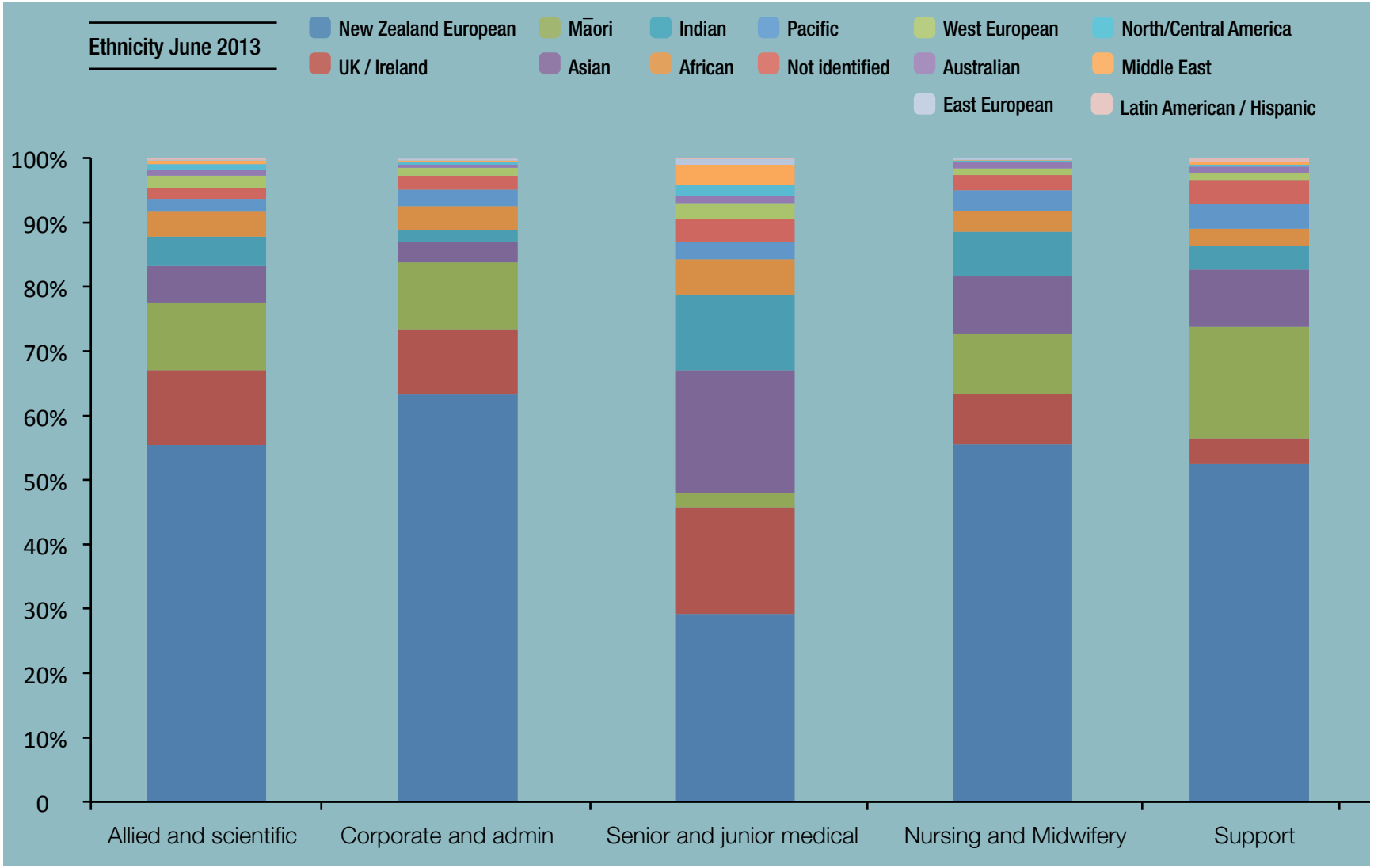
Our workforce at a glance

Professional Group	Headcount	Contracted full time equivalents	Average Age (years)	Female (headcount)	Male (headcount)
Allied and scientific	1,061	924	43.5	829	232
Corporate and other	1,147	1,040	49.6	971	176
Nursing / midwifery	2,700	2,221	45.7	2,403	297
Senior and junior medical	699	647	41.1	261	438
Support	381	320	47.1	188	193
Total	5,988	5,152	45.6	4,652	1,336

Key information about our workforce demographics is as follows:

- Our average age is 45.6, which is consistent with last year (45.5 years). 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 significantly less concentration in the younger age groups.
- Our gender mix is 78 percent female and 22 percent male. This is the same as last year.
- Over the last 12 months the total number and percentage of Māori we employ has fallen slightly from 9.9 percent to 9.5 percent of the total workforce, representing some 565 individuals. The largest number of which are employed as nurses (251). This percentage still compares favourably with the national percentage of Māori employed in DHBs (reported date March 2013) which is 7 percent or just over 3,700 people from a workforce of approximately 52,000 who have declared their ethnicity (from total workforce of 65,000).
- Our average age by occupation type is comparable to the national DHB population. The only notable difference is the support staff grouping, which with an average age of 47.1 is almost two years lower than the national average age of 49.0 years.

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


Ethnicity June 2013
New Zealand European
Māori
Indian
Pacific
West European
North/Central America
UK / Ireland
Asian
African
Not identified
Australian
Middle East
East European
Latin American / Hispanic
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0
Allied and scientific
Corporate and admin
Senior and junior medical
Nursing and Midwifery
Support

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.

Patient Karen Bunyan with Nurse Ana Dick and Dr Rubesh Hassamal in rehabilitation ward.

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 'steward' of hospital and other specialist health services. The services are provided through our provider arm, across five hospital sites, two continuing care facilities, a mental health inpatient facility, five primary birthing facilities and 16 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 Bennett Centre (mental health facility)
- Thames Hospital – rural hospital
- Tokoroa Hospital – rural hospital
- Te Kuiti Hospital – rural hospital; and
- Taumarunui Hospital – rural hospital.

We are in the process of significantly upgrading the hospital buildings on the Waiora Waikato hospital campus and at Tokoroa. The upgrading work at Thames Hospital was completed in 2011/12. Our ambitious building programme is now nearing completion. The provider arm has and will continue to incur operational costs related to this programme. These relate to change management, decanting and demolition and we will continue to incur these costs as well as the increased interest, depreciation and capital cost associated with capital spend over the timeframe of the redevelopment programme.

The provider arm, through Waikato Hospital, has maintained its preferred tertiary provider status to the Midland 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.

Planning and funding health and disability services

The funder arm is responsible for the planning and funding of the majority of 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 funder arm contracts services from Health Waikato they also contract services from a wide range of non-government organisation providers, as well as other DHBs who often provide more specialist services. The non-government organisations the funder arm has contracts with include:

- Fifty-five rest homes, a total bed capacity of 2,864 as at August 2013 (we are not the only funder / purchaser of these beds the available capacity fluctuates according to utilisation by other funded residents)
- Eighty community pharmacies
- Seventy-one GP practices
- Eighteen Māori providers
- Two Pacific providers
- Two primary care alliances; and
- One primary health organisation.

L-R Christine Woolerton, Jenni Richards,Jan Adams,Chrissi Borrie with the Minister for Social Development , Paula Bennett

P.24 National Performance Story

Health and disability services in New Zealand are delivered by a complex network of organisations and people. 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 manage performance and service delivery across the health and disability system.

The Government sets the wider strategic context for the health sector, which includes the stated goal of New Zealanders leading longer, healthier and more independent lives. This flows through to the Ministry of Health intermediate outcomes of:

- Good health and independence being protected and promoted
- A more unified and improved health and disability system
- People receiving better health and disability services; and
- The health and disability system and services can be trusted and used with confidence.

The next section provides a short summary of the kind of initiatives being undertaken that contribute to improving performance against the identified health and disability system outcomes. Initiatives often contribute to more than one of the outcomes.

Project energiser, Jen Riley with pupils from Rototuna Primary School

Dr Colin Patrick explaining the dementia map of medicine

Good health and independence are protected and promoted

We do more than simply treat people who are ill; we also have an emphasis on prevention and maintaining independence. Key initiatives included:

- Population based screening programmes for breast and cervical screening
- Implementing a ceiling and underfloor insulation project (Warm our Whare initiative)
- Funding Project Energize
- Implementing Project 270 which includes a Kia in Schools initiative in conjunction with KidsCan; and
- Implementing a pepi-pod (infant beds) initiative.

A more unified and improved health and disability system

We are part of a dynamic network of interacting organisations which make up the health system in our district. Organisations such as primary health organisations, non-government organisation providers, rest homes, other crown entities and individual health professionals are part of the health system in our district. In 2012/13 we continued our efforts to be part of a coordinated health system, not only at an operational level, but also in terms of planning together for the future. Key initiatives included:

- Our staff participating in the clinical networks which are driving the development and the implementation of the Midland DHBs Regional Services Plan
- Collaborating with the other DHBs in the Midland region to develop leadership capacity
- Working with Health Benefits Limited on areas like developing a national catalogue, banking, rehabilitation equipment and warehousing and distribution (further information is available from www.healthbenefits.co.nz)
- Evolving role of HealthShare Limited our Midland region shared service agency; and
- Working with our primary care partners (Midlands Health Network, National Hauora Coalition and Hauraki PHO) to implement initiatives like:
  - Primary options for acute care
  - Map of Medicine

People receiving better health and disability services

We are constantly making gains in the efficiency and effectiveness of the services we provide. We have increased productivity and at the same time have maintained or improved the high quality of clinical care and good access to services.

Key initiatives included:

- Introduction of the Enhanced Recovery After Surgery programme
- Continuation of our Productive Wards' Releasing Time to Care programme; and
- Supporting the national patient safety campaign 'Open for Better Care'.

The health and disability system and services are trusted and can be used with confidence

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. This helps to provide assurance that people can trust the services they use as well as the wider system.

Key initiatives included:

- Continued public accountability of our performance against the health targets
- Implementation of our Quality Strategy
- Three-year certification across all our hospitals; and
- Publication of our Annual Quality Report.

P.26 Regional Performance Story

The Midland DHBs produced a Regional Service Plan (RSP) for the 2012/13 year. The strategic intent for the Midland region is described in our RSP and is presented as part of our performance story. 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. The following table summarises the service and infrastructure priorities in the RSP.

Doriana Rivera Aliga and her 7 day old baby in Newborn Intensive Care Unit

Service Priorities	Infrastructure Priorities
Vulnerable Services • Maternity services • Renal services • Rural health • Health of older people • Radiology	• Information systems • Building the workforce • Māori Health
National Priority Services • Cardiac services • Cancer control • Elective services • Stroke services	**Key Enablers** • Health Quality and Safety Commission • National Health Committee • Asset Planning
Regional activities • Mental health and addictions • Smokefree • Trauma	

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.

Regional Outcomes

During 2012/13 we explored the potential for a common outcome measure or set of outcome measures we could monitor across the Midland region. Monitoring these measures over time is expected to give us a picture of the health of the communities living in the Midland region with logic suggesting that the activities, actions and initiatives that are implemented will impact positively on these measures. A final decision was not reached on a common set of regional outcome measures and this work is expected to continue in 2013/14.

The Midland RSP presents average life expectancy at birth information for our region as an outcome measure. The figures for 2007-09 for the region are outlined in the following table.

	Bay of Plenty DHB	Lakes DHB	Tairawhiti District Health	Taranaki DHB	Waikato DHB	NZ
Females	82.4	80.5	78.0	81.5	81.8	82.4
Males	77.5	76.4	73.8	77.2	76.9	78.4

The ability to and appropriateness of producing yearly life expectancy information is one area that is expected to be explored during 2013/14 as part of the work around regional outcome measures. During 2013/14 we will be engaging with the national process run by Statistics NZ to access life expectancy information following the March 2013 census. We expect updated life expectancy information to become available from Statistics NZ from late 2013.

How we monitor performance against our outcomes is an issue we have also explored at a local level. Further detail on this is presented in the narrative around our local performance story.

Musicial patients, Jake Wharewhiti (L) and Nigel Tupu (R) at Waikato Hospitals new Renal Centre.

Local Performance Story

Waikato DHB continues to deliver improvements in health outcomes. During 2012/13 we made significant progress, but there is still more to be done. Long-term conditions, an ageing population, workforce shortages and a tight fiscal environment are placing greater pressures on the health and disability system in our district.

Local outcomes

Our outcomes are:

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

As is evidenced in our performance story; our outcomes for our population line up directly with the Midland region outcomes. While we will be monitoring outcomes 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. However, access to health services and prevention initiatives (like Project Energize, Project Aroha and smoking cessation) are areas that we can promote and through these we believe we can improve life expectancy.

The table sets out the outcome measures we are currently monitoring and demonstrates the comparison between our population and New Zealand as a whole. The life expectancy measure results are sourced from Statistics NZ and the remaining measures and results are sourced from the NZ Health Survey.

Measure	Previous Result	Latest Result	New Zealand Comparison
Life expectancy – Male (Waikato region)	75.9 years (2000-02)	77.2 years (2005-07)	78.2 years (2005-2007)
Life expectancy – Female (Waikato region)	81.0 years (2000-02)	81.8 years (2005-07)	82.4 years (2005-2007)
Excellent, very good or good self-rated health – 15 years and over (Waikato DHB)	88% (2006/07)	89.8% (2011/12)	89.9% (2011/2012)
Excellent, very good or good parent-rated health – 0 – 14 years (Midland region)	97.6% (2006/07)	96.7% (2011/12)	97.9% (2011/2012)

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.

Brett Lightfoot from NZ Signage Company and Dana Herman charge nurse manager, ward 58, hanging display prints in the new Older Persons and Rehabilitation building

New single bedroom and ensuite in the Older Persons and Rehabilitation

Our priorities

Our priorities are a continuation from previous years, as they are not short-term issues easily resolved within a year. Strides have been taken and performance has improved, however more can be achieved.

Financials

Our final financial result for 2012/13 was a $2.188 million surplus which compares favourably with our planned budget of a $1 million surplus. Cash flows continue to be strong and our available borrowing helps ensure that our building programme can continue through these tougher times.

Cost of service statement by group for the year ended 30 June 2013

Cost of service statement by group	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Income	**$000**	**$000**	**$000**
Funder	1,095,913	1,105,983	1,063,987
Governance and Planning	5,211	5,214	5,179
Provider	727,090	722,818	699,381
Eliminations	(647,357)	(649,038)	(623,196)
	1,180,857	1,184,977	1,145,351
Expenses			
Funder	1,060,540	1,063,460	1,021,190
Governance and Planning	5,171	5,095	4,937
Provider	761,503	763,429	732,980
Eliminations	(647,357)	(649,038)	(623,196)
	1,179,857	1,182,946	1,135,911
Share of associate surplus/(deficit)	-	1	(31)
Share of joint venture surplus	-	156	-
Surplus	1,000	2,188	9,409

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

Regional collaboration

As described in the regional performance section, implementing the Midland RSP has been a continued focus in 2012/13. A number of new regional networks have been established and existing networks have continued to develop and consolidate over the year. Key highlights and progress at a regional level include:

- Midland maternity investing in the purchase of 304 pepi-pods for the region, in line with reducing sudden unexpected death of infant rates
- Midland Maternity and the Rural Health Advisory Group working together to look at rural maternity services and will use findings to inform maternity quality and safety initiatives
- Midland Regional Renal Action Group working to develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting
- Completion of a stocktake against the recommendations in the national dementia framework and identification of five key areas of work to be undertaken in 2013/14 by the regional Health of Older People group
- Agreement to undertake a six month trial of a regional cataract pathway which will start on 1 July 2013
- Commencing work on a regional theatre production planning model for orthopaedic surgery
- Transition of Tairawhiti District Health adult medical oncology, radiation oncology and haematology services from MidCentral DHB to the Midland region
- Development of a customised patient tracking trauma database to form the core of the regional Trauma Quality Improvement Programme; and
- Māori Health Framework – He Raranga-A-Tira completed.

Quality improvement

Over the past six years, quality improvement has taken on a heightened focus and a variety of improvements have been made. We have recently developed a Quality Strategy, and are committed to implementing the initiatives specified by the national Quality Improvement Committee. All our staff, clinical leaders and managers are responsible for improving quality and participating in quality improvement initiatives and projects.

There has been a string of achievements in this priority area in 2012/13. These achievements are particularly of note given the major building and service redevelopment programmes. Examples of the achievements are summarised below.

Maternity quality safety programme

The last 12 months have been a ‘year of discovery’ for the services. At the beginning of the year, a new group manager for Women’s Health was appointed and part way through the year a project manager was appointed to oversee the Waikato Maternity Quality and Safety Programme implementation plan. During this year, we have achieved a greater understanding of the quality issues. Continuous quality improvement activity can only be sustained if based on firm foundations of good governance structures, data and information, clinical leadership, and strengthened workforce. The first year of Maternity Quality Safety Programme has been focused on:

- Laying the foundations
- Establishing a project management structure
- Developing governance structures
- Strengthening the clinical workforce
- Building data and information processes; and
- Moving forward on identified quality issues.

Further detail on this area of work is detailed in our Maternity Annual Report 2012/13.

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
Waikato DHB	86%	88%	89%	88%
All DHBs	92%	93%	94%	93%

During 2012/13 we failed to reach the national target of 95 percent. This is a challenging target and we still have some way to go to reach the target. We have developed a detailed action plan to improve our performance against this indicator and will be implementing the identified actions in 2013/14. 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
Waikato DHB	108%	111%	116%	115%
All DHBs	105%	105%	106%	107%

Our target volume was 13,009, which is broken down into quarterly targets for the year. The performance results each quarter indicate what percentage of the quarterly target we have achieved. More information about our results and performance is on page 123.

Urology surgical team in action (L-R) Leann Rebalde, Jason Du, Michael Holmes, Jarad White

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 2013.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Waikato DHB	80%	82%	81%	83%
All DHBs	87%	89%	89%	90%

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

Radiation therapists Jenna Davidson and John Hall fit a positioning mask on a patient in the radiotherapy suite

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
Waikato DHB	100%	100%	99.7%	100%
All DHBs	100%	100%	99.9%	100%

The quarter three result is impacted by patient, who was ready for treatment, waiting four weeks and two days for chemotherapy. More information about our results and performance is on page 115.

Addressing chronic conditions

Our progress against this priority has been characterised by extensive work and engagement with our primary care partners through alliancing processes. Alliance Leadership Teams (ALTs) were established across the Midland region with our primary care partners; the Midlands Health Network and the National Hauora Coalition. In addition we are expecting to enter into an alliance with Hauraki PHO in early 2013/14. The ALTs are populated by clinical leaders and managers from across primary and secondary care.

The purpose of the ALTs is to lead and guide our Alliances as they improve health outcomes for our population. The ALTs provide the direction to enable the provision of increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a “best for patient, best for system” framework.

There has been a string of achievements in this priority area in 2012/13. Examples of the achievements are summarised on the following pages.

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
Waikato DHB	93%	94%	93%	96%
All DHBs	94%	95%	95%	96%

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
Waikato DHB	42%	46%	51%	61%
All DHBs	40%	43%	51%	57%

We achieved the hospitalised smokers portion of this health target for the first time in quarter four 2012/13. More information about our results and performance against both parts of this target is on page 75.

More heart and diabetes checks

Target: at least 75 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
Waikato DHB	60%	63%	67%	73%
All DHBs	52%	55%	59%	67%

More information about our results and performance is on page 91.

Te Puna Oranga staff with children and staff of Bright Stars Educare the first Māori pre-school to be smoke free in New Zealand

Organisational and workforce development

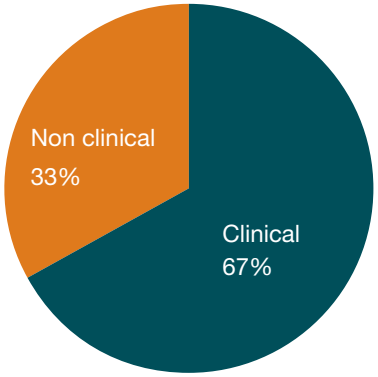
Health Workforce New Zealand (HWNZ) has overall responsibility for planning and development of the health workforce. It aims to ensure that New Zealand has a fit-for-purpose, high quality and motivated health workforce, keeping pace with clinical innovations and the growing needs and expectations of service users and the public. We regularly scan HWNZ activities to ensure alignment of the DHBs direction and to ensure that there is no duplication of effort.

During 2012/13 we completed implementation of the activities outlined in our hospital based and community based workforce plans. We are proud of the programmes and results achieved that make us stand out as caring for and promoting our diverse workforces. We publish all of our work and the outcomes on our website so other workplaces can review and use evidence based initiatives we think work for our organisation, and those with a workforce mix like ours.

Leadership, accountability and culture

We continue to demonstrate our commitment to being a good employer with a policy framework that expects all employees to be treated fairly and equitably. We have collaborated with other DHBs in the Midland region for six years to develop leadership capability. During this time 439 people have received leadership training. An outcome study of Leadership in Practice in 2010 showed that participants have been seen to apply learning and use a variety of leadership skills in practice. Evaluative measures show improvements in leadership skills from advanced participants.

The graph below indicates the proportion of participants in clinical versus non clinical roles.



Our Board of Clinical Governance has an important role and provides oversight of clinical practices, innovations, safety culture and standards. It has recently been refreshed to align with the DHB's strategy for patient safety which was approved by the Board in 2012.

Recruitment, selection an induction

We employ people from close to 50 different countries and value their contribution as their diverse skills and experiences enrich practice. We have accreditation status with Immigration NZ, and where no New Zealander is available to fill vacancies, support people from overseas into employment and to settle. We have a strong relationship with the Hamilton Migrant Centre who attend our monthly orientation session.

The recruitment and selection process we use supports equal employment opportunities using a standardised process and combines technical and behavioural aspects of the role into a competency assessment. Candidates responses are assessed against pre-determined criteria. In addition our pre-employment health screening assessment process allows for the identification of accommodations that are required so that all candidates are viewed on their merits and not on any stereotypical or other biases. We offer all candidates the opportunity to have whānau support with them at interviews.

Members of the advanced leadership in practise course ending August 2013

Employee development, promotion and exit

We are committed to having a skilled and up to date workforce. We support our staff to continuously improve their skills through access to continuing professional education, paid time off for (and in some cases fee payment) tertiary study and attending and delivering their research findings at national and international conferences.

We have invested in online learning as part of a blended learning approach to increase access to training and information. The DHBs in the Midland region collaborate on their e-learning approach.

The graphs below, indicate the people who are visiting the regional e-learning site. The graphs indicate that use of the site is increasing.

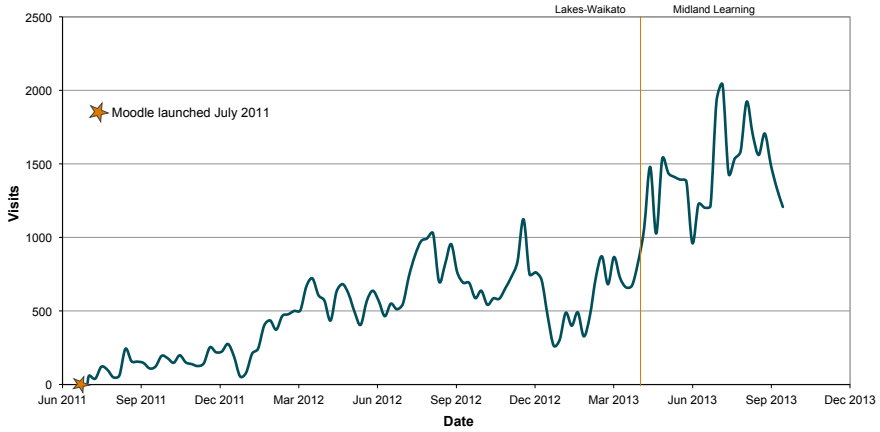
Dr Lisa Hilligan using the clinical simulation manequin

Key

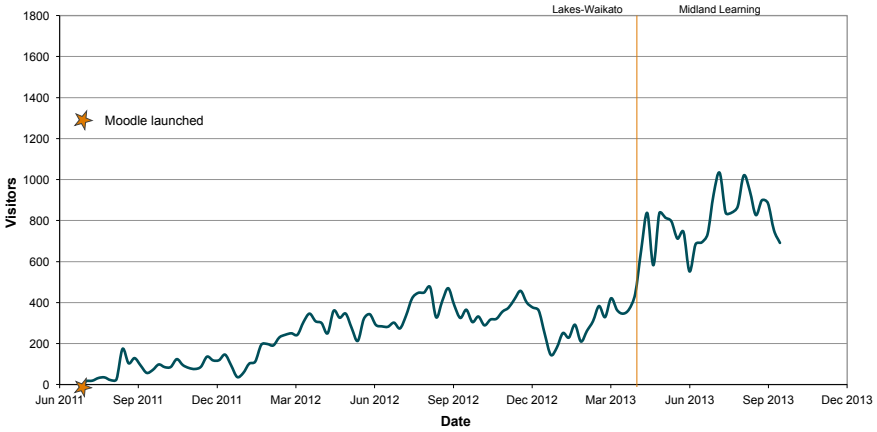
Visits: A (person at a) particular computer is using the site for an uninterrupted period of time is counted as a visit.

Visitors: A particular computer is counted as a visitor. So if I access the site at work then at home, I am counted as 2 visitors.

Moodle weekly visits (usage). Source: Google analytics

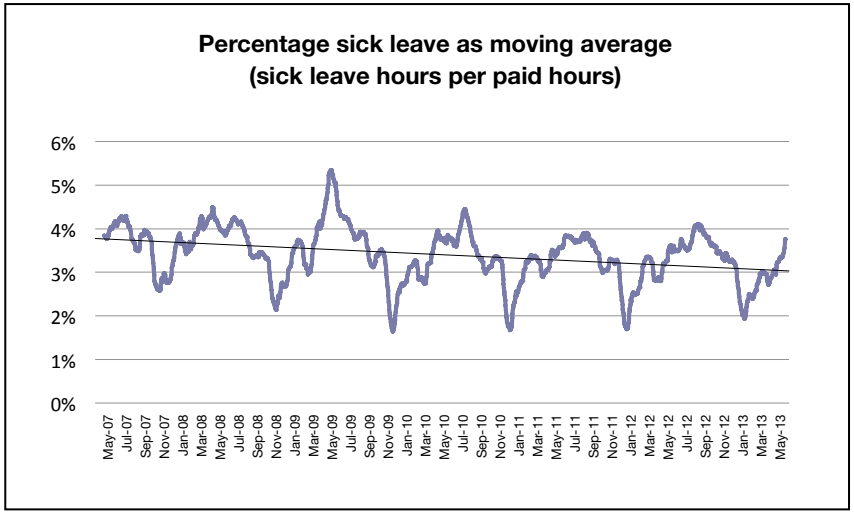


Moodle weekly visitors. Source: Google analytics



Flexibility and work design

We offer part time work for most positions to enable staff to get greater work / life balance. Part time staff make up 44 percent of our workforce. We are progressively implementing centralised rostering for our nursing, midwifery and medical workforces. Self rostering is identified by some staff as being important to balancing their work and home lives. Along with this flexibility we have a responsibility to provide a healthy and safe workplace for staff. One of the benefits of the technology is to enable the safety of rosters to be checked against factors that are known to increase fatigue and sick leave. This supports our ongoing programme to support staff who use higher than average amounts of sick leave. The use of sick leave is steadily declining as per the graph below which also shows a seasonal effect.



Remuneration, recognition and conditions

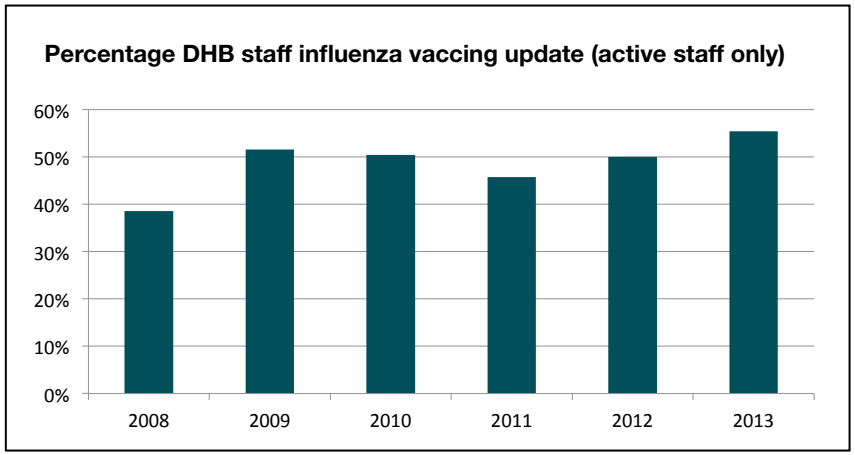
We are committed to remunerating all staff fairly and equitably according to employment agreements. We actively participate in the process of negotiating terms and conditions at the national level, as well as a number of national salary surveys. We have an equal employment opportunity policy.

Harassment and bullying prevention

We have developed a harassment and bullying prevention policy and have implemented a two hour in house training programme which is being delivered on demand and as part of our learning and development suite of education and training.

Safe and healthy environment

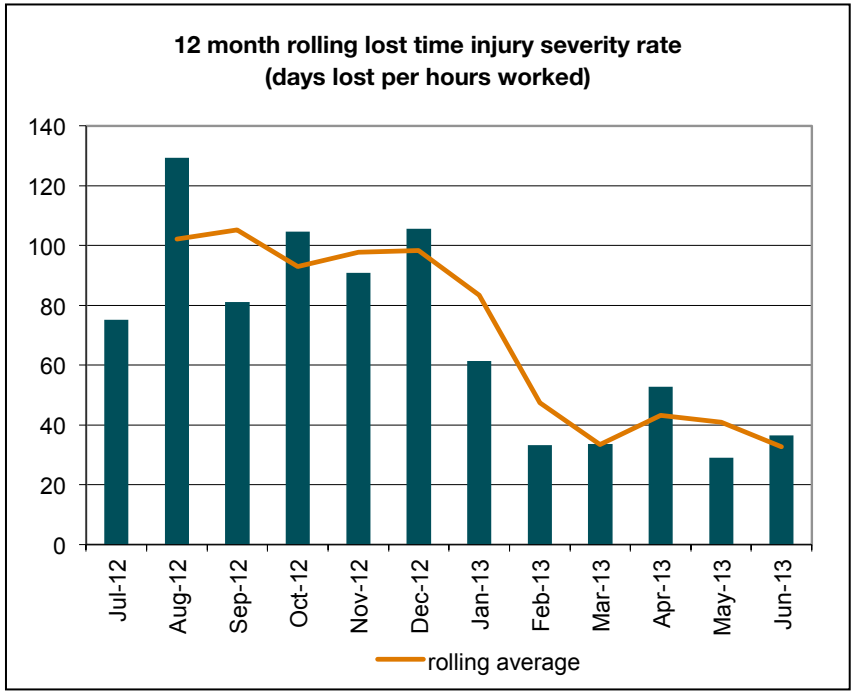
We are committed to providing a safe and healthy workplace for our staff. Every year we provide free influenza vaccinations for our staff. This year we have had a record uptake of the vaccination with 51 percent of our staff vaccinated. The graph below shows the gradual improvement of the uptake between 2008 and 2013.



The Health and Safety team also provides a health monitoring and vaccination service for our staff as part of its hazard control programme.

We are in the ACC Partnership programme. There has been a gradual reduction in the severity and number of workplace injuries. The graph below indicates that the average time off for an injury is reducing. The calculation is the number of lost time hours multiplied by the number of hours worked divided by 1,000,000.

Kurt Fredericks safety testing electronic equipment in the Biomedical Enginering department



In addition we sponsor our staff to participate in the annual Round the Bridges run / walk each year. Full and partial sponsorship of staff to lose weight through Weight Watchers has resulted in at least 5,000kg reduction so far.

We actively engage with unions at an organisational level about health and safety and equal employment opportunities via the bi-monthly Joint Union Management Consultative Forum.

Rural

A significant piece of work done in the 2012/13 year was the developments relating to the Tokoroa Co-located Health Centre. The designs for this were developed in conjunction with primary care clinicians and have been submitted to South Waikato District Council for building consent. Work onsite at the rural health hub is scheduled to begin in August 2013, with 'go live' planned for late 2013.

A benefits realisation plan has been developed in conjunction with local stakeholders, and a cross-organisation local governance group will be formed to continue to monitor benefits and to continue the journey to integration. Those relocating to the site are:

- Raukawa Charitable Trust
- South Waikato Pacific Islands Community Services
- National Hauora Coalition (one GP practice which is transferring to Hauraki PHO from 1 January 2014)
- The Cambridge Foot Clinic Tokoroa practice
- Midlands Health Network (three GP practices)
- Local midwives; and
- Two community pharmacies.

This development has come from the realisation that we simply can't continue doing the same things the same way. We need to make changes now in order to build a sustainable health system that meets the health needs of both the community and health providers. The new space at the hospital will create an environment that better services patient needs but is also more attractive for staff to work in.

There was a lot of work in 2012/13 to develop a healthcare model for the northern Ruapehu district that is both integrated and sustainable. One result was the establishment of a highly experienced and influential local governance group which will work closely with us to shape the future structure of health delivery in the area. The identified work streams are:

- Telemedicine links
- Integrated workforce
- Local directory / communication
- Midwifery
- Service integration; and
- Transport.

A project manager has been appointed to continue work on the long term solution. The focus of the work to date has been short term issues with the sustainable model still evolving.

Ocean beach, Raglan

Redevelopment

Our redevelopment programme continued through 2012/13. The programme delivers increased capacity for hospital and support services, which enables better quality of care in purpose-designed facilities. The programme began in 2005 and is now on the home straight with completion expected in 2014.

The projects which form the programme involve:

- Physical construction of new buildings or major alterations of existing buildings - coordinated by Waikato DHB's Building Programme Office
- Changes in service configuration and delivery to take up opportunities for new and improved ways of working - coordinated by Waikato DHB's Programme Management Office

During 2012/13 an exercise was undertaken to assess the seismic status of our building stock. The work undertaken was similar to what organisations have done since the 2011 Christchurch earthquake. A number of buildings were identified as being earthquake prone. It is expected that plans for the future of each earthquake prone building will be presented to our Board during 2013/14.

A summary of a number of major projects from our redevelopment programme follows.

Meade Clinical Centre

A major new five-level 39,000m² building contains a large portion of Waikato Hospital clinics, a new Critical Care area (High Dependency Unit and Intensive Care Unit), and additional theatres and interventional suites. The building links directly to the Hague Road Carpark Building. Stage one of the project (clinics, endoscopy, High Dependency) was completed in 2012/13 with the following milestones planned for the future:

- Stage two - interventional suites, some theatres and Critical Care (by August 2013)
- Stage three - Radiology (by April 2014)
- Stage four - completion of Meade Clinical Centre (April 2014)

Opening function in the new Meade Clinical Centre atrium

Older Persons and Rehabilitation Building

A totally new building built in Pembroke Street which houses two services: Older Persons and Rehabilitation and Mental Health for Older People. This project brings these services together in a purpose-built for the care of older people. It includes clinics and wards for both services and was completed in June 2013.

Taumarunui integrated health care model

This project is about integrated rural healthcare, where primary and secondary providers work collaboratively so that patients get the best possible care. It recognises the current way of delivering healthcare there is vulnerable and not sustainable, and that a focused collaborative approach is needed to put more integrated care in place. Meeting the needs of the north Ruapehu district is a priority.

Regional Renal Centre

The reconfiguration and refurbishment of the old Lions Cancer Lodge for a new Regional Renal Centre, with an additional 120m² of space, was completed in November 2012. The centre opened its doors to patients on Monday 26 November. Located at the eastern end of the Waiora Waikato Hospital campus, the facility will cater for renal patients who come for dialysis treatment from throughout the Midland region. The previous unit had become too small and unable to cater for the demand.

Patient William Hill with occupational therapist Ellen Van Der Wee

Minister of Health Tony Ryall (L) with Jan Adams and patient Paris Falwasser in the new renal centre

Tokoroa Hospital co-location of health services

This project is the same project highlighted under the rural priority. The focus is on renovating and using two wards at Tokoroa Hospital which have been largely unused for many years, and convert them into spaces for primary health care and non-government service provider tenants. This is a step towards better integration of health services in the South Waikato.

Demolition of Smith building

A 1960s building that has seven storeys and held many medical wards and services, Smith Building was demolished in July 2013 as part of the construction of the Meade Clinical Centre.

Demolition of the Smith building

Part 2 Statement of Service Performance

New Older Persons and Rehabilitation Building, Hamilton

In order to access 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 2012/13 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 2011/12 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 2012/13.

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 provides an overview of the impact portion of our performance story.

Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People have timely and appropriate access to 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 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

Output class funding

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

The actual 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 2012/13. Output class allocations are based on the costing system rules to separate and assign costs, therefore total revenue and total costs will be different to the statement of comprehensive income.

Cost of service statement by output class for the year ended 30 June 2013

	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Income	$000	$000	$000
Intensive assessment and treatment services	759,874	736,799	645,702
Early detection and management	259,187	263,263	272,628
Prevention	25,183	27,025	30,334
Rehabilitation and support	123,262	127,068	154,711
	1,167,506	1,154,155	1,103,375
Expenses			
Intensive assessment and treatment services	746,649	757,025	623,752
Early detection and management	248,287	230,875	266,866
Prevention	27,349	28,798	31,302
Rehabilitation and support	144,221	135,426	172,015
	1,166,506	1,152,124	1,093,935
Share of associate surplus/(deficit)	-	1	(31)
Share of joint venture surplus/(deficit)	-	156	-
Surplus/(deficit)	1,000	2,188	9,409

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 report on whether or not we have achieved the target by using the following symbols:

✓ Achieved

✗ Not achieved

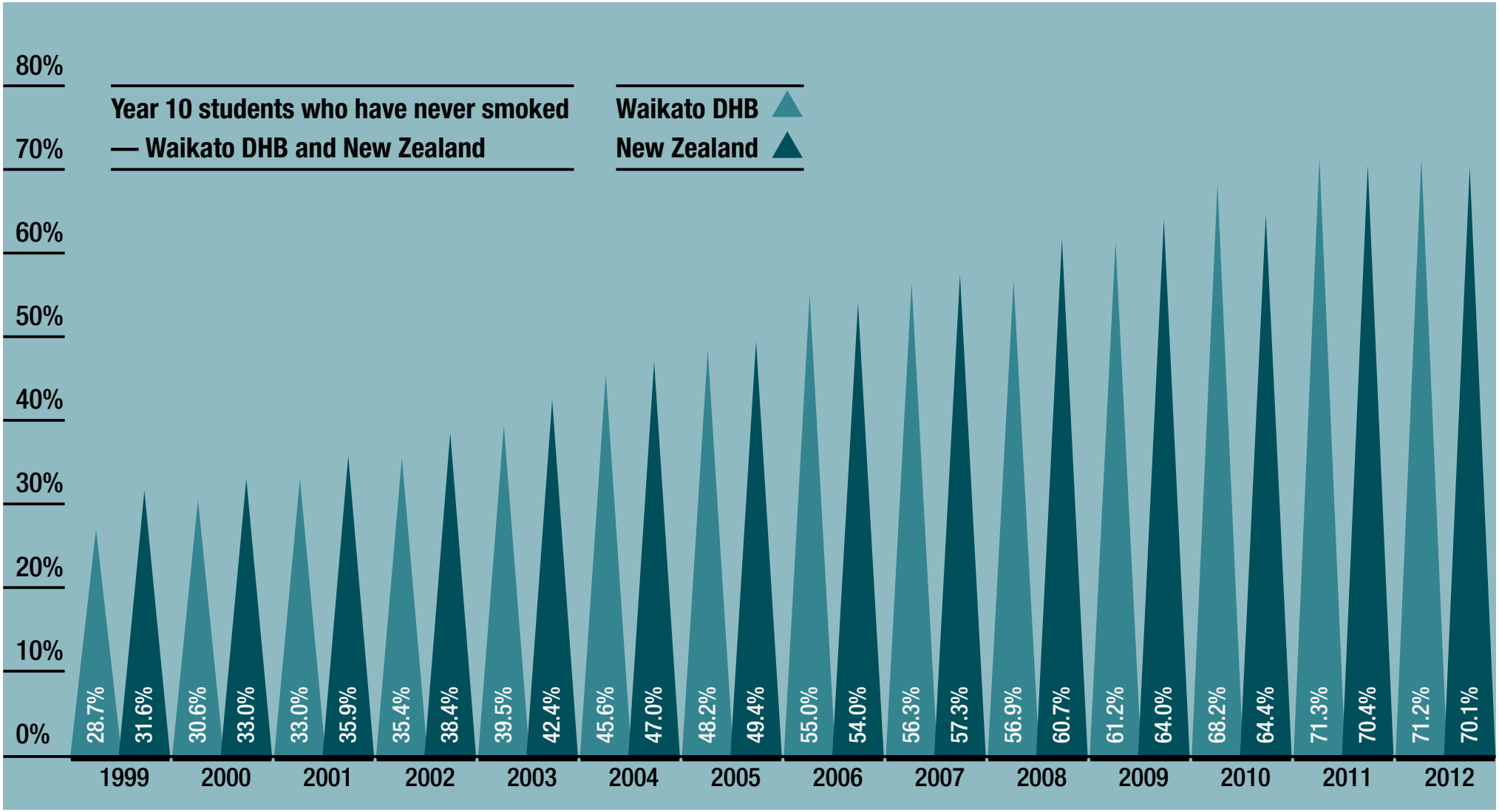
Long-term impact	**People take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Impact measures	An increase in the percentage of Year 10 students who have never smoked	Crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	• Increased percentage of people who have an adequate fruit and vegetable consumption • Decrease in the percentage of people considered obese

P.48

People take greater responsibility for their health

Fewer people smoke

Impact measure



Measure	Baseline 2009	Previous year 2011	Target 2012	Result 2012
An increase in the percentage of Year 10 students who have never smoked	61.2%	71.3%	66.0%	✓ 71.2%

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 improve the health of the population in the short, medium and long-term. We expect that by increasing the percentage of Year 10 students who have never smoked, it 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.

Waikato DHB performance

This measure is reported by calendar year as it links in with the school year calendar school. The results against this measure at a national and local level has been tracking upwards since the late 1990s. The 2011 and 2012 results have remained at a similar level around the 70% - 71% mark and we will continue to monitor this to determine if the results have reached a plateau or whether they will return to the upwards trend.

The baseline figure of 61.2 percent differs from the baseline of 60.5 percent in the Statement of Intent 2012/13. This is because updated information was released and it has been used in this report. The target for 2012 was set before the 2011 result had been finalised.

P.50

People take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure

Measure	2009 / 2010			2010 / 2011			2011 / 2012		
	Waikato DHB	Midland DHBs	New Zealand	Waikato DHB	Midland DHBs	New Zealand	Waikato DHB	Midland DHBs	New Zealand
Crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	16.39	19.28	17.04	16.31	17.06	13.98	17.54	26.44	34.12

Significance of measure

Immunisation can prevent a number of diseases and is a very cost effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Waikato DHB performance

During 2012/13 we engaged with our colleagues in the Midland region to determine what impact measure or measures where appropriate to monitor for this portion of our performance story. The result was the identification of the 'three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0 – 14 year olds' measure. As a region we have used this impact measure in our 2013/14 Statement of Intent and will report against it in our next Annual Report.

The annual results for the previous three years at the local, regional and national level are presented in the table. Over the three years the results against this measure are increasing which means more 0 – 14 year olds are being hospitalised for vaccine preventable diseases. We will be looking at this in 2013/14 and implementing actions to respond.

Paediatrics nurse Lisa VanWalraven (L) and mother Hannah Print (R) with baby Talyn about to be immunised

P.52

People take greater responsibility for their health

Improving health behaviours

Impact measure

Measure	Baseline 2006 / 2007	Target 2012 /2013	Result 2011 / 2012
Increased percentage of people who have an adequate fruit and vegetable consumption	70%	72%	Not able to be reported on

Measure	Baseline 2006 / 2007	Target 2012 /2013	Result 2011 / 2012
Decrease in the percentage of people considered obese	28.3%	28.0%	✗ 34.3%

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 your risk for several diseases and health conditions and improve your overall quality of life. Regular physical activity can help protect you 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

National results show that obesity levels have increased with approximately one million adults classified as obese in 2011/12 (about 28 percent of the adult population of New Zealand). The obesity rate has increased by two percent since 2006/07.

The local results listed below are sourced from the published results of the New Zealand Health Survey published in 2012/13. The national results are also provided in brackets. The results are:

- 67.5% of our population meet vegetable intake guidelines of three plus servings a day (66.8%)
- 55.0% of our population meet fruit intake guidelines of two plus servings a day (57.5%)
- 34.3% of our population have a body mass index of 30 or more (29.7%)

We will be reviewing whether or not there is a more appropriate measure we can monitor against our improving health behaviours impact.

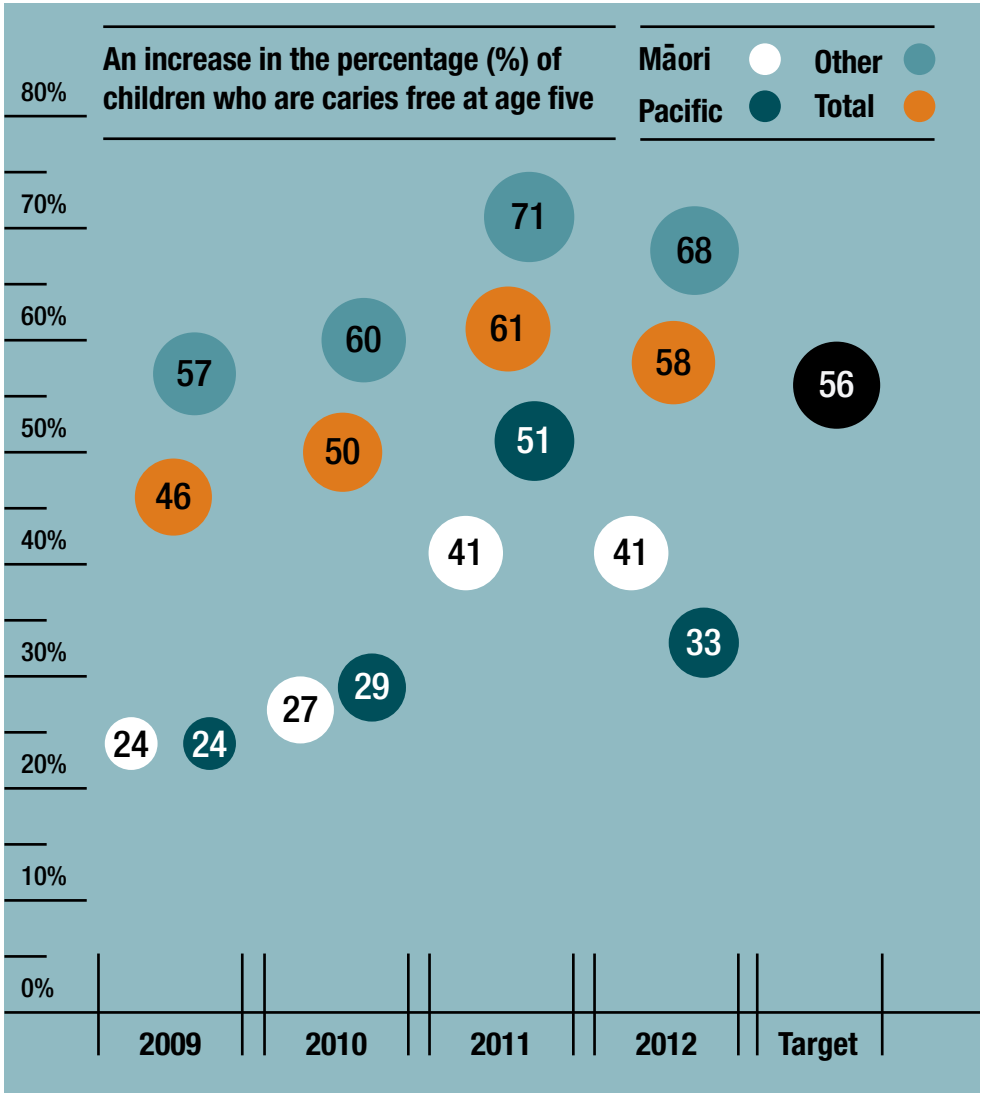
Long-term impact	**People stay well in their homes and communities**			
Intermediate impacts	An improvement in childhood oral health	Long term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	People maintain functional independence
Impact measures	• An increase in the percentage of children who are caries free at age five • A reduction in the mean decayed, missing and filled teeth score at year eight	Percentage of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol	A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable	Decrease in percentage of population aged 65 and over in DHB subsidised residential care at rest home level

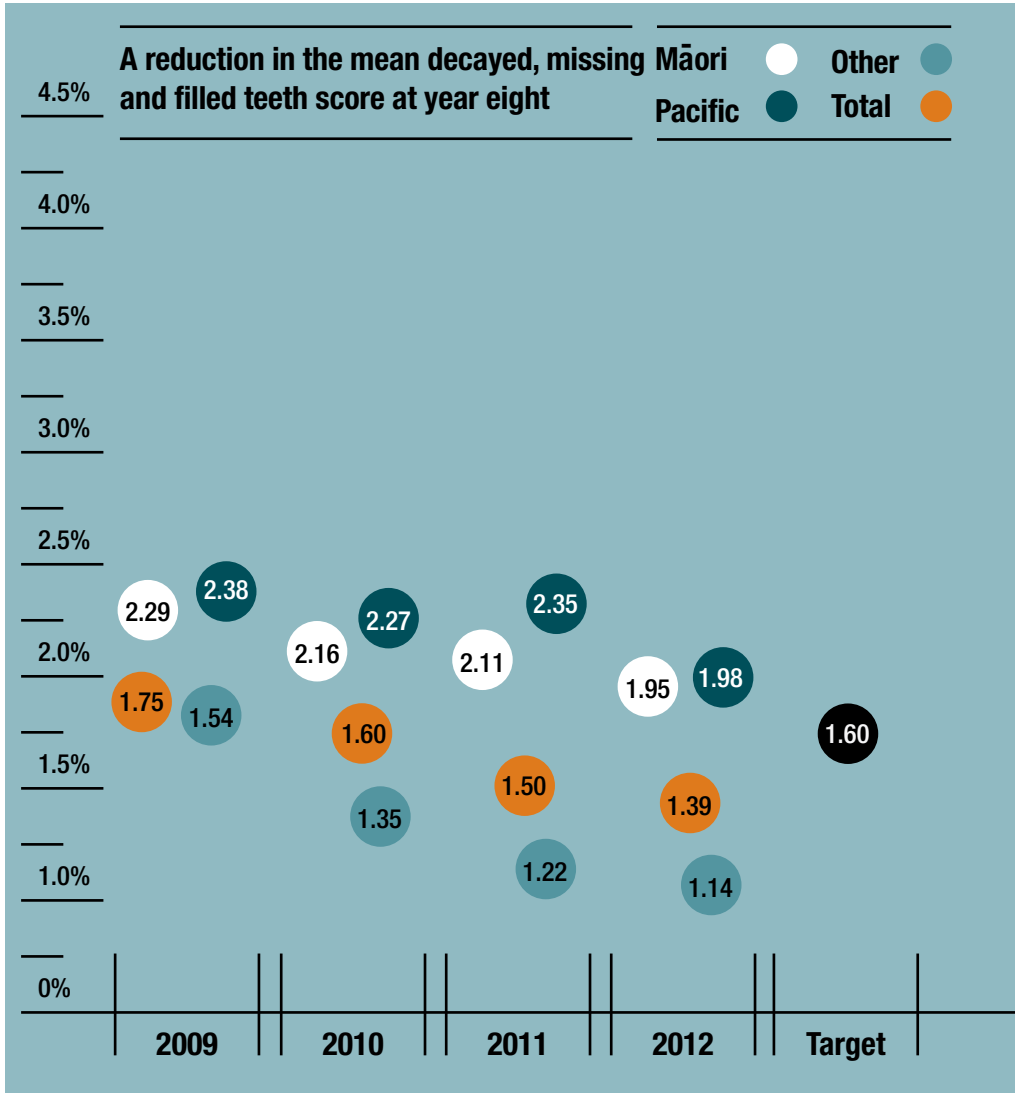
P.54

People stay well in their homes and communities

An improvement in childhood oral health

Impact measure





Measure	Baseline 2010	Previous year 2011	Target 2012	Result 2012
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 51% Other 71% Total 61%	Māori 56% Pacific 56% Other 56% Total 56%	✗ Māori 41% ✗ Pacific 33% ✓ Other 68% ✓ Total 58%
A reduction in the mean decayed, missing and filled teeth score at year eight	Māori 2.16 Pacific 2.27 Other 1.35 Total 1.60	Māori 2.11 Pacific 2.35 Other 1.22 Total 1.50	Māori 1.60 Pacific 1.60 Other 1.60 Total 1.60	✗ Māori 1.95 ✗ Pacific 1.98 ✓ Other 1.14 ✓ Total 1.39

Significance of measure

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self-esteem and quality of life.

Waikato DHB performance

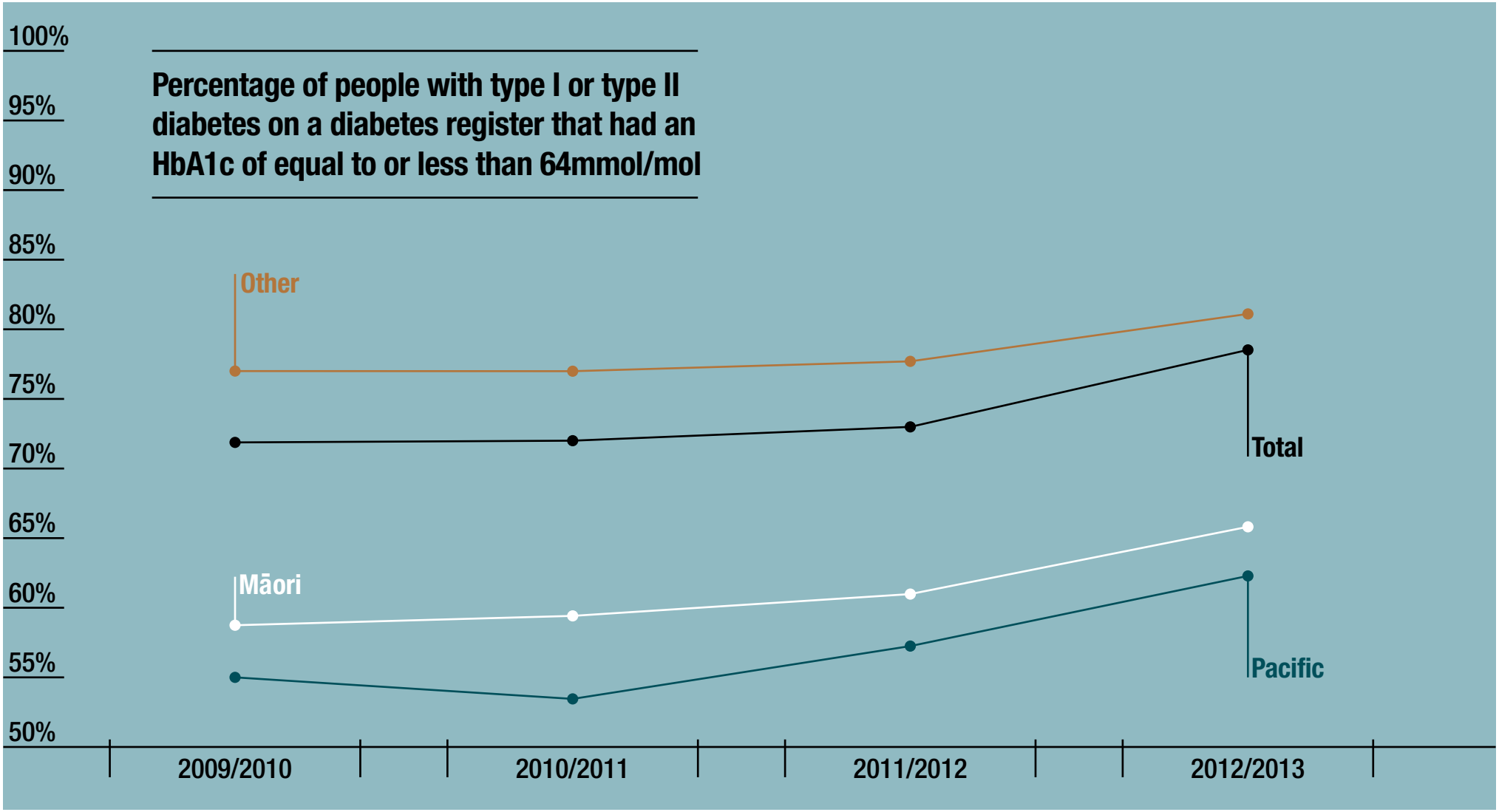
These measures are reported by calendar year as they link in with the school year calendar.

For the caries free measure, we achieved the target for the Other ethnic group in 2012 with 1,858 of the 2,725 children in this group being caries free. We failed to achieve the targets for the Māori (554 out of 1,362 tamariki caries free) and Pacific (30 out of 90 children caries free) ethnic groups. Our performance has improved for this measure for all four groups and this improvement can be attributed to the increase in preschool enrolment and improved access to oral health services.

To further improve performance the preschool co-ordinator will improve communication with kohanga reo and other Māori organisations to increase awareness and focus on oral health. The Oral Health Service will continue to focus efforts on Plunket and well-child / tamariki ora providers, preschoolers, their parents and early childhood centres.

Results for the decayed, missing and filled teeth measure show almost 4,500 year eight children were seen by our Community Oral Health Services. We achieved the target for the Other ethnic group and for the Total population. While we have not achieved the targets for the Māori and Pacific populations, the gaps between results for these groups and the Other ethnic group is reducing.

The population group had poor oral health at 5 years of age which was reflected in the 2004/ 2005 statistics which showed an average decayed, missing and filled teeth score of over 2.3 and caries free percentage of between 34% and 43%. Our interventions have made an impact on the oral health of this group. The group now has a decayed, missing and filled teeth score of 1.39 and are 54% caries free and at 12 years of age. One of the reasons for this improved performance is a change of practice which has increased the number of patients having routine bitewing radiographs. It is likely this has increased identification of decay compared to previous methodology. The Community Oral Health Service plans to continue with a strong preventative focus moving forward.


Percentage of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Other
Total
Māori
Pacific
2009/2010
2010/2011
2011/2012
2012/2013

Measure	Baseline April - December 2011	Previous year 2011/2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol	Māori 60.6% Pacific 54.4% Other 77% Total 73.0%	Māori 61% Pacific 57% Other 77% Total 73%	Māori 70% Pacific 70% Other 70% Total 70%	✗ Māori 66% ✗ Pacific 63% ✓ Other 82% ✓ Total 78%

Significance of measure

Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. Diabetes is one of the group of conditions which are a leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Diabetes is important as a major and increasing cause of disability and premature death. It is also a good indicator of the responsiveness of a health service to the people in most need.

This measure relates to diabetics enrolled with a primary health organisation who have had their diabetes annual review.

Waikato DHB performance

During 2012/13 we have been working with our primary care partners using an alliance approach on the development of their Long Term Conditions (LTC) Programmes. These programmes include the national requirement around Diabetes Care Improvement Packages (DCIPs), which replaced the diabetes Get Checked Programme in 2012/13. This measure was part of the Get Checked Programme.

The national decision to replace the Get Checked Programme followed a review which found the programme was not producing the desired improvement in outcomes for people with diabetes. The review concluded the Get Checked Programme added little clinical value to existing New Zealand general practice care processes. The programme finished on 30 June 2012.

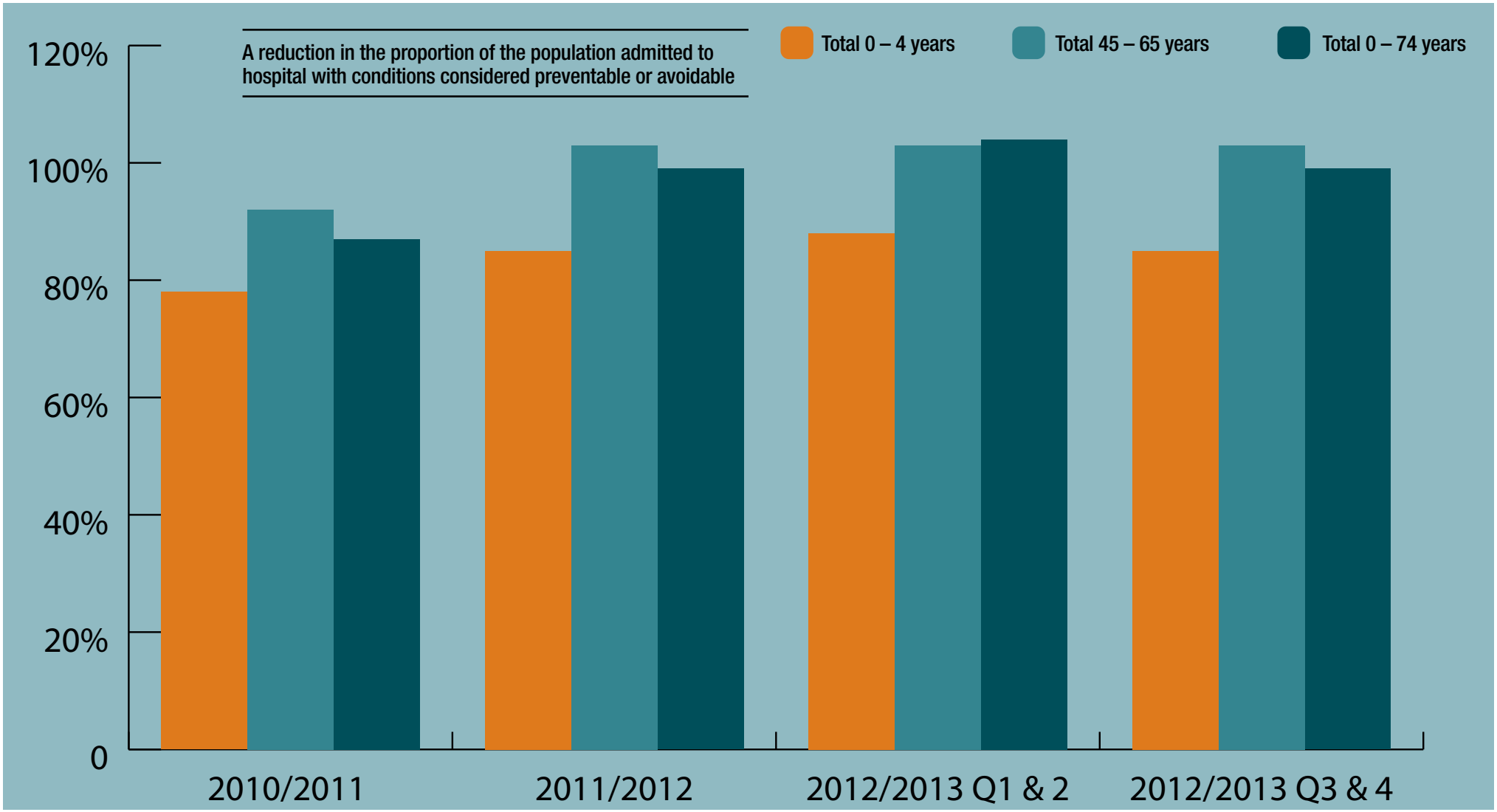
The transition between the Get Checked Programme and the local primary care LTC Programmes is thought to have had an impact on the performance against this measure.

P.58

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 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 0 – 4 years	78%	84%	Remain below 95% of national rate	✓ 85%
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 45 -64 years	92%	97%	Remain below 95% of national rate	✗ 102%
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable 0 – 74 years	87%	90%	Remain below 95% of national rate	✗ 97%

Significance of measure

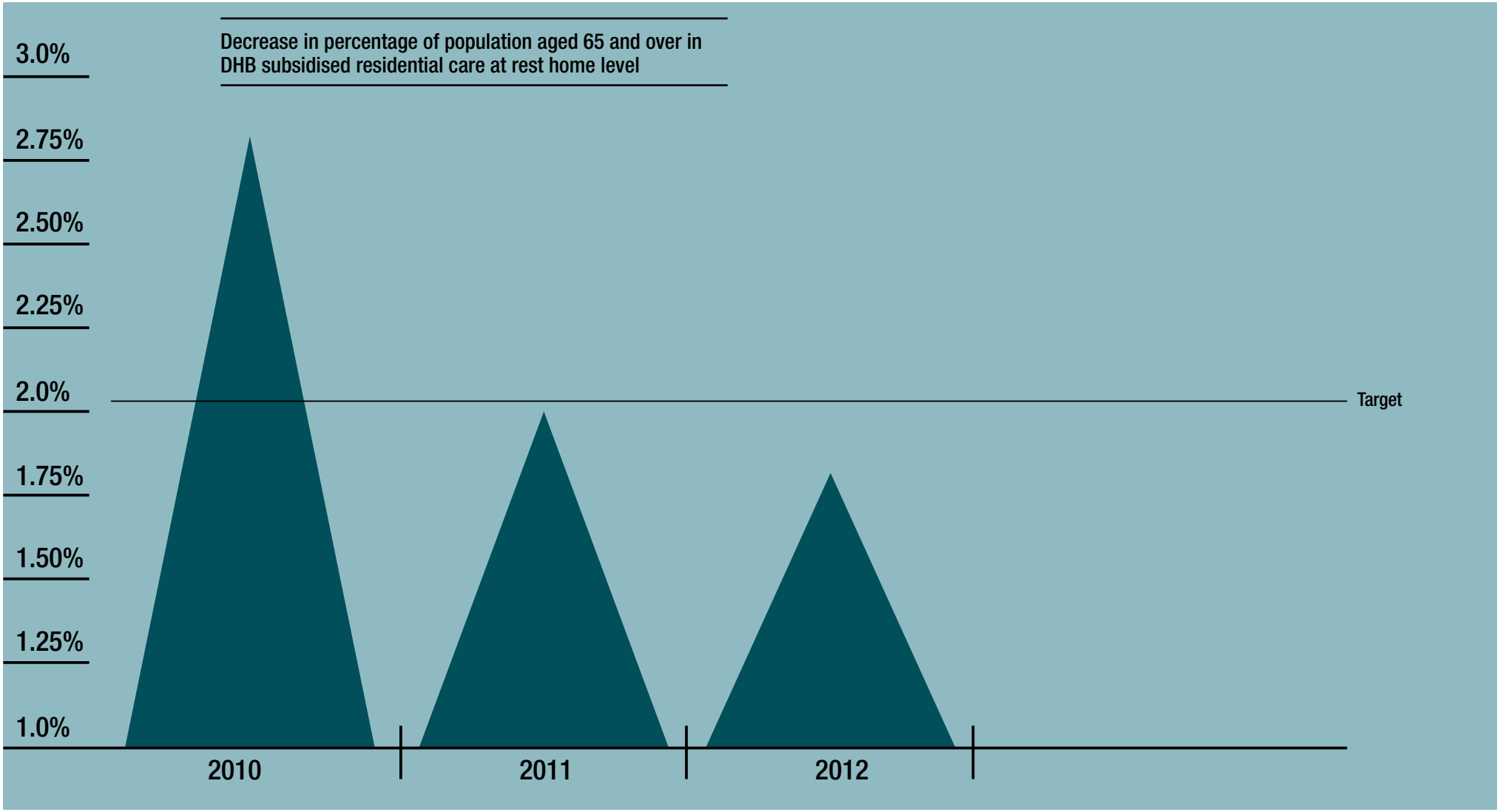
Reducing the number of avoidable hospital admissions ensures that patients are able to utilise services that are provided in the community setting rather than in hospitals. This will free up hospital staff and resources for more acute and urgent cases while also ensuring the services being funded in 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

The 2012/13 figure is as at 31 March 2013 as the national standardisation process impacts on the reporting timeliness. Our results show that avoidable hospital admissions have increased in all age bands since the baseline year.

The 45 - 64 year age range is of most concern with our overall performance in this age band being 102 percent, which is a ten percent increase since the 2010/11 year. Significant programmes are in place in a number of areas where our rates are high for this age band. These include the heart failure programme, diabetes initiatives and the primary options programme. The primary options programme commenced with one of our primary care partners in Hamilton in October 2012 and will be rolled out across the entire district by February 2014. The programme provides additional funding for patients to access primary care to enable them to avoid secondary services and can be expected to impact on admissions for areas like cellulitis, constipation and dehydration where our admission levels are higher than national rates.

During 2013/14 further analysis will occur in the key areas driving the increase in avoidable hospital admissions to identify the opportunities to reduce this level.


Decrease in percentage of population aged 65 and over in DHB subsidised residential care at rest home level
3.0%
2.75%
2.50%
2.25%
2.0%
1.75%
1.50%
1.25%
1.0%
Target
2010
2011
2012

Measure	Baseline 2010	Previous year 2011	Target 2012	Result 2012
Decrease in percentage of population aged 65 and over in DHB subsidised residential care at rest home level	2.77%	1.98%	2.05%	✓ 1.78%

Significance of measure

This measure provides an indication of the effectiveness of increasing home and community support options for older people, which enable them to remain in their home to receive the assessed level of care, rather than enter institutional care to receive the same level of service. The expected growth in the proportion of older people with complex care needs means that there will be a corresponding growth in the rate of expenditure to meet these 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 us in managing the rate of growth in expenditure on Health of Older People Services.

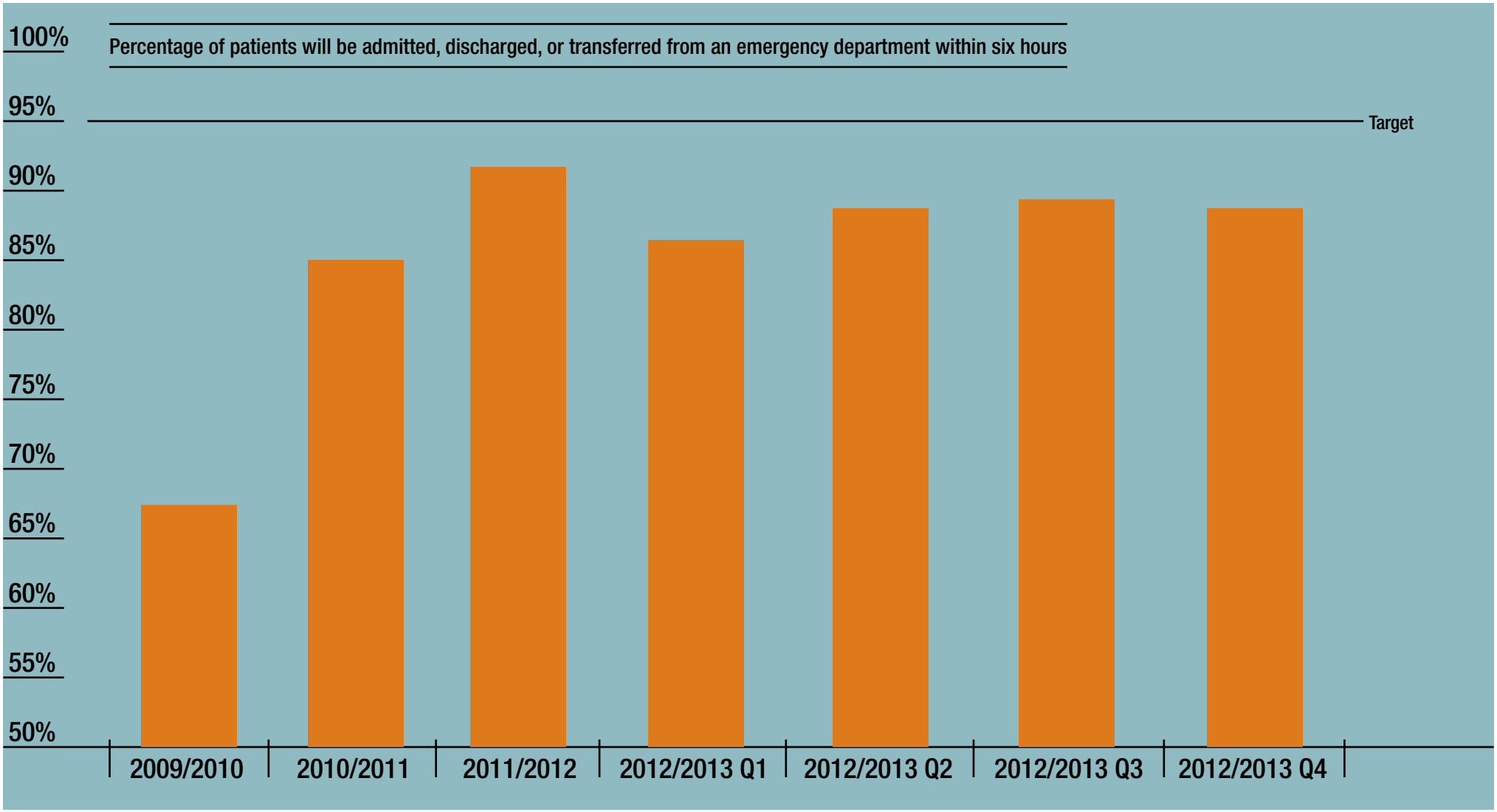
Waikato DHB performance

Calculation of the result against this measure relies on rest homes sending in claims for processing and payment. During 2012/13 it was identified there were delays in the system which impacted on the results presented against this measure. To improve the accuracy of the results reported we have determined that the calendar year is the better time period for reporting. This time period has been used in the reporting above.

This change in time period for the measure means the results do not align with the ones published in our Annual Report for 2011/12.

One of the key influences of this measure is the extent to which home and community support services provide options for clients who may otherwise need to access rest home level services. Therefore, the result reflects the impact of increasing both long term home and community support options and short term restorative options for older people in our district.

Long-term impact	**People receive timely and appropriate specialist care**			
Intermediate impacts	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 and addictions	More people with end stage conditions are supported
Impact measures	Percentage of patients will be 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	Improving the health status of people with severe mental illness through improved access	


Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Target
2009/2010
2010/2011
2011/2012
2012/2013 Q1
2012/2013 Q2
2012/2013 Q3
2012/2013 Q4

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours	85%	92%	95%	✗ 88%

Significance of measure

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 us this is Waikato and Thames Hospital emergency departments only.

Waikato DHB performance

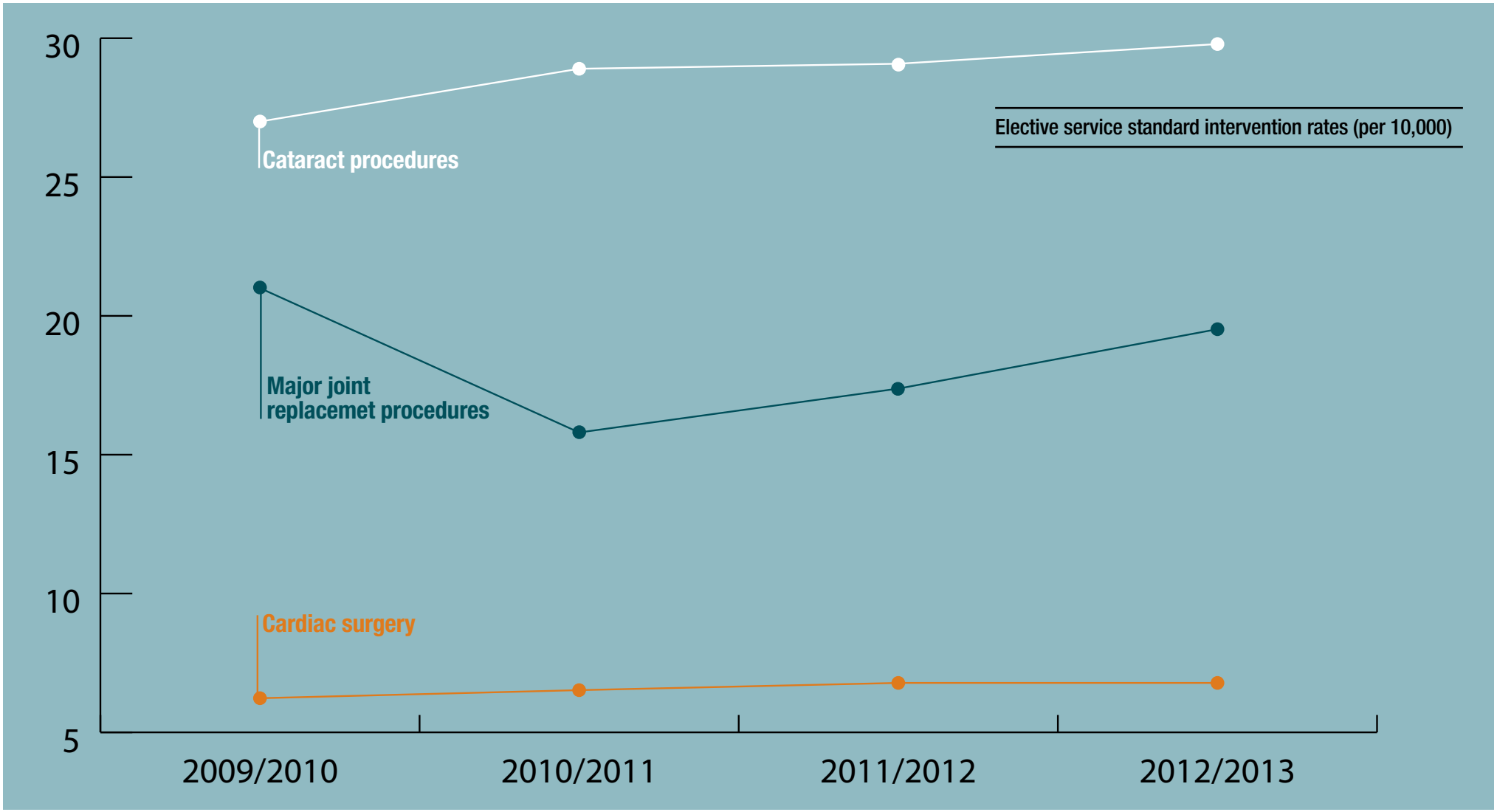
Factors like the increase in presentations to emergency departments, the capacity and availability of primary care providers and people's ability to afford private healthcare impact on our ability to achieve this target. For example, the volume of people presenting at Waikato and Thames Hospital emergency departments has increased almost 19 percent (12,993 presentations) over the last four years.

We have developed a detailed action plan to reach the target. The plan includes both actions to improve processes and systems in the hospital, as well as working with primary care to reduce the demand and ensure that people are seen in the right setting based on their needs.

Activities from the plan include:

- primary options development which is expected to divert care and diagnostics away from the emergency department
- an Acute Care GP liaison position which strengthens the linkages between primary care and the hospital
- establishment of a clinical group with a view to providing a plan of care for individuals that present frequently to the emergency department

This measure links with the measure around people who are triage level four and five presenting to emergency departments.


30
25
20
15
10
5
2009/2010
2010/2011
2011/2012
2012/2013
Elective service standard intervention rates (per 10,000)
Cataract procedures
Major joint replacemet procedures
Cardiac surgery

Measures	Baseline 2009 / 2010	Previous year 2011/2012	Target 2012/2013	Result 2012/2013
Elective service standardised intervention rates (per 10,000) — **Major joint replacement procedures**	21	17.38	21	✗ 19.52
Elective service standardised intervention rates (per 10,000) — **Cataract procedures**	27	29.08	27	✓ 29.79
Elective service standardised intervention rates (per 10,000) — **Cardiac surgery**	6.23	6.78	6.5	✓ 6.78

Significance of Measure

Timely access to elective services is a measure of the effectiveness of the health system. Meeting standard intervention rates will support better sooner more convenient health services by improving or maintaining access to elective services, and ensuring people receive better and more timely access to health services, regardless of where they live. Knowing that access to services is equitable will improve the public's trust and confidence in the public health system.

Due to the reliance on National Minimum Data Set data (where the deadline for submission is about one month after the end of the quarter), the data used to derive this measure is one quarter in arrears.

Waikato DHB performance

We have a standardised intervention rate for joints of 19.52 against a target of 21.00. Whilst this remains below the national target this has increased from the previous year so progress is trending upwards. Additional planned investment is occurring in orthopaedics for 2013/14 which should enable us to move to the national target.

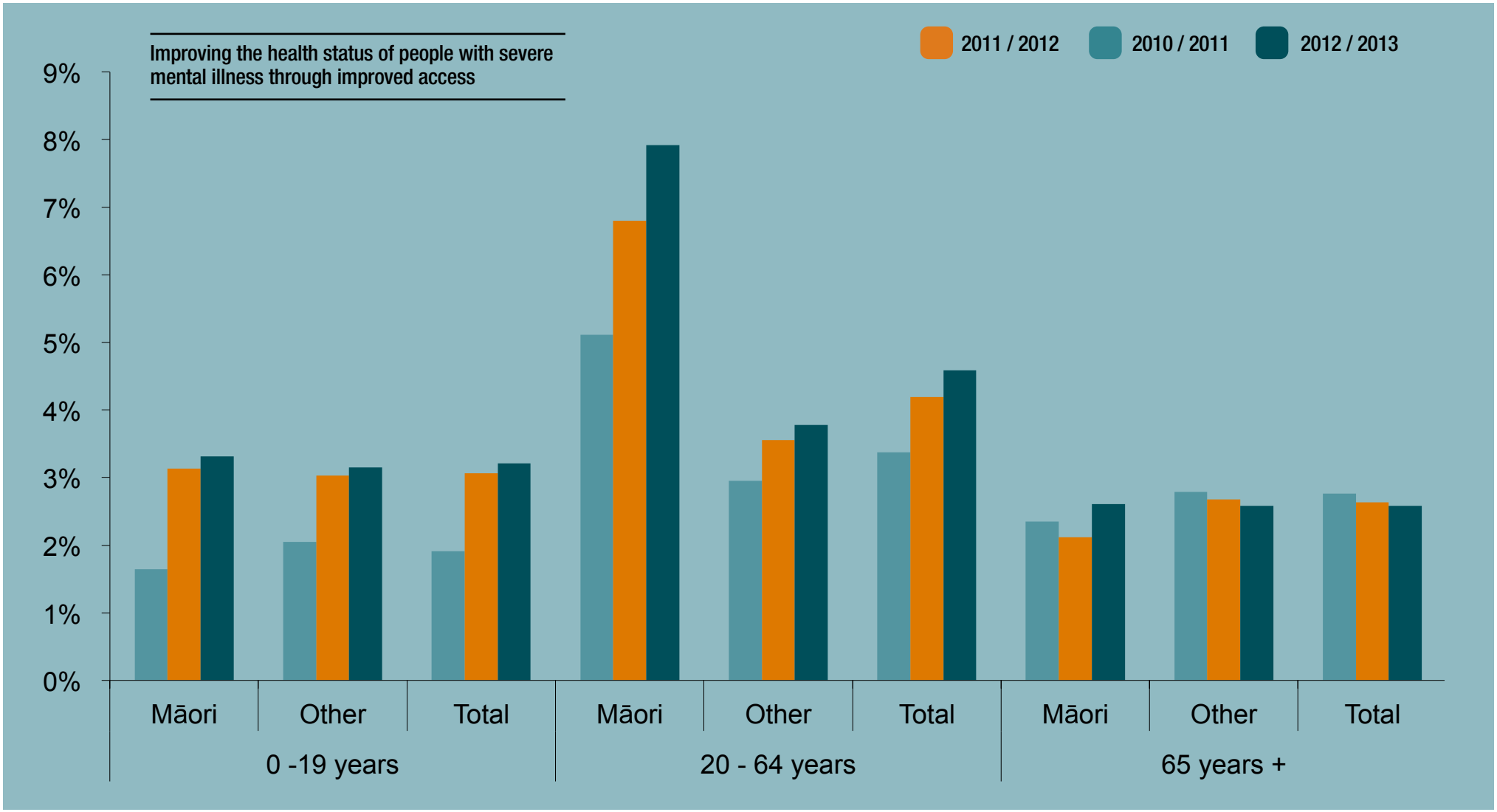
Standardised discharge information was not available for major joint replacements or cataract procedures. The result reported is as at December 2012.

P.68

People receive timely and appropriate specialist care

Improving the health status for people with a severe mental illness and addictions

Impact measure



Measure	Baseline at at March 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Improving the health status of people with severe mental illness through improved access for **0-19 year olds**	Māori 1.25% Other 1.71% Total 1.56%	Māori 3.13% Other 3.03% Total 3.06%	Māori 3.02% Other 3.02% Total 3.02%	✓ Māori 3.31% ✓ Other 3.15% ✓ Total 3.21%
Improving the health status of people with severe mental illness through improved access for **20-64 year olds**	Māori 3.86% Other 2.59% Total 2.83%	Māori 6.80% Other 3.55% Total 4.19%	Māori 6.05% Other 3.29% Total 3.82%	✓ Māori 7.92% ✓ Other 3.78% ✓ Total 4.59%
Improving the health status of people with severe mental illness through improved access for **65+ year olds**	Māori 1.77% Other 2.70% Total 2.63%	Māori 2.12% Other 2.68% Total 2.76%	Māori 2.50% Other 2.97% Total 2.94%	✓ Māori 2.61% ✗ Other 2.58% ✗ Total 2.58%

Significance of measure

It is estimated that at any one time, 20 percent of the New Zealand population will have a mental illness or addiction, and three percent are severely affected by mental illness. The World Health Organisation (WHO) predicts that depression will be the second leading cause of disability by 2020.

Better access to a broad range of services improves people's mental health and wellbeing, and contributes to recovery.

The results for this measure are as at 31 March 2013.

Waikato DHB performance

We continue to provide access to children and young people requiring mental health and addictions services above agreed targets. In previous years babies involved in a mother and baby support pilot were incorrectly coded as receiving mental health services when the service was actually provided to the mother. From December 2012 reporting records the mother as the service user not the baby.

We have exceeded the access rate targets for adults. The access rate for Māori adults of 7.92%. The national rate is 7.15%.

In relation to mental health addiction service access rates, Health Waikato Mental Health Services for Older People have been focused on a high level of consult liaison being provided to primary health, rest homes and the memory clinic, which could be resulting in fewer direct referrals to the service.

People receive timely and appropriate specialist care

More people with end stage conditions are supported

Impact measure

Significance of measure

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process.

There are a number of providers involved in the provision of care for people with end stage conditions, including hospices, hospital palliative care services as well as a number of primary palliative care providers. Care for people with end stage conditions is often known as palliative care. Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.

Waikato DHB performance

The Palliative Care Council of New Zealand have identified a lack of data on the need for palliative care in New Zealand's population, current service provision and service utilisation as a pressing concern. Without evidence and data it is impossible to monitor and evaluate progress.

In response to this situation the Palliative Care Council of New Zealand embarked on a significant health needs analysis project. Estimates for the need for palliative care were published in 2011. A second set of information was published in June 2013 in relation to palliative care capability and capacity in New Zealand.

We expect to be able to use the data and methodologies from the Palliative Care Councils work to determine the most appropriate set of impact and output measures for this part of our performance story.

As part of the midland annual planning process we investigated what measures would be appropriate for this part of our performance story. We have yet to settle on a set of measures and identifying these will be a priority in 2013/14.

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

Our outputs

Outputs in this context are final goods and services that are supplied to a person, group or organisation outside Waikato DHB. They do not include goods and services produced entirely for consumption within the DHB.

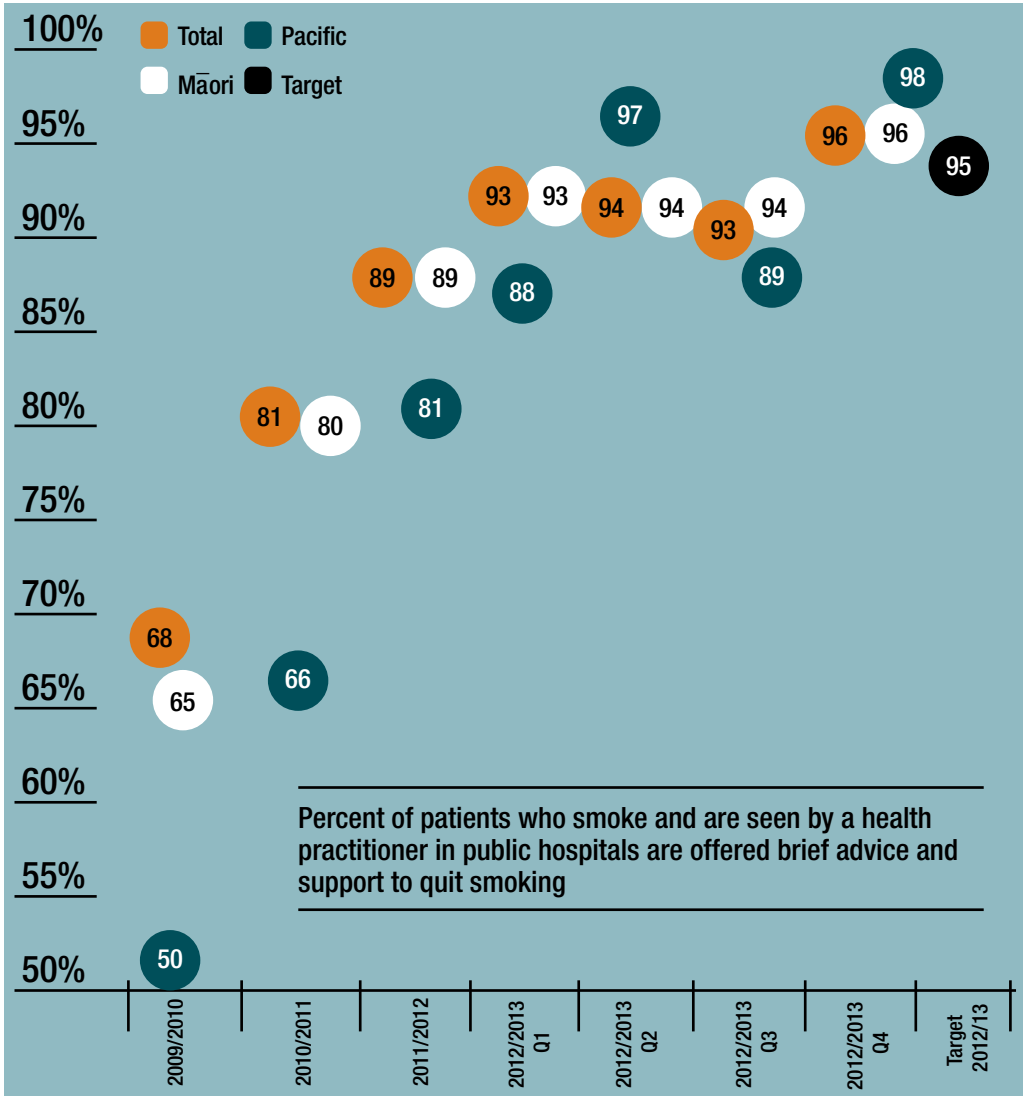
Long-term impact	**People take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Output Performance Measures	• Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking • Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking • Number of education sessions with tobacco retailers • Number of controlled purchase operations with tobacco retailers	• Percentage of population over 65 years who are immunised against influenza • Percentage of eight months olds who have had their primary course of immunisation on time • Percentage of two year olds fully immunised	• Percentage of infants fully and exclusively breastfed • Number of schools participating in the Health Promoting Schools initiative • Percentage of schools participating in the Health Promoting Schools initiative • Percentage of decile 1 and 2 schools participating in the Health Promoting Schools initiative • Percentage of Kura Kaupapa Māori primary schools participating in Project Energize • Percentage of total primary schools participating in Project Energize

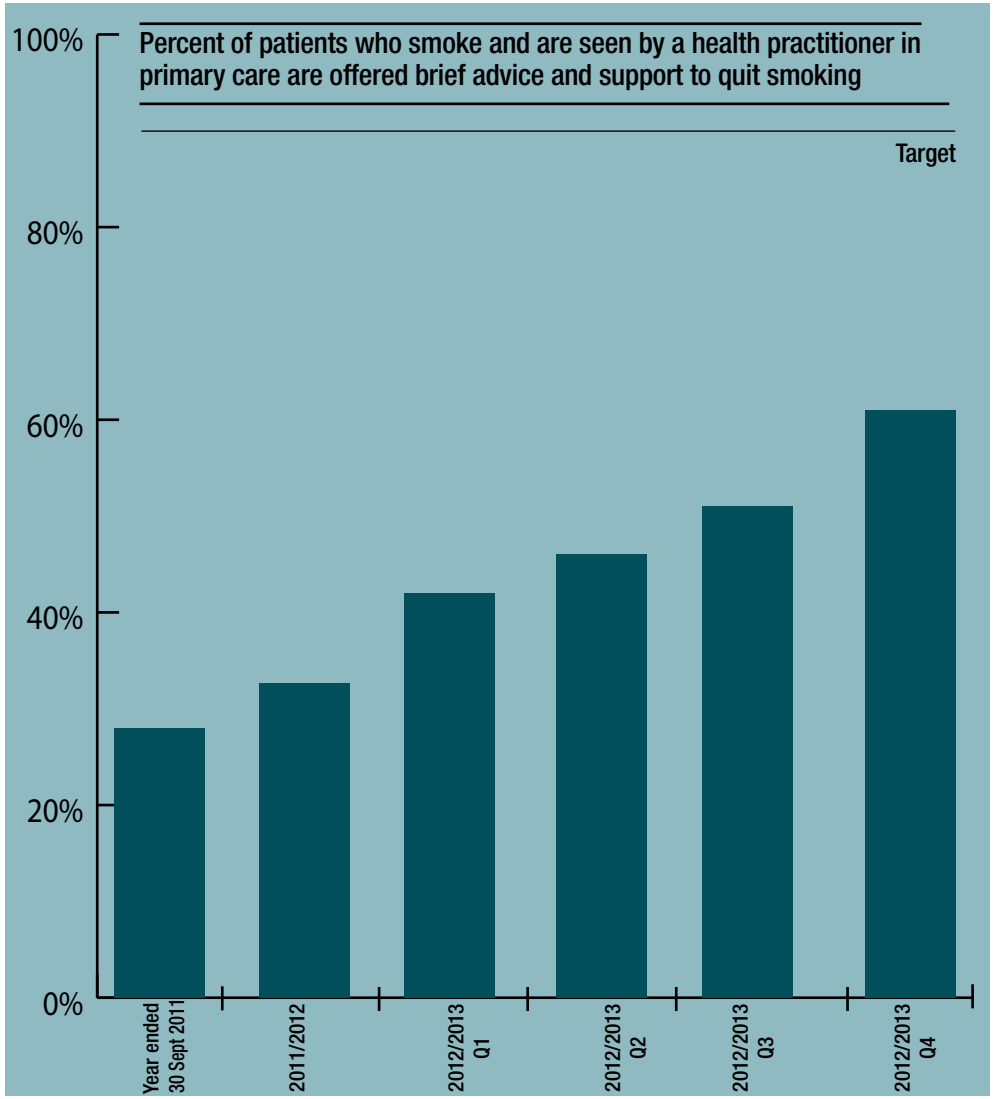
P.74

People take greater responsibility for their health

Fewer people smoke

Output measure





Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking	28%	37%	90%	✗ 61%
Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	81%	89%	95%	✓ 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 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.

Waikato DHB performance

The previous years result reflects final information received by the Ministry of Health. This figure differs from the result presented in our Annual Report 2011/12 which was based on preliminary figures.

Our results against the primary care portion of this measure have steadily increased since this measure was introduced. We have been working with our primary care alliances during the year to increase capability in general practice to effectively support people to quit smoking and will continue to do so in 2013/14. Key initiatives include:

- A cessation co-coordinator role has been introduced by one of our alliance partners to coordinate training, ensure links to community support services, work towards a practice cessation plan, and generally to support practices to have robust systems, processes and planning for smoking cessation.
- Use of a data-recording, reminding and decision support tool for practices which has been reported to work well at practice level to provide on-the-spot cessation advice and classification, as well as automated referrals to Quitline.
- Establishment of a Clinical Leader for smoking cessation by one of our alliance partners to advance the smoking cessation work of GPs, to work on the primary-secondary interface, and to provide GP-based advice to their smoking cessation project.
- Implementation of a coordinated communications and social marketing plan.

Waikato DHB performance (continued)

We achieved the national health target level against the hospitalised smokers portion of the health target for the first time during 2012/13. The activities we delivered in 2012/13 that enabled our improved performance included:

- weekly feedback for Charge Nurses and Midwives in areas which are not meeting target, which remains the most effective strategy to remind wards/units each smoker missed means they do not meet target.
- a review of clinical notes for these missed events identified a potential area of improvement. A solution was implemented which involved ensuring a wider range of patients notes are checked rather than a reliance on the ABC sticker. This will be closely monitored by the Nurse Coordinator.

Our birthing population data tells us that we have high proportion of births to young Māori women. We have high smoking rates and many of our women live in higher deprivation areas which impact on health inequality and health outcomes. This has led to a planned focus on smoking during pregnancy which will continue into 2013/14. We are planning to report on our progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit in 2013/14.

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Number of education sessions with tobacco retailers	80	109	120	✓ 287
Number of controlled purchase operations with tobacco retailers	80	92	120	✓ 191

Significance of measure

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

A controlled purchase operation is when underage 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

In addition to standard tobacco control purchase operations, joint operations have been conducted with NZ Police in Hamilton and South Waikato targeting underage sales of synthetic cannabis products. Our performance reflects a purposeful increase in the capacity of our Population Health Service with an increase from two to four designated Smokefree Enforcement Officers.

P.78

People take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measures	Baseline 2010 / 2011	Previous year Dec 2011	Target Dec 2012	Result Dec 2012
Percentage of population over 65 years who are immunised against influenza — **high need**	62.50%	63.13%	63.50%	✓ 64.92%
Percentage of population over 65 years who are immunised against influenza — **total**	63.00%	63.86%	63.50%	✓ 64.75%

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

The results presented are as at December of 2011 and December of 2012 which incorporates the full year 'flu season'. Influenza vaccinations are generally provided through primary care. A number of initiatives were developed and implemented with our primary care partners in 2012/13 so the improvement in performance is positive.

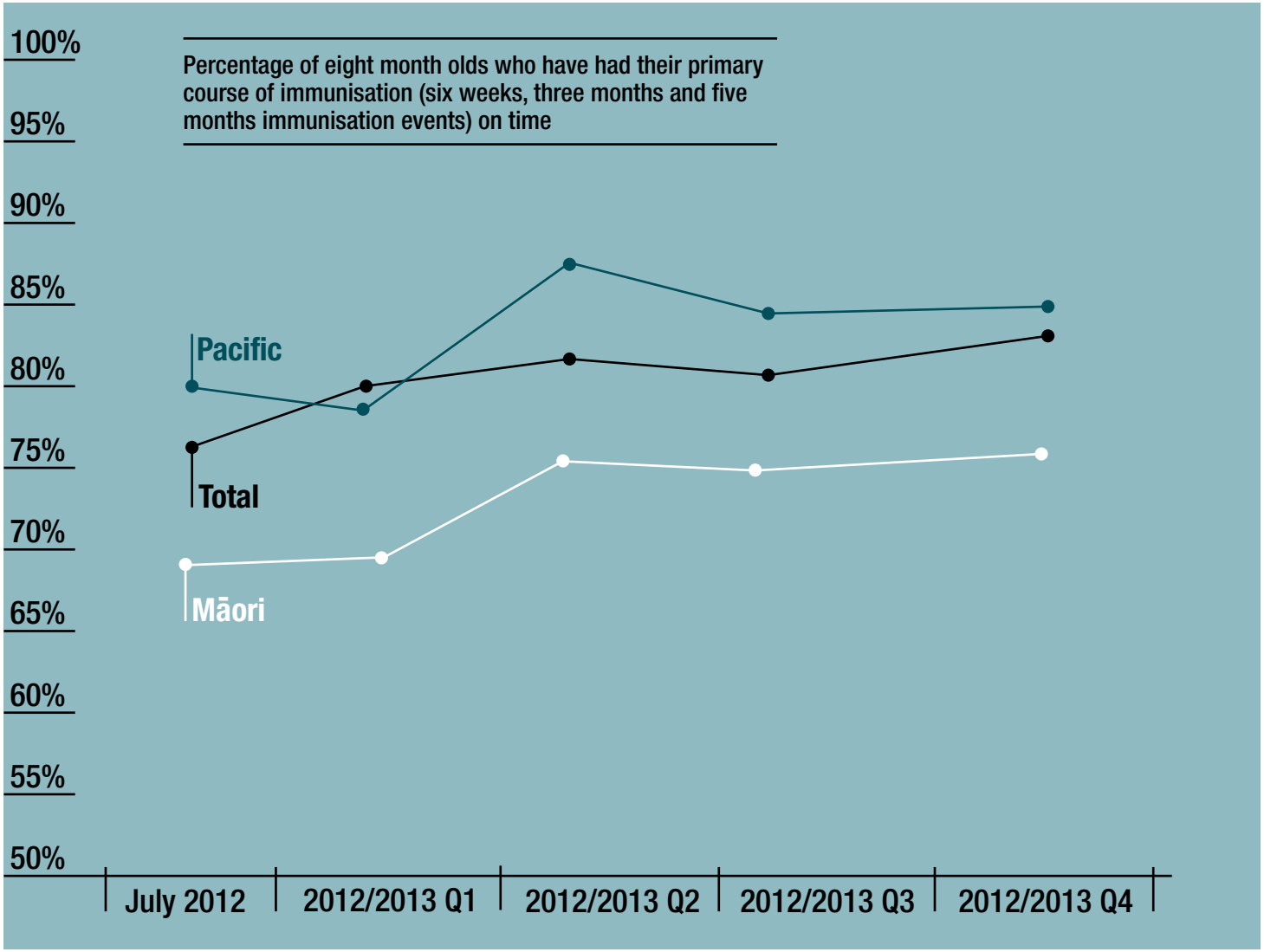
Patient Lillian Lane

P.80

People take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure



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. The diseases protected against include diphtheria, tetanus, whooping cough, polio, hepatitis B, haemophilus influenzae type B, pneumococcal, measles, mumps and rubella.

Although New Zealand's two-year-old immunisation rates have increased remarkably since 2009 from 80 percent to 93 percent in 2012, low immunisation rates prior to this time, has enabled the breakthrough of diseases prevented by vaccine, such as measles and whooping cough. Increasing coverage for eight-month-olds will also require system improvements in the whole immunisation system. The immunisation target of increasing eight month olds coverage will support early enrolment and on-going engagement with primary care and well child services.

It is still important we measure coverage at the two year old age milestone as this will provide more information about the immunisation system.

Measure	Baseline 31 July 2012	Target	Result 2012 / 2013
Percentage of eight month olds who have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Māori 68% Pacific 80% Total 76%	Māori 85% Pacific 85% Total 85%	✗ Māori 75.9% ✓ Pacific 85.1% ✗ Total 83.2%

Measure	Baseline 2009 / 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of two year olds fully immunised	Māori 66% Pacific 74% Total 81%	Māori 92% Pacific 96% Total 92%	Māori 95% Pacific 95% Total 95%	✗ Māori 85.50% ✗ Pacific 91.20% ✗ Total 87.40%

Waikato DHB performance

The immunisation at eight months old measure was a new national health target introduced for the 2012/13 year and the Ministry of Health released baseline data for DHBs to use in early 2012/13.

The baseline data was not available in time to be included in our Statement of Intent for 2012/13 but we have used it as part of the information presented above.

Our quarter four result for the total population of 83 percent means that we needed to have immunised an extra 26 more eight month olds during the quarter to achieve the target level. Our quarter four immunisation coverage for children aged 24 months result for the total population was 88 percent against a target of 95 percent. The seven percent difference represents 103 children not immunised on time.

Our performance levels against these indicators at a total population and especially for our Māori and Pacific population are a concern. Recent changes in the service configuration, some gaps and overlaps in geographic service provision have emerged. We have been working with all the PHOs and outreach immunisation service providers to seek resolution.

People take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2009 / 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012
Percentage of infants fully and exclusively breastfeed — **6 weeks**	74%	69%	74%	✗ Māori 61% ✗ Pacific 63% ✗ Other 73% ✗ Total 69%
Percentage of infants fully and exclusively breastfeed — **3 months**	57%	56%	57%	✗ Māori 45% ✗ Pacific 52% ✓ Other 58% ✗ Total 54%
Percentage of infants fully and exclusively breastfeed — **6 months**	27%	26%	27%	✗ Māori 15% ✗ Pacific 25% ✓ Other 27% ✗ 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.

Waikato DHB performance

The data presented in the results column is Plunket data only and is for the 2012 calendar year. A portion of the work undertaken in this area was directed through the Health Eating Healthy Action (HEHA) project. This national project finished in 2011/12 and this was expected to have an impact on the results we were able to achieve in 2012/13. While the HEHA project resources were not available in 2012/13 we planned and implemented a number of other activities to support our population and positively impact on breastfeeding rates. These initiatives included:

- Hapū Wānanga (Māori kaupapa antenatal and parenting programme designed by Māori for Māori)
- Wahakura Project - a total of 30 weavers were targeted to be trained to weave and distribute 100 wahakura to high-risk whānau. Resources integrating messages in the area of safe sleeping, breastfeeding and smoke free were also developed to accompany each wahakura.
- Pepi-Pods Project – the project brings together messages associated with safe sleeping practices, smoke free whānau, violence free and breastfeeding into one package.

Measures	Baseline Jan 2010 - Dec 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Number of schools participating in the Health Promoting Schools initiative	80	39	80	✗ 37
Percentage of schools participating in the Health Promoting Schools initiative	64.50%	16%	64.50%	✗ 13%
Percentage of decile 1 to 4 schools participating in the Health Promoting Schools initiative	100%	35%	100%	✗ 27%

Significance of measure

A function of the DHB is to 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. The Health Promoting Schools programme supports healthy school environments. It aims to improve students' health and wellbeing and contribute to improved learning outcomes. Through the Health Promoting Schools programme we can positively influence health behaviours.

Waikato DHB performance

This programme is provided by our Population Health Service and is available to all primary schools classified as decile one to four in our district (this equates to 124 schools). As noted in our 2012/13 statement of forecast service performance Cognition Education was contracted by the Ministry of Health to look at the development of a new framework for the Health Promoting Schools Programme. The development of a new framework was completed in 2012/13 and it has had a significant impact on the provision of the Health Promoting Schools programme. DHBs are required to adopt the new framework for the programme which was expected to result in a 50 percent decrease in school participation in the early stages of implementation.

The measure in relation to the percentage of decile one to four schools participating in Health Promoting Schools differs from the measure in the 2012/13 statement of forecast service performance, which related to decile one and two schools only. This has been done to line up with reporting to the Ministry of Health.

The definition of the measures has changed since the baselines were presented in our Statement of Intent for 2012/13. The change means that the way the results are now calculated is more representative of the school participation status.

P.84

People take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2009	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	100%	93.80%	100%	✓ 100%
Percentage of total primary schools participating in Project Energize	98.80%	98.80%	98.80%	✓ 100%

Significance of measure

Project Energize is a school-based initiative focused on improving children's physical activity and nutrition. Through Project Energize we can positively influence health behaviours and reduce the risk factors associated with many chronic conditions.

Waikato DHB performance

Project Energize is managed and provided by Sport Waikato. A team of Energizers delivers the service with each Energizer supporting a number of schools in a specified geographic area. A dietician and community paediatrician provides clinical support for the project.

There are 244 primary schools in our district with 14 Kura Kaupapa Māori primary schools. All but one of the schools has an Energizer assigned to provide practical 'hands on' support. The other school already has a Sports Coordinator funded by another government organisation so a decision was made not to duplicate the resource. The school does participate in Project Energize through tournaments, inter-school activities, kiwisport and workforce professional development.

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 under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services • Percentage of pre-school and primary school children (0 – 12 years) who have not been examined according to their planned recall period • Percentage of adolescents accessing DHB funded oral health services	• Percentage of eligible population who have had a cervical smear • Percentage of eligible population who have had a breast screen in the last the 24 months • Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years • Percentage of people with diabetes who are enrolled with a primary health organisation and have had a diabetes annual review	• Percentage of population enrolled with a primary health organisation • Percentage of triage level four and fives presenting to emergency department • Percentage of rest home residents on high dose vitamin D supplementation • Percentage of eligible children have their B4 School Checks completed	• Number of residential respite bed days (health of older people services) • Ratio of completed comprehensive clinical assessments undertaken by NASC using contact assessment tool : MDS-HC tool • Number of visit days of intermediate care delivered - START • Number of bed days of intermediate care delivered - Transitional care • In home respite (carer support) days utilised (health of older people services) • Proportion of people with dementia who have been assessed as having a MAPIe score ≥3 who have a completed care plan • Decrease in proportion of population 65 years or older in DHB subsidised residential care at rest home level • Percentage of needs assessment and service co-ordination (NASC) waiting times for new assessments within 20 working days • Referral to service planning within 20 working days (NASC services) • Number of clients on caseload (primary mental health and addictions) • Number of primary mental health and addictions packages for care

Dr Sarah Davidson and patient Riley Bennett in Maxillofacial and Dental Depatment, Waikato hospital

Measure	Baseline 2009	Previous year 2011	Target 2012	Result 2012
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services	46%	66.4%	68.0%	✓ 70.1%
Percentage of pre-school and primary school children (0 – 12 years) who have not been examined according to their planned recall period	15.0%	19.0%	7.0%	✗ 9.0%
Percentage of adolescents accessing DHB funded oral health services	66%	72.5%	75.0%	✗ 72.5%

Significance of measure

Research shows that improving oral health in childhood and adolescence has benefits over a lifetime. Oral health measures are reported annually (in quarter three) for the previous calendar year except for the adolescent measure which is reported annually in quarter four.

The baseline for these measures has been updated to reflect actual 2009 results which will enable better comparison better years. The target for the enrolment measure has been updated to align with the target in our Annual Plan for 2012/13. These figures will differ from those presented in our Statement of Intent for 2012/13.

Waikato DHB performance

These measures are reported by calendar year as they link in with the school year calendar.

Preschool enrolment increases reflect successful working relationships between our Community Oral Health Service and the Well Child Providers. The increase in enrolments has meant some capacity issues for the service which are reflected in the percentage of children who have not been able to be examined according to their planned recall period arrears. The percentage of arrears is also impacted by the current manual processes, staff vacancies and turnover and the growth in the population we serve (3.6 percent more than estimated projections). An action plan has been initiated aimed at reducing the arrears over the first half of 2013/14.

An issue with appointment attendance has been identified which will be investigated in 2013/14. However, a lack of an electronic record system increases the complexity of responding to this issue. We have been working towards implementing an electronic record system in this area. The original business case for a software solution and the associated costings are being reviewed. It is expected this will be completed in early 2013/14.

The results for the adolescent oral health measure equates to 17,508 young people accessing DHB funded oral health services. Our result compares favourably with the result for the Midland region (66 percent) and the national result (70 percent).

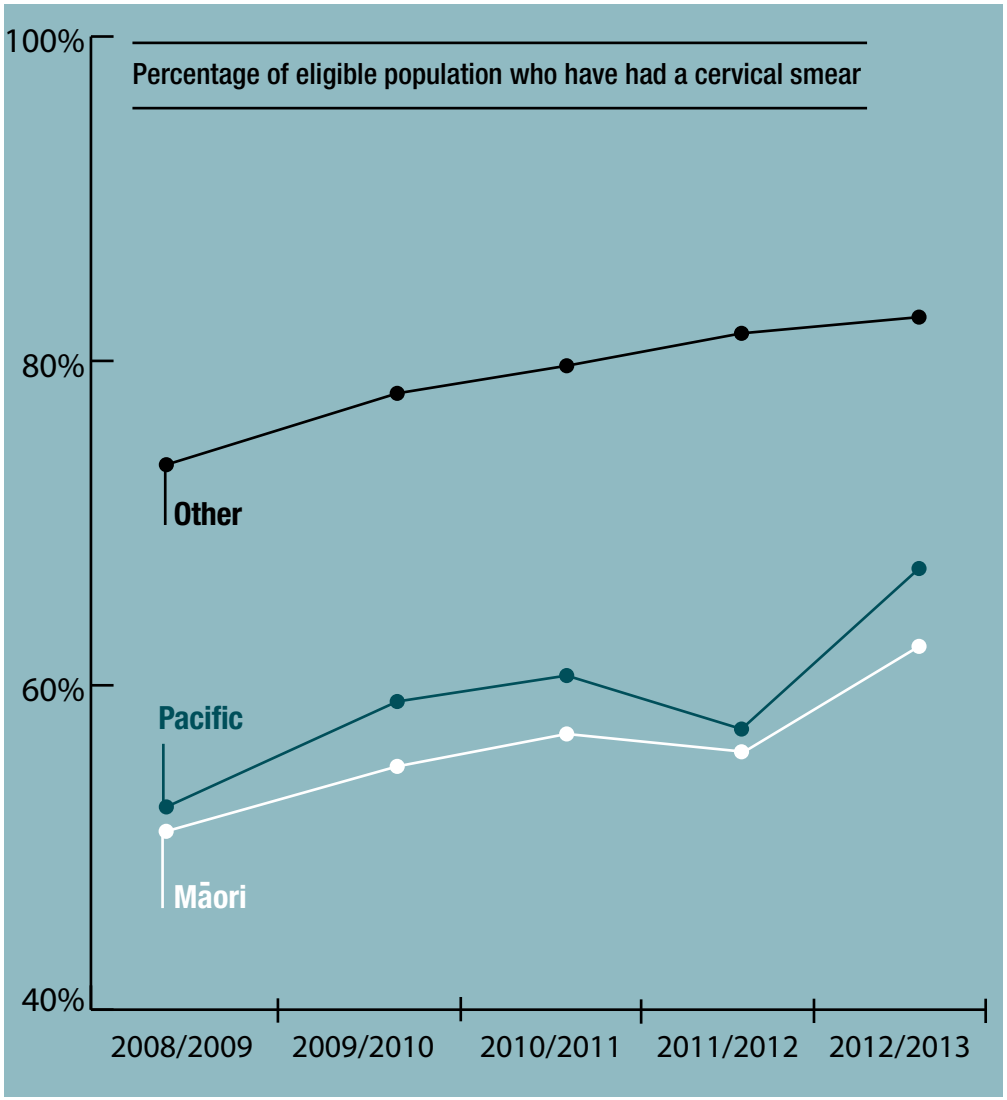
The Ruapehu District Council removed fluoride from the Taumarunui water supply in 2011 and Hamilton City Council made the same decision in 2013, which goes against evidence that it reduces tooth decay. We will continue to monitor the impacts of these decisions.

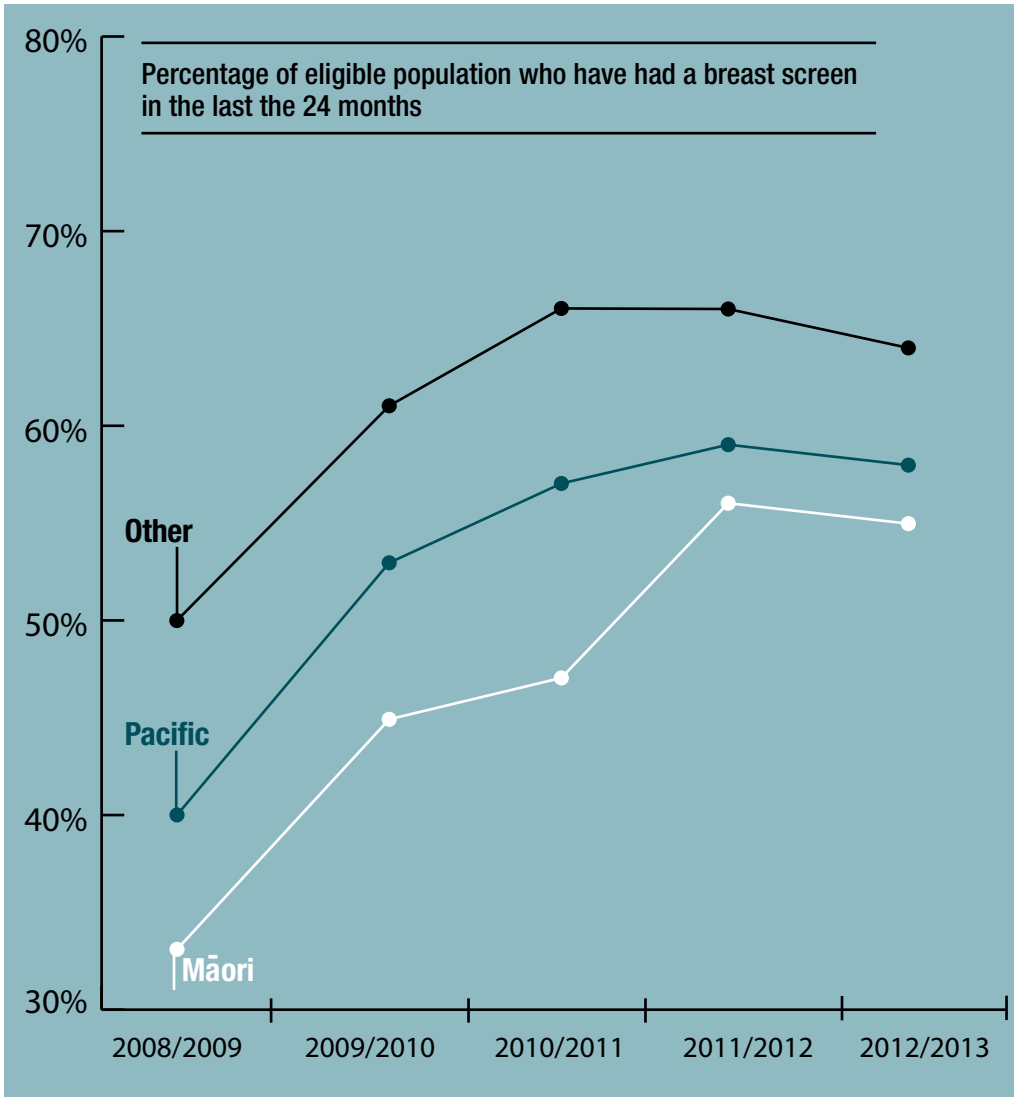
P.88

People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure





Measure	Baseline 2008 / 2009	Previous year 2011 / 2012 (as at March 2012)	Target 2012 / 2013	Result 2012 / 2013
Percentage of eligible population who have had a cervical smear	Māori 51.1% Pacific 52.5% Other 73.6%	Māori 55.9% Pacific 57.9% Other 81.7%	Māori 75% Pacific 75% Other 75%	✗ Māori 62.4% ✗ Pacific 67.2% ✓ Other 82.7%
Percentage of eligible population who have had a breast screen in the last the 24 months	Māori 47% Pacific 57% Other 66%	Māori 55.7% Pacific 58.5% Other 66.0%	Māori 70% Pacific 70% Other 70%	✗ Māori 54.7% ✗ Pacific 57.7% ✗ Other 63.9%

Significance of measure

The eligible population for the cervical smear 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 our Sexual Health Service will also provide this service as part of a sexual health clinical assessment.

The eligible population for the breast screening measure is women aged 50-69. 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.

Waikato DHB performance

There has been an increase in our performance against the cervical screening target during 2012/13. The gap between coverage rates for different ethnic groups appears to be shrinking which is a positive result.

In June 2013 the breast screening service has converted to digital mammography; it is hoped that the 2013/14 year will see significant gains being made towards achieving this target. Annual breast screening mobile visits to Tokoroa will commence in 2013 to increase Pacific Island coverage. In the second half of 2012/13, Breastscreen Midland and Te Puna Oranga (Māori Health Service) have been devising strategies to address the low Māori breast screening rates in our district. The following projects / services have been initiated to address the issue:

- Tuhikaramea Breastscreening Project - Te Puna Oranga staff were seconded to Tuhikaramea Medical Practice to contact, enrol and book eligible Māori and Pacific women belonging to the practice, into the Breastscreening Aotearoa (BSA) Programme
- Breastscreen Midland and Te Puna Oranga (Māori Health Service) Partnership - a Service Level Agreement (SLA) was put in place to increase the breast screening coverage of Māori wahine
- A Kaitiaki position focused on improving Māori screening rates and experiences has been established
- Breastscreening Kaiwhiriwhiri - a Kaiwhiriwhiri position is in the process of being established and has been made possible through funding contributed by Breastscreen Midland and the National Screening Unit.

Cardiac patient Doreen Moore being assessed by clinical nurse specialist Alison Mc Alley

Measure	Baseline as at June 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years	Māori 33.40% Pacific 38.10% Other 44.4% Total 42.10%	Māori 48.8% Pacific 49.4% Other 58.7% Total 57.0%	Māori 75% Pacific 75% Other 75% Total 75%	✗ Māori 62% ✗ Pacific 64% ✓ Other 76% ✗ Total 73%

Significance of measure

By increasing the percentage of people having cardiovascular disease risk assessments we ensure these are identified early and managed appropriately.

Waikato DHB performance

We have worked with our primary care partner alliances in 2012/13 to improve performance against this measure. Significant ground has been made. However, performance against this measure for the Māori and Pacific populations within our district needs to improve. We expect that through a strong focus on achieving this target and the delivery of our alliance partners long term conditions programmes the performance will reach the target levels in 2013/2014.

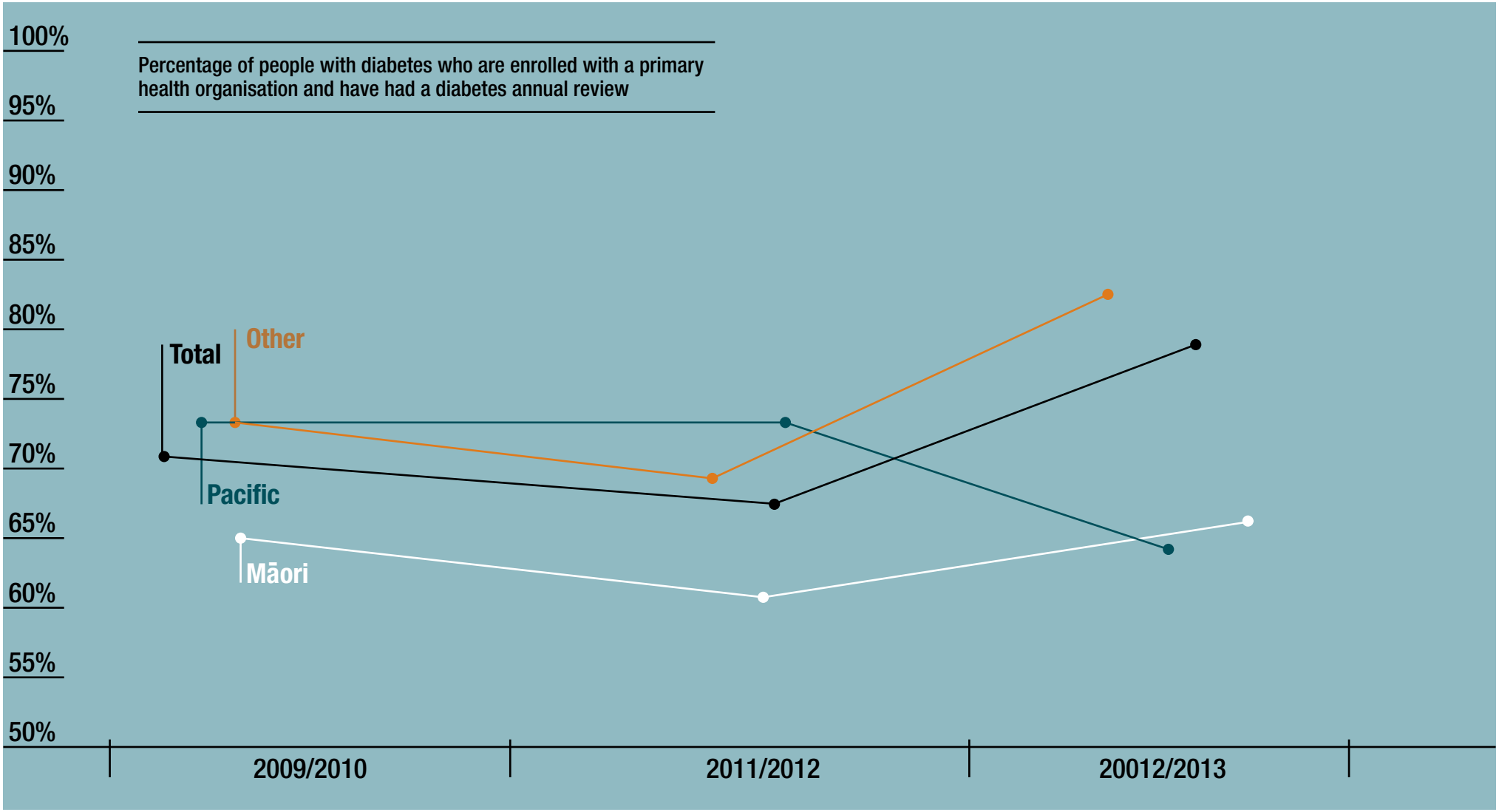
This measure forms part of the long term conditions programmes that have been developed during 2012/2013 and full implementation is expected to occur in 2013/2014.

P.92

People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure



Measure	Baseline 2009 / 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of people with diabetes who are enrolled with a primary health organisation and have had a diabetes annual review	Māori 65% Pacific 73% Other 73% Total 71%	Māori 61% Pacific 73% Other 69% Total 67%	Māori 70% Pacific 70% Other 70% Total 70%	✗ Māori 61% ✗ Pacific 57% ✓ Other 73% ✓ Total 70%

Significance of measure

Diabetes is important as a major and increasing cause of disability and premature death. It is also a good indicator of the responsiveness of a health service to the people in most need.

Waikato DHB performance

During 2012/13 we have been working with our primary care partners on the development of their Long Term Conditions (LTC) Programmes. These programmes include the national requirement around Diabetes Care Improvement Packages (DCIPs), which replaced the diabetes Get Checked Programme in 2012/13. This measure was part of the Get Checked Programme.

The decision to replace the Get Checked Programme followed a review of the programme which found it was not producing the desired improvement in outcomes for people with diabetes. The review concluded the Get Checked Programme added little clinical value to existing New Zealand general practice care processes.

The Get Checked Programme finished on 30 June 2012; however the annual reviews continued in 2012/13 during the transition between the Get Checked Programme and the local primary care LTC Programmes.

From 2013/14 the diabetes annual reviews will be incorporated into a broader cardiovascular disease risk assessment.

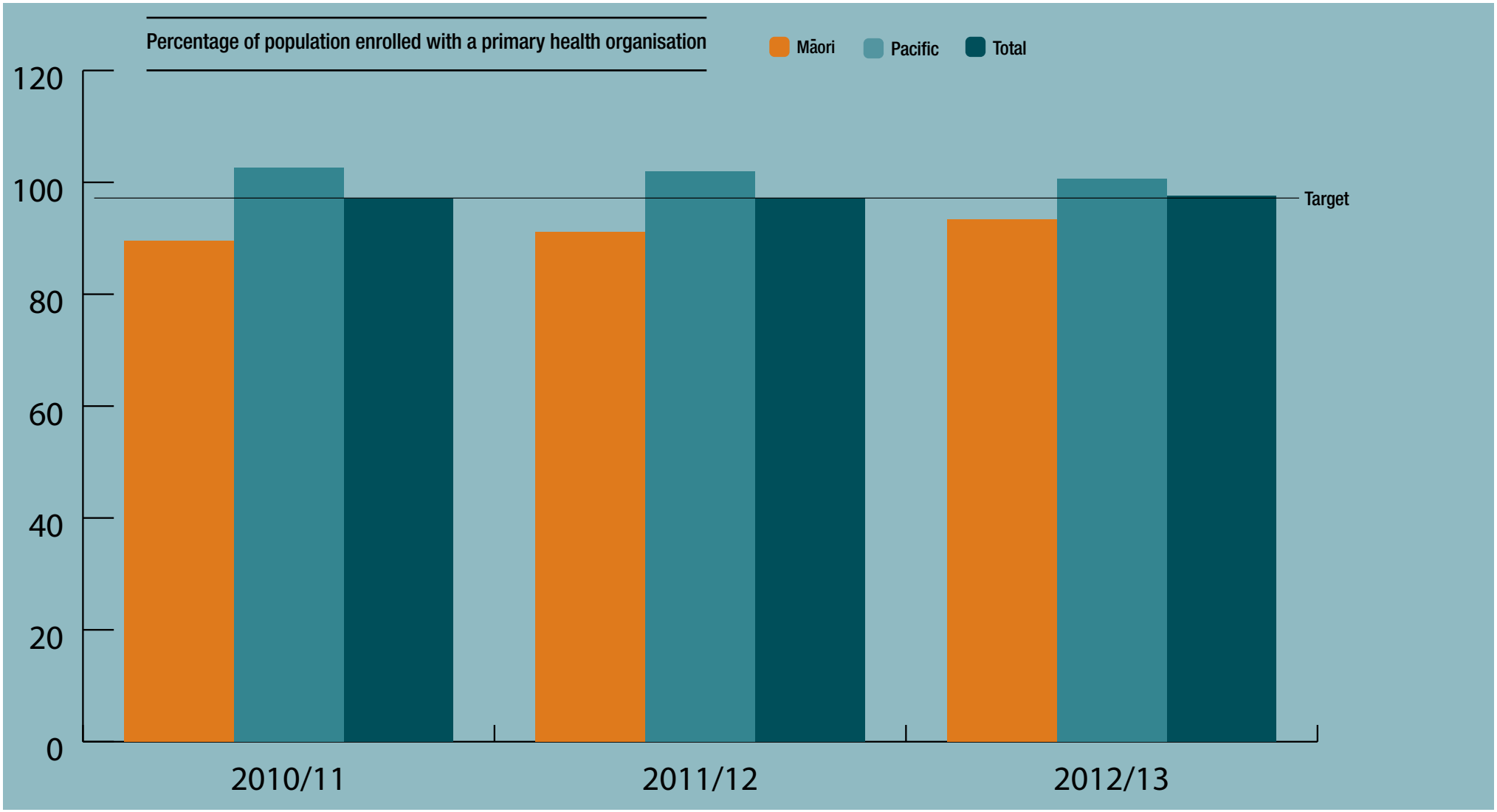
The baseline figures have been updated to reflect the final 2009/10 results. This has been done to provide more meaningful data and enable comparisons.

P.94

People stay well in their homes and communities

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

Output measure



People stay well in their homes and communities

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

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of population enrolled with a primary health organisation	Māori 89.5% Pacific 102.6% Total 97.0%	Māori 91.1% Pacific 102.0% Total 97.2%	Māori 97.0% Pacific 97.0% Total 97.0%	✗ Māori 93.4% ✓ Pacific 100.6% ✓ Total 97.6%

Significance of measure

Access to primary care has been shown to have positive benefits in maintaining good health. It can also reduce the economic cost of ill health by early intervention.

Waikato DHB performance

The percentage of the population enrolled with a primary health organisation has risen slightly between 2011/12 and 2012/13. The results for the Pacific population are higher than 100 percent because the denominator for this measure is based on Statistics NZ projections, which only provide an estimate of the true denominator.

As at June 2013, there were approximately 5,367 Māori not enrolled in a primary care organisation. This compares to 7,860 Māori not enrolled as at June 2012.

Nurse Emma Keenan with patient Betty Murphy in the Emergency department

People stay well in their homes and communities

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

Output measure

Measure	Baseline 2009 / 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of triage level four and fives presenting to emergency department	49.70%	48.00%	45.00%	✓ 45.00%

Significance of measure

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

This measure links closely to the 'percentage of patients admitted, discharged, or transferred from an emergency department within six hours' measure.

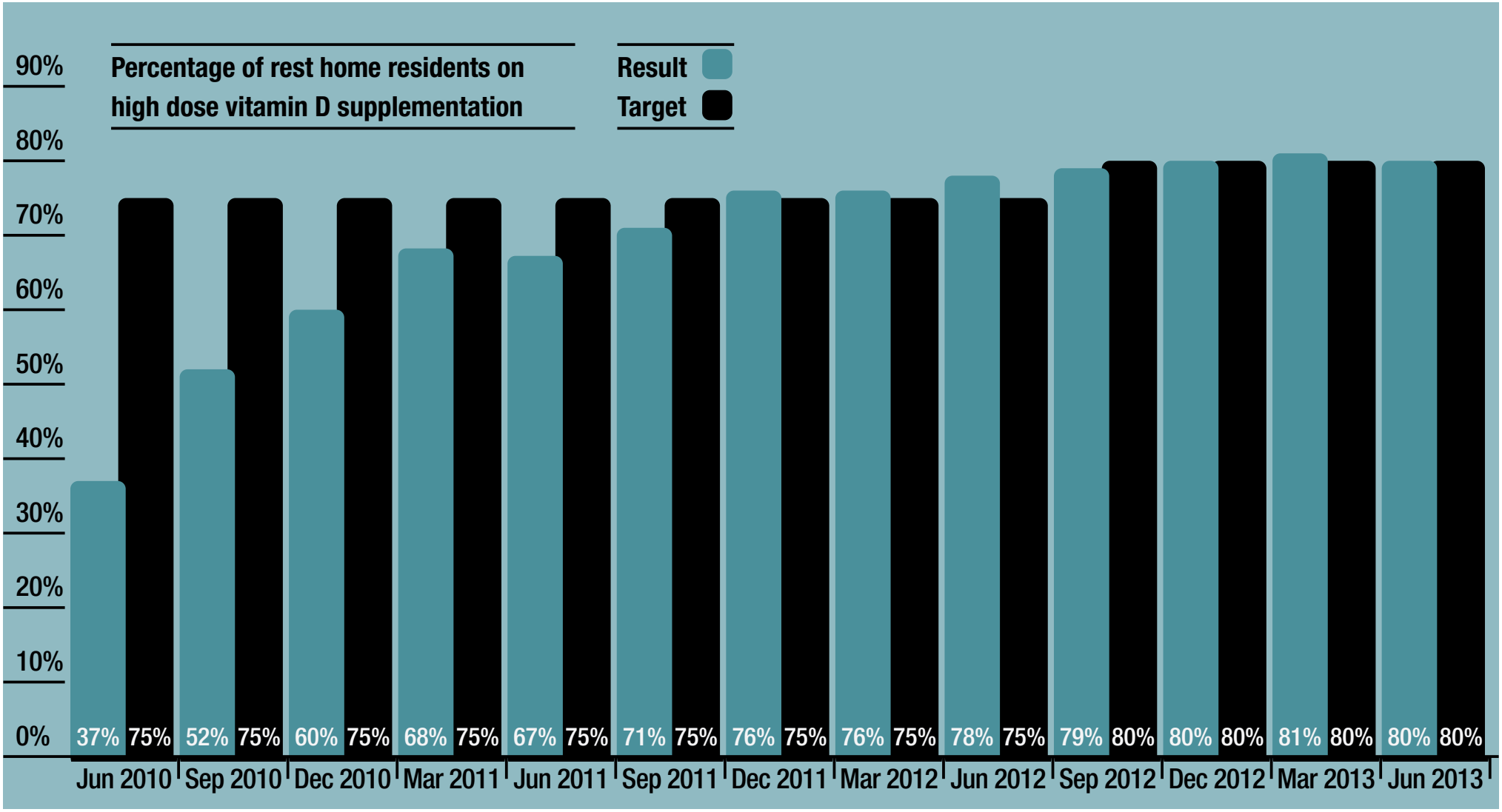
There has been a focus on working with our primary care alliance partners to reduce demand on emergency departments and this appears to be reflected in our results.

P.98

People stay well in their homes and communities

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

Output measure



People stay well in their homes and communities

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

Output measure

Measure	Baseline at Dec 2010	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of rest home residents on high dose vitamin D supplementation	60%	78%	80%	✓ 80%

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 are supporting an ACC funded programme that ensures high dose vitamin D supplementation is available to residents through prescription from a GP.

People stay well in their homes and communities

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

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of eligible children have their B4 School Check completed – High needs	85%	95%	at least 80%	✓ 80%
Percentage of eligible children have their B4 School Check completed – total	92%	81%	at least 80%	✓ 80%

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.

B4 School Checks are provided free in primary care to Waikato children who turn four each year. Waikato DHB Community Services carry out the B4 School Checks for children who don't get to primary care.

Waikato DHB performance

These checks are predominantly carried out in primary care. The families of the children who miss their checks are contacted and if they are hard to reach they are referred to our public health nursing service.

Patient Mikayla Whyte having a vision check

P.102

People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure

Number of residential respite bed days (health of older people services)

Baseline 2010 / 2011

5,859.50

Previous year 2011 / 2012

6,461

Target 2012 / 2013

6,500

Result 2012 / 2013

✗ 6,491

Significance of measure

This measure relates to the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside the home. Currently people allocated carer support do not always use their full allocation per annum.

Waikato DHB performance

The result presented is based on claim information received as at 30 June 2013. Calculation of the result against this measure relies on claims being sent in for processing and payment. There is often a three or four month lag in claiming. We expect that when all claims have been received and processed that the final 2012/13 result will be an increase on the reported 2012/13 reported result. To improve the usefulness of this measure we will use a calendar year reporting period moving forward.

Carer support utilisation is monitored quarterly and there is a dedicated role in place to determine why allocated carer support is not being utilised. We have taken action on all aspects that we can address; however the final choice is up to the service user to use the carer support days allocated.

Measure

Ratio of completed comprehensive clinical assessments undertaken by NASC using contact assessment tool: MDS-HC tool

Baseline 2010 / 2011

New measure

Previous year 2011 / 2012

New Measure

Target 2012 / 2013

70 : 30

Result 2012 / 2013

✗ Not able to be reported

Significance of measure

Needs Assessment and Service Coordination (NASC) provides a more consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information.

MDS - HC stands for Minimum Data Set – Home Care.

Waikato DHB performance

The reporting system for this measure does not appear robust enough to provide accurate information. While initial results suggest that the 2012/13 result was 52 : 48, we will be undertaking a review of this reporting system during 2013/14.

Measure

Number of visit days of intermediate care delivered – START

Baseline 2010 / 2011

4,932

Previous year 2011 / 2012

12,129

Target 2012 / 2013

17,500

Result 2012 / 2013

✓ 17,674

Significance of measure

The Supported Transfer and Accelerated Rehabilitation Team (START) provides intensive in-home rehabilitation to those discharged from hospital, focusing on achieving personal, meaningful goals identified by the patient and their family. Impacts of this service are expected to include a decreased length of stay in hospital, avoidance of hospital admissions; enabling patients to live healthier and more independent lives.

Waikato DHB performance

START has rolled out to all geographical areas within our district during the 2012/2013 year. In addition START is now accessible to primary care for admission avoidance via the primary options for acute care processes.

Measure

Number of bed days of intermediate care delivered - Transitional care

Baseline 2010 / 2011

4,597

Previous year 2011 / 2012

4,010

Target 2012 / 2013

6,300

Result 2012 / 2013

✗ 1,970

Significance of measure

Intermediate care is delivered by those health services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. Provision of this service aims to reduce pressure on hospital beds enabling patients to live healthier and more independent lives.

Waikato DHB performance

Utilisation of transitional care bed days is decreasing due to the implementation of the START programme where specialist rehabilitation services are delivered in a person's own home (if suitable). It is expected that utilisation of transitional care will continue to decline. Some transitional care providers have already exited their level three transitional care service (home-based) contracts due to a lack of referrals.

While the target we set has not been achieved this is a positive result in relation to this measure as it means a reduction in pressure on hospital beds.

P.104

People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure

In home respite (carer support) days utilised (health of older people services)

Baseline 2010 / 2011

7,409

Previous year 2011 / 2012

7,663

Target 2012 / 2013

8,300

Result 2012 / 2013

✗ 7,477

Significance of measure

Intermediate care is delivered by those health services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. Provision of this service aims to reduce pressure on hospital beds enabling patients to live healthier and more independent lives.

Waikato DHB performance

Calculation of the result against this measure relies on claims being sent in for processing and payment. There is often a three or four month lag in claiming. We expect that when all claims have been received and processed that the final 2012/13 result will be an increase on the 2012/13 result.

To improve the usefulness of this measure we will use a calendar year reporting period moving forward.

Measure

Proportion of people with dementia who have been assessed as having a MAPIe score ≥3 who have a completed care plan

Baseline 2010 / 2011

New measure

Previous year 2011 / 2012

100%

Target 2012 / 2013

90%

Result 2012 / 2013

✓ 100%

Significance of measure

This measure enables us to monitor appropriateness of service allocation based on clinical need. MAPIe stands for Method of Assigning Priority for level of service.

Waikato DHB performance

Data shows that in 2012/13 392 out of 392 people with dementia in our district who were assessed as having a MAPIe score of 3 or greater had a completed care plan.

Measure

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

Baseline 2010 / 2011

81%

Previous year 2011 / 2012

89%

Target 2012 / 2013

100%

Result 2012 / 2013

✗ 87%

Significance of measure

This measure enables us to monitor the responsiveness and timeliness to NASC to service demand.

Waikato DHB performance

This measure is based on the monthly reports provided by our NASC service. We will be reviewing the methodology and data collection systems for this measure to ensure accuracy, reliability and usefulness in 2013/14.

The transition to the InterRAI assessment tool has meant an increase in the time taken to complete a NASC which has impacted on our efforts to achieve the target for 2012/13.

Measure

Referral to service planning within 20 working days (NASC services)

Baseline 2010 / 2011

92%

Previous year 2011 / 2012

92%

Target 2012 / 2013

100%

Result 2012 / 2013

✗ 99%

Significance of measure

This measure enables us to monitor the timeliness of service allocation to identified need.

Waikato DHB performance

This measure is based on the monthly reports provided by our NASC service. We will be reviewing the methodology and data collection systems for this measure to ensure accuracy, reliability and usefulness in 2013/14.

Almost 5,500 NASCs were provided during the year. This compares with approximately 4,400 in 2011/12.

People stay well in their homes and communities

More people maintain their functional independence

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 /2012	Target 2012 / 2013	Result 2012 / 2013
Number of clients on caseload (primary mental health and addictions)	218	1,441	230	✓ 2,832
Number of primary mental health and addictions packages of care	318	201	540	✗ 192

Significance of measure

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.

Waikato DHB performance

Packages of care are now fully utilised and any carry over of packages from previous years has ended.

There has been minimal uptake of psychiatrist advice during 2012/13 which is reflected in our results. We will be reviewing this area in 2013/14.

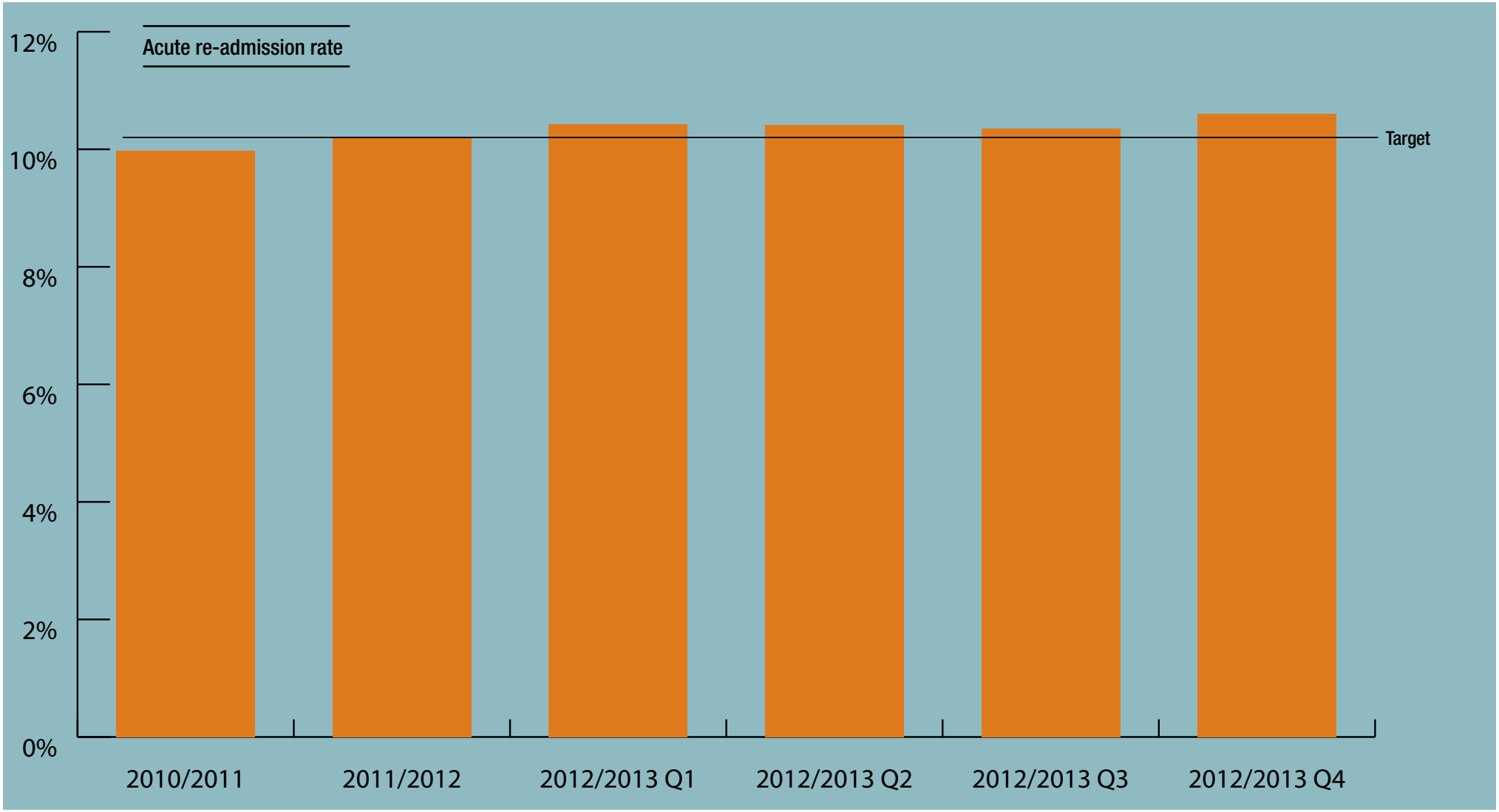
Long-term impact	**People receive timely and appropriate specialist care**			
Intermediate impacts	People are seen promptly for acute care	People have appropriate access to ambulatory, elective and arranged services	Improved health status for people with severe mental illness and addictions	More people with end stage conditions are supported
Output Performance Measures	• Acute re-admission rate • Waiting time for acute theatre (24 hours) • Waiting time for acute theatre (48 hours)	• Rate of Hospital Acquired Bloodstream Infections • Average length of inpatient stay • Everyone needing radiation or chemotherapy treatment will have this within four weeks • Elective and arranged day of surgery rate • Elective and arranged day surgery admissions • Theatre utilisation • Percentage of people who did not attend (DNA) their scheduled appointment for an outpatient service • Percentage of caesarean deliveries • Number of government funded elective surgical discharges for Waikato DHB domiciled patients • Number of outpatients on waiting lists • Number of inpatients on waiting lists who wait > 5 months • Number of long stay patients (greater than 20 days length of stay) • Percentage of patients who have their Adult Deterioration Detection System (ADDS) score accurately calculated and documented • Percentage of patients who trigger, have an appropriate response (i.e. medical review) within the escalation timeframe • Output delivery against plan – inpatients • Output delivery against plan – outpatients • Percentage of inpatients with pressure ulcers as a complication • Percentage of inpatients with urinary tract infections as a complication • Percentage of inpatients with surgical wound infections as a complication	• Percentage of adults and older people (20 years plus) with enduring serious mental illness who have a relapse prevention plan • Percentage of children and young people (under 19 years) who have been in secondary care treatment for one or more years who have a treatment plan • Percentage of people referred for non-urgent mental health or addiction services are seen within three weeks • Percentage of people referred for non-urgent mental health or addiction services are seen within eight weeks • Percentage of children and young people (0 – 19 years) referred and seen by an alcohol and other drug health professional within three weeks • Percentage of people who have contact with adult mental health and addiction services within seven day post discharge from the adult inpatient unit • Average length of stay in an adult mental health and addiction inpatient unit	• Percentage of people in palliative care who died on the Liverpool Care Pathway

P.108

People receive timely and appropriate specialist care

People are seen promptly for acute care

Output measure



Measure	Baseline 2010 / 2011	Previous year 2011 /2012	Target 2012 / 2013	Result 2012 / 2013
Acute re-admission rate	9.97%	10.19%	10.20%	✗ 10.60%

Significance of measure

Unplanned readmissions 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.

Waikato DHB performance

As a result of work undertaken this year a much clearer distinction is now able to be drawn between acute readmission as an indicator of the quality of care and readmissions that is an indication of the administrative process. For example, in New Zealand all patients who attend an Emergency Department for longer than three hours are administratively admitted. Consequently, DHBs that have multiple Emergency Departments, like Waikato, are likely to have high readmission 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, often for extended outpatient visits which end up as administrative admissions due to their duration.

Readmissions for unpredicted clinical reasons are important to monitor. They are 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. We have noted an upward trend in this indicator for some time. Consequently we have committed to a number of service actions to address readmission rates in 2013/14. The first one of these service priorities is to improve end of life care. The initial step in this process will be completed with the transfer of the palliative care service from our inpatient wards to Hospice Waikato from 1 July 2013.

People receive timely and appropriate specialist care

People are seen promptly for acute care

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 /2012	Target 2012 / 2013	Result 2012 / 2013
Waiting time for acute theatre (24 hours)	80%	79.40%	80%	✗ 74.3%
Waiting time for acute theatre (48 hours)	93%	91.10%	95%	✗ 88.85%

Significance of measure

Early access to appropriate diagnostics in the acute phase is essential in providing faster treatment and better outcomes for patients.

Waikato DHB performance

Monitoring of acute access allows the service to focus resources as appropriate. We deliberately set ambitious targets for these measures knowing that they would be very challenging to achieve. Changes brought about through our redevelopment programme are expected to have a positive impact on our performance against these measures.

These measures should be read in conjunction with our theatre utilisation measure.

Measure	Baseline 2010 / 2011	Previous year 2011 /2012	Target 2012 / 2013	Result 2012 / 2013
Rate of hospital acquired bloodstream infections	15.97 per 1,000 bed days	0.20 per 1,000 bed days	14.00 per 1,000 bed days	✓ 0.15 per 1,000 bed days

Significance of measure

Hospital-acquired infections are a serious problem and can cause significant additional issues or a prolonged stay in hospital. They pose a serious risk to the safety of patients and hospital staff; and the cost of dealing with them is high. A significant proportion of hospital-acquired infections can be avoided.

Waikato DHB performance

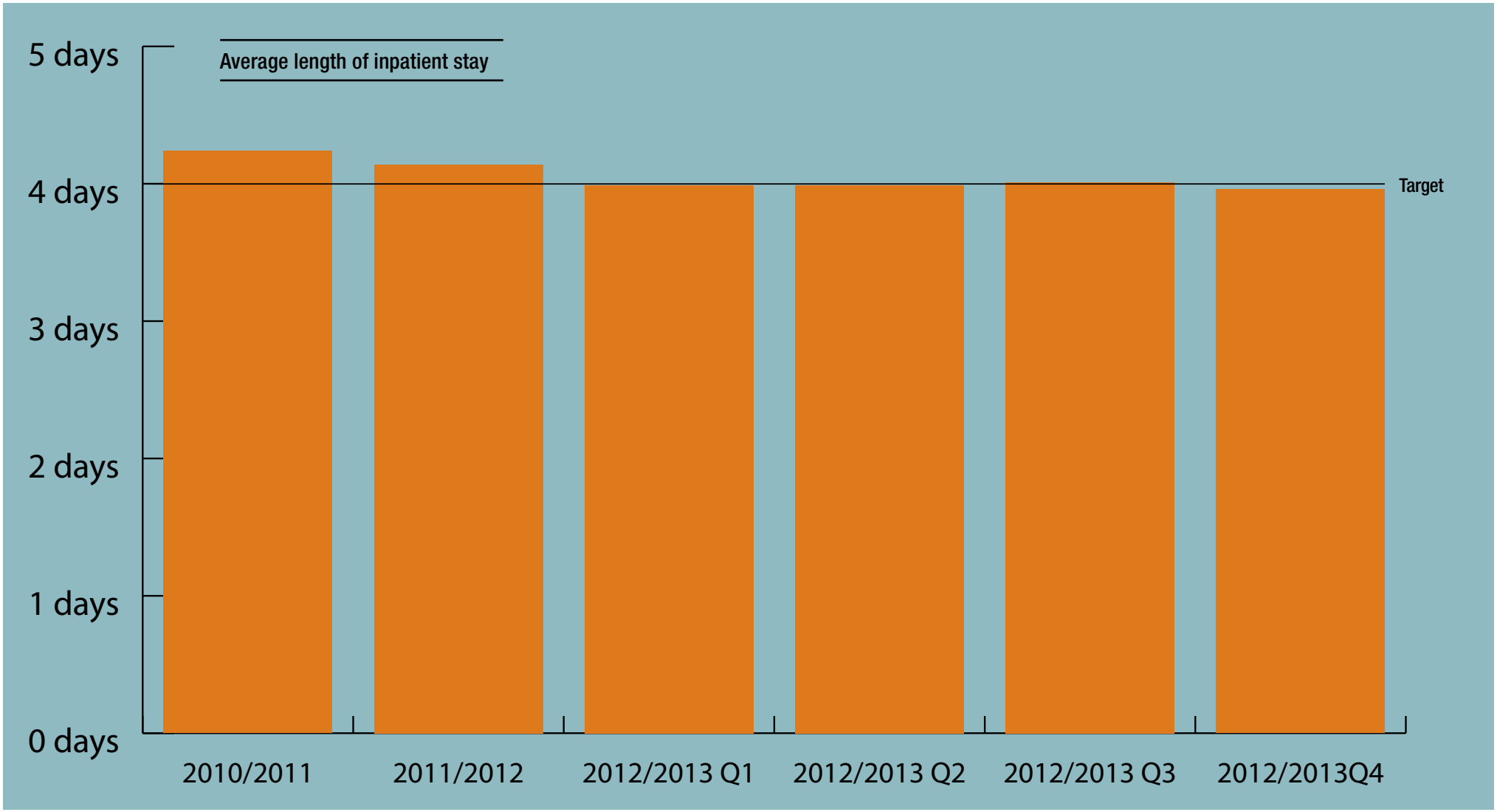
On review of the results for this measure we have identified an issue with the methodology used to determine the baseline and set targets. Moving forward we will use the methodology which produced our 2011/2012 and 2012/2013 results.

P.112

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure



Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Average length of inpatient stay	4.24 days	4.14 days	4.00 days	✓ 3.96 days

Significance of measure

In this context, elective or arranged is when a patient's admission is planned in advance. 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.

Due to the reliance on national systems, the data used to derive this measure will be for one quarter in arrears.

Waikato DHB performance

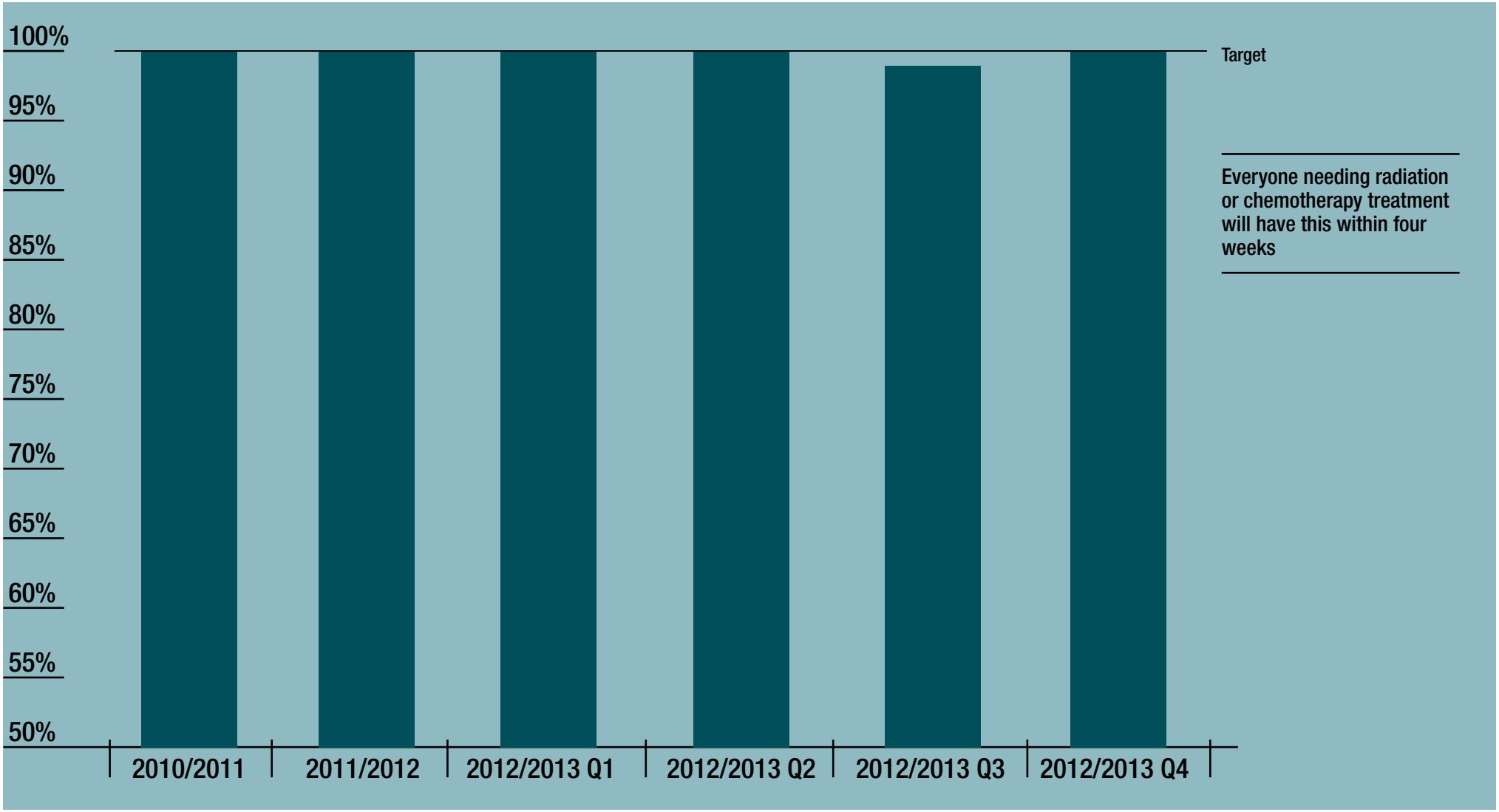
We have increased our focus on ensuring that long stay patients (length of stay greater than 20 days) do not become stranded as a result of the complexity of their diagnosis, care requirements, or future care options (barriers to hospital discharge). This has impacted on our performance against this measure.

P.114

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure



Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Everyone needing radiation or chemotherapy treatment will have this within four weeks	100%	100%	100%	✓ 100%

Significance of measure

Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Services are provided by the Regional Cancer Centre located at Waikato Hospital.

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:

- participating in the development and implementation of a regional plan that aligns the priority areas identified in the report New Models of Care for Medical Oncology
- implement and further develop the Midland Chemotherapy Nursing Certification Framework (developed 2011/2012)
- work with the Midland Cancer Network to identify which cancer multi-disciplinary meetings (MDMs) are required to be held locally and which are to be held regionally or supra-regionally
- regional implementation of video conferencing to allow clinicians to participate in regional MDMs

We have interpreted the four weeks part of the target as being from the decision to treat to treatment start. 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.

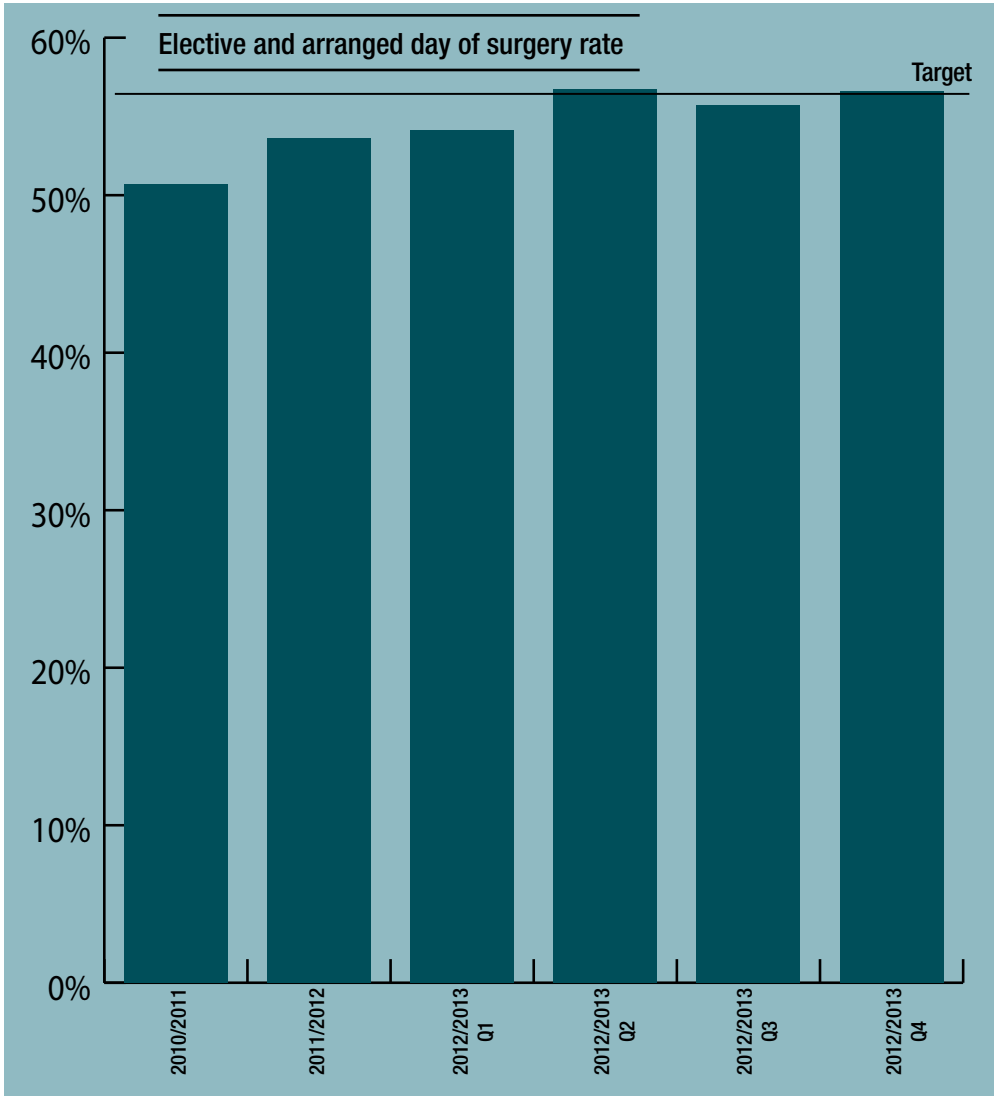
Our quarterly result for this target was 100% except for quarter three when it was 99.7%. The result was impacted by one patient waiting four weeks and two days for chemotherapy.

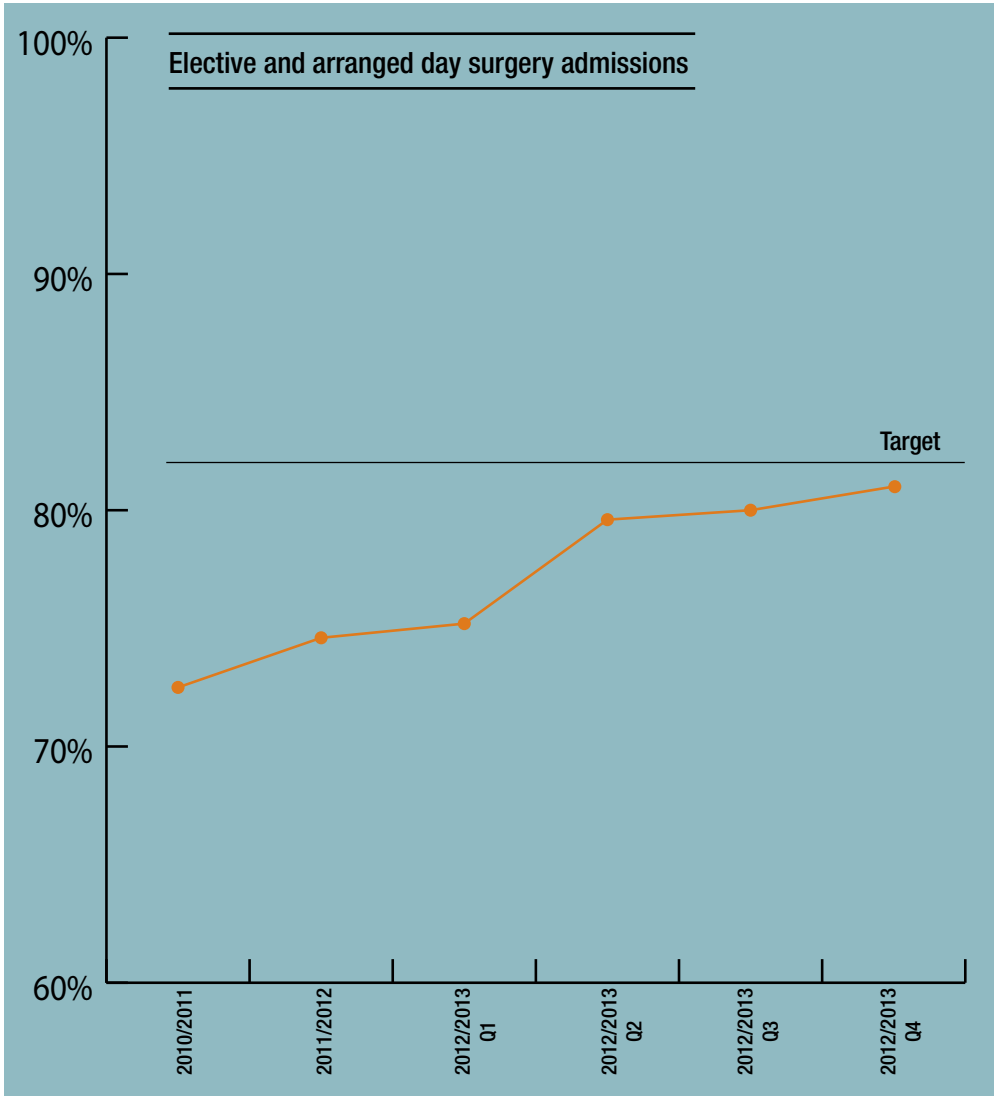
P.116

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure





Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Elective and arranged day of surgery rate	50.7%	53.6%	56.2%	✓ 56.6%
Elective and arranged day surgery admissions	72.5%	74.6%	82.0%	✗ 81.0%

Significance of measure

Admitting more elective and arranged patients on the day of surgery means that resources are used in a more cost-effective manner, and additional capacity is made available.

Due to reliance on the National Minimum Data Set (where the deadline for submission is about one month after the end of each quarter) the data used to derive this measure is one quarter in arrears.

Waikato DHB performance

We have significantly increased the percentage of elective and arranged day of surgery admissions during the 2012/13 year, and now it is less than one percent off target. This achievement has been partly due to the Elective Care Coordinator Project which has so far been piloted in the three largest surgical specialties. The addition of a MediHotel in early 2013 has also assisted specialties to undertake surgical preparation in higher risk groups without admitting them to hospital (e.g. the vulnerable elderly taking bowel preparation).

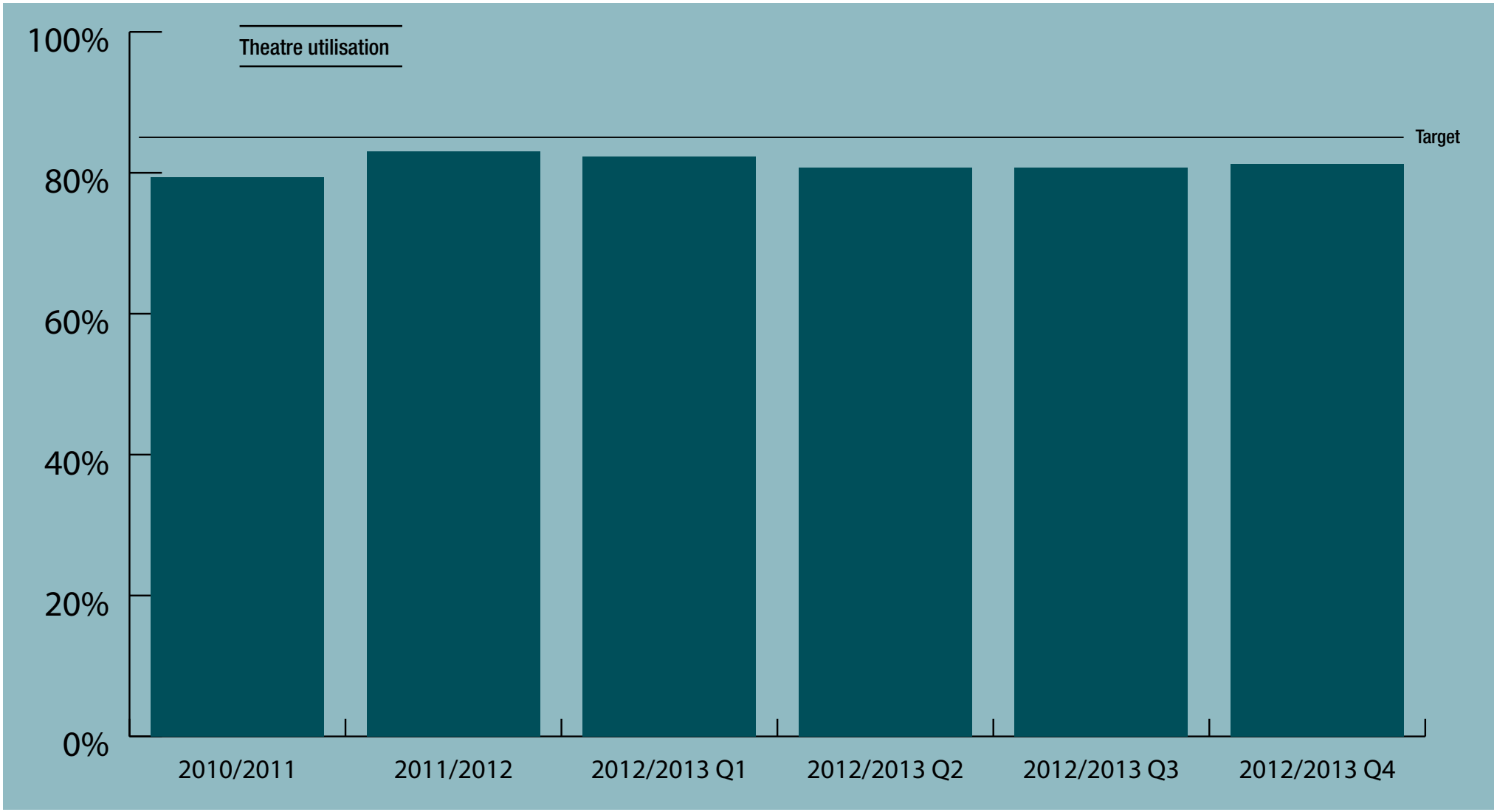
The focus for 2013/14 will be on enhancing day of surgery admission rates for cardiothoracic and cardiac patients, especially those who travel from throughout the Midland region and who have significant co-morbidities.

P.118

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure



Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Theatre utilisation	79.40%	83%	85%	✗ 81.3%

Significance of measure

Increasing theatre utilisation rates will mean that resources are used in a more cost-effective manner, and that additional capacity is made available for achieving year on year growth in elective surgery, thereby improving hospital productivity. This will allow DHBs to treat more people for the same resource, or the same number of people at a lower cost. Increasing delivery through optimal use of theatre time will improve access and reduce waiting times.

Waikato DHB performance

The barrier to higher utilisation is the number of half day theatre sessions that are still in the schedule. When the new theatres, that are part of the Meade Clinical Centre project, are commissioned, the schedule is being redesigned with one of the core principals being the maximisation of all day theatre sessions. These sessions are much more efficient than half day sessions. We expect this will occur in October 2013 when the new theatres are commissioned.

The baseline for this measure has been updated from the result as at quarter three 2010/11 to the quarter four result. It has also been updated to include acute theatre information. These updates allow for more meaningful comparison between results.

This measure should be viewed in conjunction with the measures related to waiting times for acute theatres.

Empty outpatient seats in the Meade Clnical Centre

Measure

Percentage of people who did not attend (DNA) their scheduled appointment for an outpatient service

Baseline 2010 / 2011

10.40%

Previous year 2011 / 2012

10.21%

Target 2012 / 2013

8.00%

Result 2012 / 2013

✗ 10.00%

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. This measure relates to Waikato DHB outpatient services.

Waikato DHB performance

We continue to focus on reducing the number of patients who do not attend their scheduled outpatient appointment. There are a number of actions we have undertaken to reduce this number including text reminders, changing processes to proactively update outpatient information and provision of grants to community transport providers.

Measure

Percentage of caesarean deliveries

Baseline 2010 / 2011

20.30%

Previous year 2011 / 2012

18.91%

Target 2012 / 2013

≤ 20.30%

Result 2012 / 2013

✓ 19.15%

Significance of measure

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

Waikato DHB performance

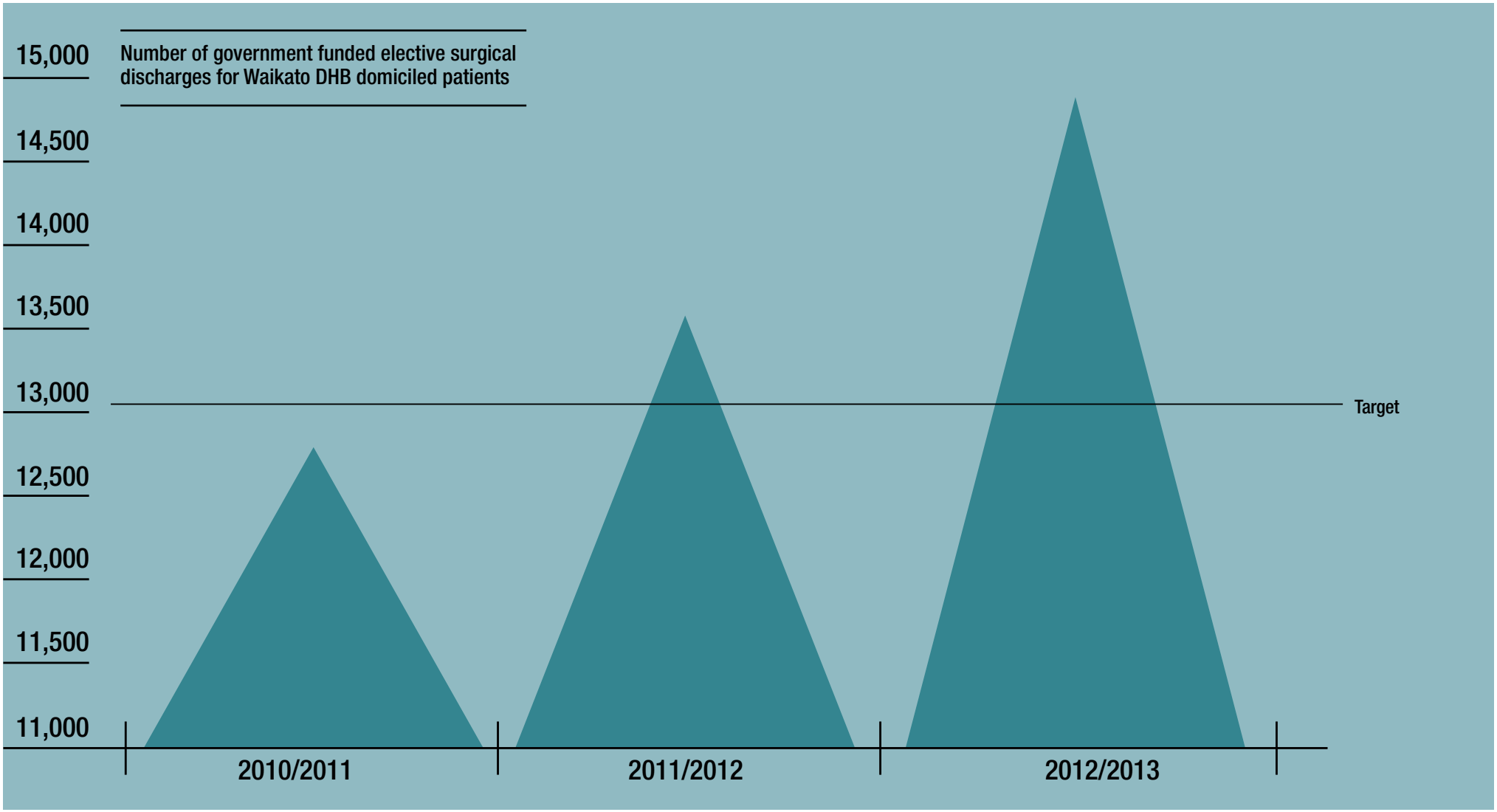
The result presented is based on data available for the 2012/13 year. At the time of writing there was 7.5 months of data missing from a small provider. From our analysis, we expect the impact of the missing data to mean the 2012/13 result we have presented is likely to be artificially high. Extrapolating the 2012/13 data we do have from the provider for the full year would deliver a result of 18.87 percent.

P.122

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure



People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure

P.123

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Number of government funded elective surgical discharges for Waikato DHB domiciled patients	12,737	13,579	13,009	✓ 14,925

Significance of measure

Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery is expected to improve access and reduce waiting times.

Waikato DHB performance

We have exceeded our target against this measure by 15 percent.

P.124

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Number outpatients on waiting lists	291 > 6 months	295 > 5 months	0 > 5 months	✗ 81 > 5 months
Number inpatients on waiting lists who wait > 5 months	450 > 6 months	282 > 5 months	0 > 5 months	✗ 34 > 5 months
Number of long stay patients (greater than 20 days length of stay)	984	764	886	✓ 703

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 get the number of long wait patients (those waiting greater than five months) down to zero by 30 June 2013. Until then, no patients should have been waiting greater than six months. Although a significant reduction has been made we have not met the targets and while we are seeing further progress each week, we do not expect to meet this target until September 2013. We are actively planning for the requirement timeframe change to four months in December 2013.

Significant efforts have been made by our staff to make improvements in this area against a backdrop of increasing emergency department attendances, increasing acute presentations, unexpected surgeon sick leave and the significant disruption associated with the redevelopment programme including ward and outpatient moves. We received excellent support from Lakes District Health Board and private providers in making progress against this target.

The results are subjected to a review of why each patient breached the timeframes. This occurs monthly and traditionally reduces the numbers by a significant amount as those breaches for patient related reasons rather than capacity related can be removed. The results in this section are provisional until relevant breach reviews have been completed.

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure

P.125

Measure	Baseline 2010 / 2011	Previous year 2011 /2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of patients have their Adult Deterioration Detection System (ADDS) score accurately calculated and documented	New Measure	New Measure	100%	Not able to be reported on
Percentage of patients who trigger (due to an escalating ADDS score), have an appropriate response (i.e. medical review) within the escalation timeframe	New Measure	New Measure	100%	Not able to be reported on

Significance of measure

Early detection helps to ensure early appropriate action and response.

Waikato DHB performance

These are new measures for 2012/13 and we are currently only able to report results for the January 2013 to August 2013 period. We recognise that July and August fall outside the period therefore we have not included them in the results for 2012/13.

The 2013 results for January to August were 83 percent and 59 percent respectively.

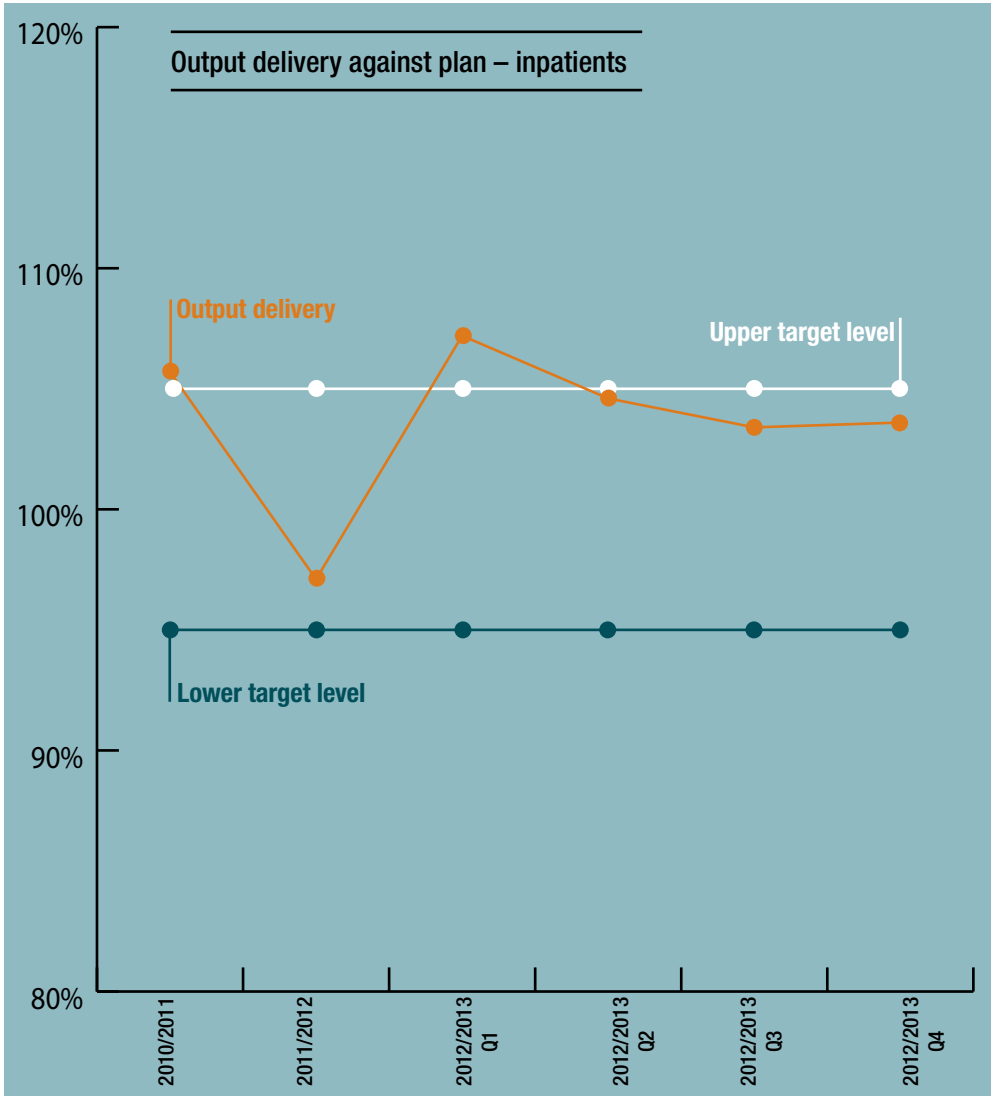
A complete audit of all notes will be completed in early 2013/14 to ascertain why the targets are not being met. Further training on the correct processes around ADDS is being formulated and we expect to implement this training in 2013.

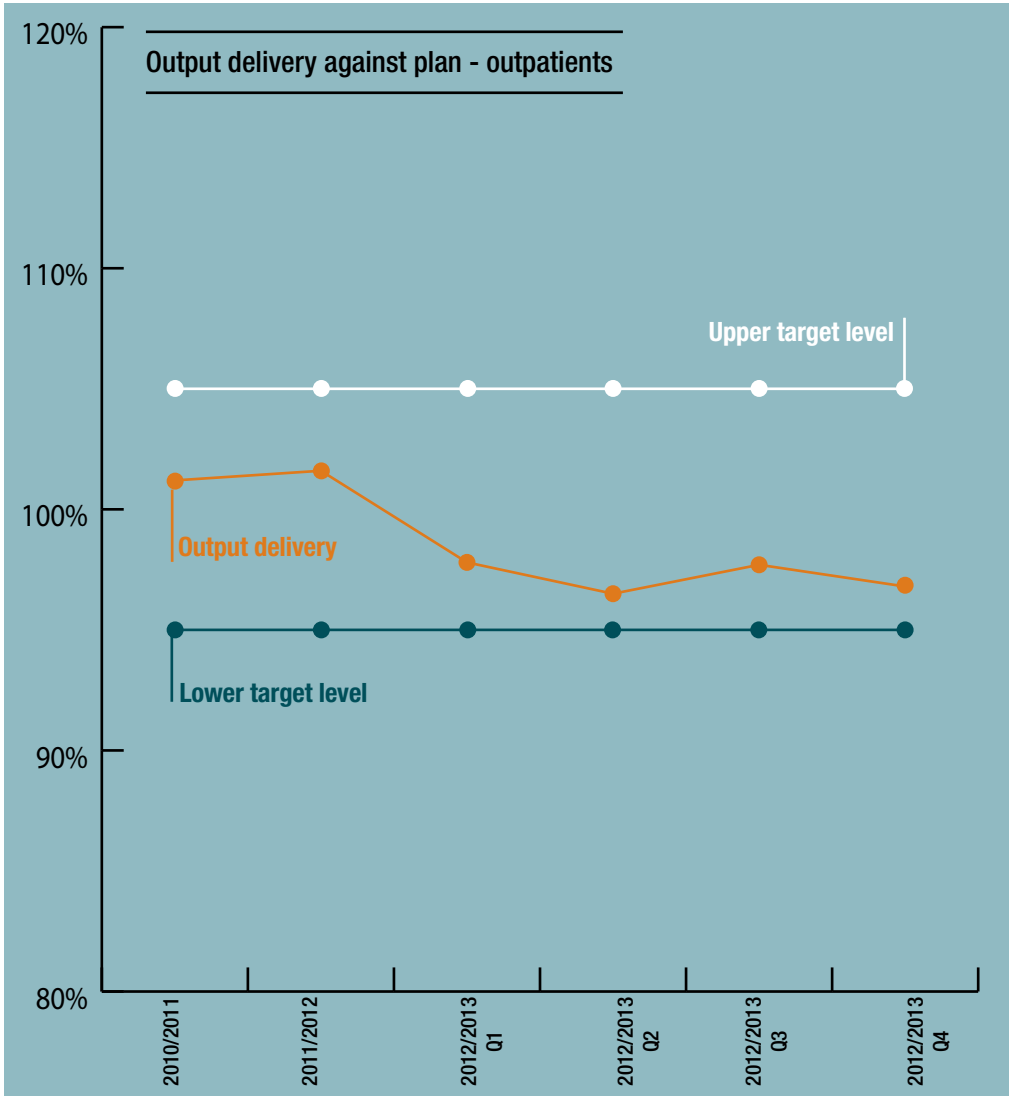
P.126

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure





Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Output delivery against plan – inpatients	105.7%	97.10%	95%-105%	✓ 103.6%
Output delivery against plan – outpatients	101.2%	101.6%	95%-105%	✓ 96.8%

Significance of measure

Important and interrelated elements in managing hospital production of outputs are: the ability to forecast outputs accurately; the realism of annual plans, specifically production plans; and the ability to manage to plan during the year. The results are based on year to date information at April 2013.

Waikato DHB performance

The surgical component of the output delivery against plan for inpatients was 105.5%. This was primarily due to the push to meet waiting time targets combined with an increase in acute demand primarily in general surgery and orthopaedics. The increase in acute demand is because of the reintroduction of a spinal orthopaedic service in November 2012 with spinal patients now receiving surgery during acute presentation in line with best practice guidelines (previously patients were much more likely to be managed conservatively).

The outpatient output delivery volume is down on plan predominantly in the allied health and maternity areas. The under delivery of allied health volume is partly due to more accurate identification of ACC cases and partly due to staff vacancies. The maternity under delivery against plan is due to a shifting of the foetal maternity service from Waikato DHB to Auckland DHB due to key staff vacancies in this service.

Baselines have been changed to refect final 2010 / 2011 results to enable comparison between years.

P.128

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure

Measure	Baseline	Previous year 2011 / 2012	Target 2012/2013	Result 2012/2013
Percentage of inpatients with pressure ulcers as a complication	2.60%	1.60%	2.50%	✓ 1.50%
Percentage of inpatients with urinary tract infections as a complication	3.80%	1.83%	3.00%	✓ 1.80%
Percentage of inpatients with surgical wound infections as a complication	0.50%	0.99%	0.50%	✓ 0.80%

Significance of measure

Reducing complications has been identified as an approach to improving care and saving resources.

Waikato DHB performance

Quality improvement is one of our local priorities and we have undertaken a number of initiatives in this area. Further detail is available in our quality report for 2012/2013.

Initiatives that have impacted on our performance against these measures include increasing the number of alternating pressure reducing mattresses and implementing the Surgical Site Infection Surveillance Project.

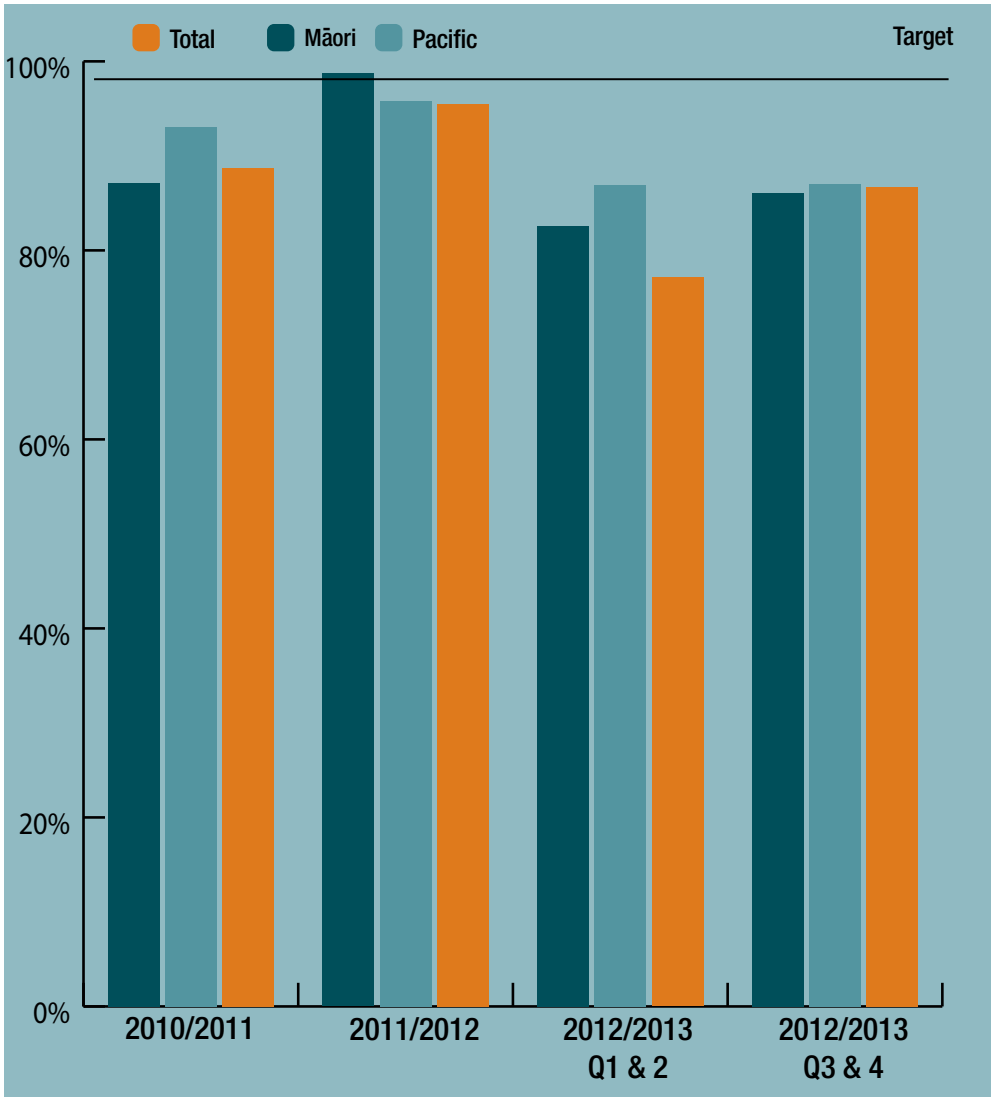
Gateway student Melissa Dobb (L) and Jess Horn (R) registered nurse, gowning up to do a dressing change

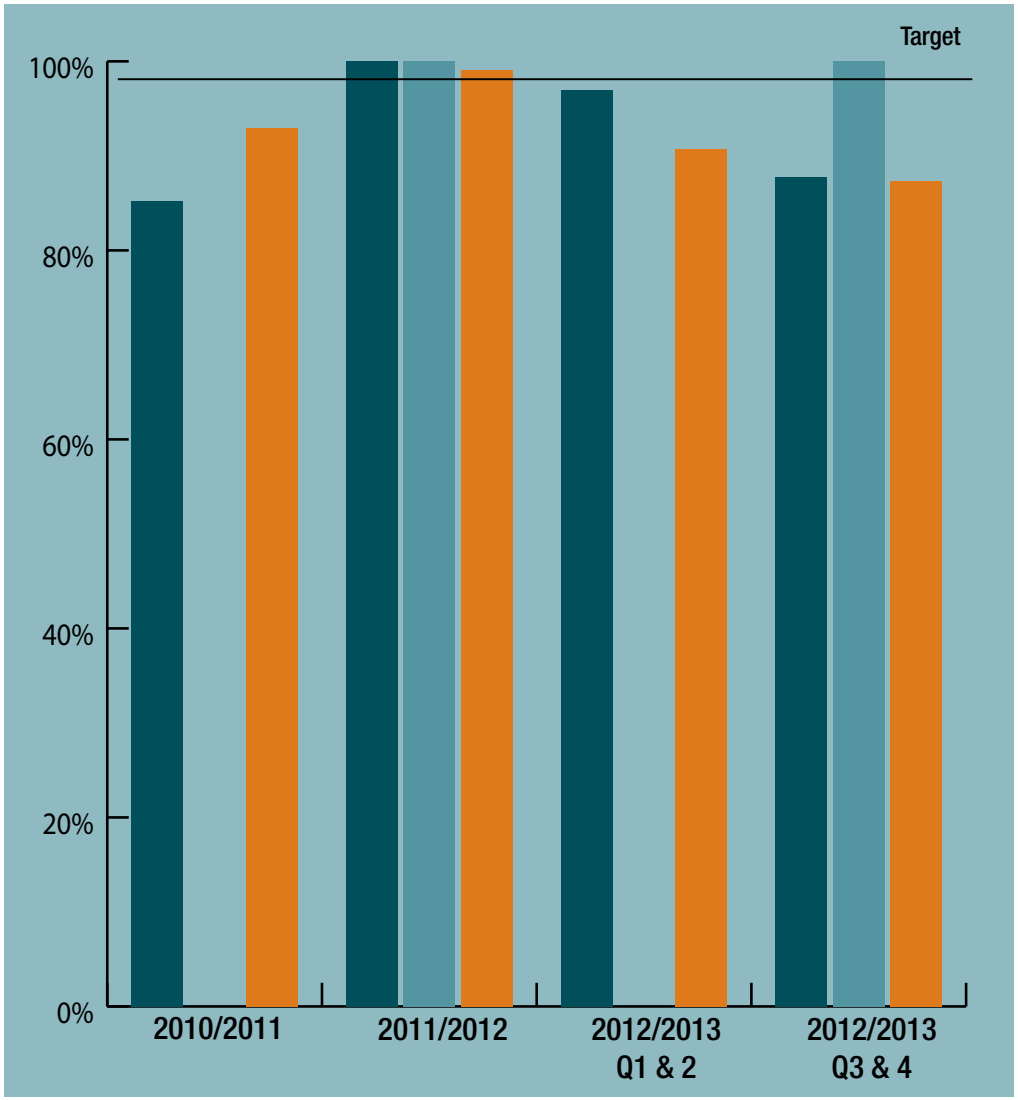
P.130

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure





People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure

P.131

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of adults and older people (20 years plus) with enduring serious mental illness who have a relapse prevention plan	Māori 87.17% Pacific 93.10% Total 88.74%	Māori 98.72% Pacific 95.83% Total 95.45%	Māori 98.0% Pacific 98.0% Total 98.0%	✗ Māori 86.10% ✗ Pacific 87.0% ✗ Total 86.7%
Percentage of children and young people (under 19 years) who have been in secondary care treatment for one or more years who have a treatment plan	Māori 85.19% Pacific 0% Total 92.99%	Māori 97.56% Pacific 100% Total 97.61%	Māori 98.0% Pacific 98.0% Total 98.0%	✗ Māori 87.80% ✓ Pacific 100% ✗ Total 87.30%

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.

Waikato DHB performance

Performance against these measures has been impacted by service structure changes between September 2012 and February 2013. It is expected that our performance will improve during 2013/14 to be more aligned with the results we achieved in 2011/12. Performance is monitored through a real time reporting dashboard. The performance measures are embedded as a standard agenda item at service clinical governance and team meetings, with team leaders accountable for improving performance.

Performance against these measures can be heavily impacted by the number of people in the population groups. The actual numbers of the people covered by these measures at June 2013 was:

20 years plus
- Māori 302
- Pacific 23
- Total 1,102

Under 19 years
- Māori 49
- Pacific 1
- Total 283

Baselines for this measure have been updated to reflect final results which will enable comparisons to be made. Pacific and Māori information has also been added to ensure information for decision making around reducing health inequalities is available.

P.132

People receive timely and appropriate specialist care

Improved health status for people with severe mental illness and addictions

Output measure

Measure	Baseline 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of people referred for non-urgent mental health services are seen within – three weeks	Child and youth 43% Adults 47% Older persons 57%	Child and youth 55% Adults 60% Older persons 75%	✓ Child and youth 66.20% ✓ Adults 87.70% ✓ Older persons 82.20%
Percentage of people referred for non-urgent mental health services are seen within – eight weeks	Child and youth 66% Adults 65% Older persons 72%	Child and youth 70% Adults 75% Older persons 80%	✓ Child and youth 84.60% ✓ Adults 94.60% ✓ Older persons 89.50%
Percentage of people referred for non-urgent addiction services are seen within – three weeks	Child and youth 70% Adults 46% Older persons 63%	Child and youth 70% Adults 60% Older persons 80%	✗ Child and youth 68.4% ✓ Adults 61.20% ✗ Older persons 66.70%
Percentage of people referred for non-urgent addiction services are seen within – eight weeks	Child and youth 82% Adults 71% Older persons 100%	Child and youth 87% Adults 75% Older persons 95%	✓ Child and youth 89.5% ✓ Adults 83.1% ✗ Older persons 66.7%

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

We have achieved all the targets for mental health services; but have not reached the addictions services targets for the child and youth age group (for three weeks) and the older person's target. There were a low number of referrals for older persons requiring addiction services (9 reported in the 12-month period) within our district. The low number of referrals means one referral can have a significant effect on waiting time targets for this group.

Data quality issues have impacted our reported performance against these waiting times targets during 2012/13. As this indicator is new we have spent some time trying to understand the indicator's parameters and how the Programme for the Integration of Mental Health Data (PRIMHD) data underlying this information 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 data (extracted from PRIMHD) that forms the basis of the waiting times report 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.

Measure

Percentage of people who have contact with adult mental health and addiction services within seven day post discharge from the adult inpatient unit

Baseline 2009 / 2010

New Measure

Previous year 2011 / 2012

71.64%

Target 2012 / 2013

80%

Result 2012 / 2013

✓ 86.21%

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 readmission. 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

This measure has been monitored through the national mental health adult key performance indicator project over the past 12 months. It is reported at all levels of the service.

Measure

Average length of stay in an adult mental health and addiction inpatient unit

Baseline 2011 / 2012

New Measure

Target 2012 / 2013

Between 14 and 21 days

Result 2012 / 2013

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

Waikato DHB performance

This measure has been monitored through the national mental health adult key performance indicator project over the past 12 months. While our result for 2012/13 is outside the identified target band it shows we have performed slightly better than anticipated against this measure.

People receive timely and appropriate specialist care

People have appropriate access to ambulatory, elective and arranged services

Output measure

Measure	Baseline 2010 / 2011	Previous year 2011 / 2012	Target 2012 / 2013	Result 2012 / 2013
Percentage of people in palliative care who died on the Liverpool Care Pathway	New Measure	New Measure	90%	Unable to be reported on

Significance of measure

Liverpool Care Pathway is an internationally recognised tool capable of driving up the quality of care of the dying, irrespective of place of care or diagnosis. The pathway provides guidance on the different aspects of care required including comfort measures, anticipatory prescribing for symptom, and discontinuation of inappropriate interventions. Additionally psychological and spiritual care and family support is included.

Waikato DHB performance

During 2012/2013 we identified issues with reporting against this measure. The 2012/2013 result is not available. We are working on refining the reporting process to enable us to report a result against this measure in the future.

Measure

Total number of pharmaceutical items dispensed in the community

Baseline 2010 / 2011

5,339,890

Previous year 2011 / 2012

5,570,617

Target 2012 / 2013

5,500,000

Result 2012 / 2013

✗ 5,015,669

Significance of measure

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

Waikato DHB performance

The result for 2012/2013 is sourced from PHARMAC. The reduction in numbers is due to changing pharmacy dispensing agreements which remove the ability/need to dispense many items with high frequency.

Measure

Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

Baseline 2010 / 2011

99.6%

Previous year 2011 / 2012

99.8%

Target 2012 / 2013

99.6%

Result 2012 / 2013

✓ 100%

Significance of measure

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

Waikato DHB performance

This measure relates to a service provided by a non-government organisation and we expect the levels of performance will continue to be maintained.

Part 3 Financial Statements

Mah-jong players at age concern

Statement of comprehensive income

For the year ended 30 June 2013

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Income		**$000**	**$000**	**$000**	**$000**	**$000**
Patient care revenue	1	1,168,616	1,125,480	1,164,827	1,168,616	1,125,480
Other operating income	2	14,898	17,941	15,023	15,222	18,852
Finance income	3	1,342	1,240	1,007	1,139	1,019
Total income		1,184,856	1,144,661	1,180,857	1,184,977	1,145,351
Expenses						
Personnel costs	4	458,948	446,578	466,386	458,948	446,578
Depreciation	5	29,254	27,266	32,021	29,254	27,266
Amortisation	6	4,412	3,895	4,476	4,412	3,895
Outsourced services		61,015	48,169	41,865	61,015	48,169
Clinical supplies		118,598	119,430	120,154	118,598	119,430
Infrastructure and non-clinical expenses		65,664	64,965	68,253	65,664	64,965
Other district health boards		47,568	53,371	53,739	47,568	53,371
Non-health board providers		366,854	344,623	359,444	366,854	344,623
Other operating expenses	7	7,628	6,794	7,911	7,613	6,779
Finance costs	8	8,818	7,103	10,634	8,818	7,103
Capital charge	9	14,202	13,732	14,974	14,202	13,732
Total expenses		1,182,961	1,135,926	1,179,857	1,182,946	1,135,911
Share of associate surplus/(deficit)	10	1	(31)	-	1	(31)
Share of joint venture surplus	11	156	-	-	156	-
Surplus		2,052	8,704	1,000	2,188	9,409
Other comprehensive income						
Increase/(decrease) in revaluation reserve	12	-	(129)	-	-	(129)
Other comprehensive income for the year		-	(129)	-	-	(129)
Total comprehensive income for the year		2,052	8,575	1,000	2,188	9,280

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

The accompanying notes form part of these financial statements.

Statement of changes in equity

For the year ended 30 June 2013

	Note	Group		Parent		
		2013 Actual	2012 Actual	2013 Budget	2013 Actual	2012 Actual
		$000	$000	$000	$000	$000
Balance at 1 July		186,927	180,228	185,860	181,177	173,773
Comprehensive income						
Surplus/(deficit) for the year		2,052	8,704	1,000	2,188	9,409
Other comprehensive income/(expense)		-	(129)	-	-	(129)
Total comprehensive income for the year		2,052	8,575	1,000	2,188	9,280
Owner transactions						
Capital contributions from the Crown		26,139	318	26,139	26,139	318
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	212,928	186,927	210,805	207,313	181,177

The accompanying notes form part of these financial statements.

Statement of financial position

As at 30 June 2013

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Assets		**$000**	**$000**	**$000**	**$000**	**$000**
Current assets						
Cash and cash equivalents	13	5,694	8,970	20	-	3,206
Receivables and prepayments	14	24,496	26,316	38,931	24,479	26,315
Inventories	15	7,883	7,621	9,919	7,883	7,621
Assets held for sale	16	40	137	-	40	137
Total current assets		38,113	43,044	48,870	32,402	37,279
Non-current assets						
Property, plant and equipment	5	547,110	481,569	563,459	547,110	481,569
Intangible assets	6	13,576	6,719	6,962	13,576	6,719
Investment in associate	10	31	30	30	31	30
Investment in joint venture	11	194	38	69	194	38
Total non-current assets		560,911	488,356	570,520	560,911	488,356
Total assets		599,231	531,400	619,390	593,313	525,635

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Liabilities		**$000**	**$000**	**$000**	**$000**	**$000**
Current liabilities						
Cash and cash equivalents	13	-	-	-	207	-
Borrowings	17	40,373	29,651	23,549	40,373	29,651
Employee entitlements	18	81,741	77,310	79,014	81,741	77,310
Trade and other payables	19	57,281	63,411	80,318	56,978	63,396
Provisions	20	680	822	595	680	822
Total current liabilities		180,075	171,194	183,476	179,979	171,179
Non-current liabilities						
Borrowings	17	191,880	159,659	211,859	191,880	159,659
Employee entitlements	18	13,805	13,477	13,250	13,805	13,477
Provisions	20	336	143	-	336	143
Total non-current liabilities		206,021	173,279	225,109	206,021	173,279
Total liabilities		386,096	344,473	408,585	386,000	344,458
Net assets		212,928	186,927	210,805	207,313	181,177
Equity						
Crown equity	12	83,846	59,901	88,511	83,846	59,901
Revaluation reserve	12	52,730	52,730	52,859	52,730	52,730
Retained earnings	12	70,737	68,546	69,435	70,737	68,546
Trust funds	12	5,615	5,750	-	-	-
Total equity		212,928	186,927	210,805	207,313	181,177

For and on behalf of the board

Graeme Milne, Chair
Waikato DHB
23 October 2013

Sally Christie, Deputy Chair
Waikato DHB
23 October 2013

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2013

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Cash flows from operating activities		**$000**	**$000**	**$000**	**$000**	**$000**
Operating receipts		1,185,752	1,154,692	1,189,000	1,185,788	1,155,603
Interest receipts		1,326	1,240	999	1,139	1,019
Payments to suppliers		(672,627)	(641,916)	(650,362)	(672,613)	(641,901)
Payments to employees		(454,409)	(442,127)	(465,036)	(454,409)	(442,127)
Interest payments		(8,746)	(6,803)	(10,632)	(8,746)	(6,803)
Capital charge paid		(13,841)	(17,419)	(14,974)	(13,841)	(17,419)
Goods and services tax (net)		(783)	1,751	170	(783)	1,751
Net cash flows from operating activities	21	36,672	49,418	49,165	36,535	50,123
Cash flows from investing activites						
Purchase of property, plant and equipment		(94,312)	(104,137)	(117,775)	(94,312)	(104,137)
Purchase of intangible assets		(12,564)	(3,907)	(6,254)	(12,564)	(3,907)
Receipts from sale of property, plant and equipment		40	341	-	40	341
Net cash flows from investing activities		(106,836)	(107,703)	(124,029)	(106,836)	(107,703)

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Budget	Parent 2013 Actual	Parent 2012 Actual
Cash flows from financing activities		**$000**	**$000**	**$000**	**$000**	**$000**
Capital contribution from the Crown		26,139	318	26,139	26,139	318
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowing		42,943	65,000	50,919	42,943	65,000
Repayment of borrowings		-	(3,353)	-	-	(3,353)
Net cash flows from financing activities		66,888	59,771	74,864	66,888	59,771
Net increase/(decrease) in cash and equivalents		(3,276)	1,486	-	(3,413)	2,191
Cash and cash equivalents at beginning of year		8,970	7,484	20	3,206	1,015
Cash and cash equivalents at end of year	13	5,694	8,970	20	(207)	3,206

The accompanying notes form part of these 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 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

The financial statements of Waikato DHB for the year ended 30 June 2013 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 (NZIAS) 1.

The financial statements were authorised for issue by the board on 26 October 2013.

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 NZIFRS 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.

Judgements made by management under NZIFRS that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are disclosed in note 31.

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 prepared 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 NZIFRS 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. MoH 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 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	3 - 78 years	1 - 33%
Building fit out	2 - 71 years	1 - 50%
Plant and equipment	2 - 40 years	2 - 50%

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 en 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 and 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 estimated 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.

1: Patient care revenue	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Health and disability services (MoH contracted revenue)	1,011,634	981,558	1,011,634	981,558
ACC contract revenue	8,783	9,267	8,783	9,267
Revenue from other district health boards	124,887	111,611	124,887	111,611
Clinical Training Agency revenue	10,048	10,281	10,048	10,281
Other patient care related revenue	13,264	12,763	13,264	12,763
	1,168,616	1,125,480	1,168,616	1,125,480

2: Other operating income	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Donations and bequests received	446	475	770	1,386
Rental income	980	992	980	992
Net gain on sale of property, plant and equipment	12	52	12	52
Other income	13,460	16,422	13,460	16,422
	14,898	17,941	15,222	18,852

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

3: Finance income	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Interest income	1,342	1,240	1,139	1,019
	1,342	1,240	1,139	1,019

4: Personnel costs	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Salaries and wages	444,210	433,406	444,210	433,406
Increase/(decrease) in liability for employee entitlements	4,759	4,451	4,759	4,451
Contributions to superannuation schemes	9,979	8,721	9,979	8,721
	458,948	446,578	458,948	446,578

5: Property, plant and equipment	Group 2013 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2011	28,450	225,832	167,882	104,197	526,361
Additions	-	-	-	105,099	105,099
Transfers	-	50,030	11,594	(61,624)	-
Disposals	-	-	(13,487)	-	(13,487)
Reclassifications	-	-	(129)	-	(129)
Balance at 30 June 2012	28,450	275,862	165,860	147,672	617,844
Balance at 1 July 2012	28,450	275,862	165,860	147,672	617,844
Additions	-	-	2,595	92,184	94,779
Transfers	-	121,616	15,919	(137,535)	-
Disposals	-	(577)	(2,069)	-	(2,646)
Reclassifications	30	70	(59)	-	41
Balance at 30 June 2013	28,480	396,971	182,246	102,321	710,018

5: Property, plant and equipment (continued)	Group 2013 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 2011	-	13,025	109,203	-	122,228
Depreciation charge for the year	-	14,911	12,355	-	27,266
Disposals	-	-	(13,197)	-	(13,197)
Reclassifications	-	-	(20)	-	(20)
Transfer to assets held for sale	-	(2)	-	-	(2)
Balance at 30 June 2012	-	27,934	108,341	-	136,275
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
Carrying amounts	$000	$000	$000	$000	$000
At 1 July 2011	28,450	212,807	58,679	104,197	404,133
At 30 June 2012	28,450	247,928	57,519	147,672	481,569
At 1 July 2012	28,450	247,928	57,519	147,672	481,569
At 30 June 2013	28,480	353,670	62,639	102,321	547,110

5: Property, plant and equipment (continued)	Parent 2013 Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2011	28,450	225,832	167,882	104,197	526,361
Additions	-	-	-	105,099	105,099
Transfers	-	50,030	11,594	(61,624)	-
Disposals	-	-	(13,487)	-	(13,487)
Reclassifications	-	-	(129)	-	(129)
Balance at 30 June 2012	28,450	275,862	165,860	147,672	617,844
Balance at 1 July 2012	28,450	275,862	165,860	147,672	617,844
Additions	-	-	2,595	92,184	94,779
Transfers	-	121,616	15,919	(137,535)	-
Disposals	-	(577)	(2,069)	-	(2,646)
Reclassifications	30	70	(59)	-	41
Balance at 30 June 2013	28,480	396,971	182,246	102,321	710,018

5: Property, plant and equipment (continued)	Parent 2013 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 2011	-	13,025	109,203	-	122,228
Depreciation charge for the year	-	14,911	12,355	-	27,266
Disposals	-	-	(13,197)	-	(13,197)
Reclassifications	-	-	(20)	-	(20)
Transfer to assets held for sale	-	(2)	-	-	(2)
Balance at 30 June 2012	-	27,934	108,341	-	136,275
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
Carrying amounts	$000	$000	$000	$000	$000
At 1 July 2011	28,450	212,807	58,679	104,197	404,133
At 30 June 2012	28,450	247,928	57,519	147,672	481,569
At 1 July 2012	28,450	247,928	57,519	147,672	481,569
At 30 June 2013	28,480	353,670	62,639	102,321	547,110

Valuation
The most recent valuation of land and buildings was carried out by M.J. Snelgrove, an independent registered valuer with CBRE and a member of the New Zealand Institute of Valuers. The valuation was carried out at 30 June 2010.

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

Restrictions on 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.

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.

5: Property, plant and equipment (continued)

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 is therefore not reflected in the value of the land.

Property, plant and equipment under construction
Costs incurred up to balance date on the Building Programme total $410.9 million (2012: $329.0 million). Outstanding commitments for the acquisition of property, plant and equipment at 30 June 2013 total $33.2 million (2012: $60.6 million).

6: Intangible assets

	Group Software	Parent Software
Cost	**$000**	**$000**
Balance at 1 July 2011	29,342	29,342
Additions	3,907	3,907
Disposals	(1,676)	(1,676)
Reclassifications	129	129
Balance at 30 June 2012	31,702	31,702
Balance at 1 July 2012	31,702	31,702
Additions	11,216	11,216
Disposals	-	-
Reclassifications	59	59
Balance at 30 June 2013	42,977	42,977
Amortisation and impairment losses	**$000**	**$000**
Balance at 1 July 2011	22,742	22,742
Amortisation charge for the year	3,895	3,895
Disposals	(1,674)	(1,674)
Reclassifications	20	20
Balance at 30 June 2012	24,983	24,983
Balance at 1 July 2012	24,983	24,983
Amortisation charge for the year	4,412	4,412
Disposals	-	-
Reclassifications	6	6
Balance at 30 June 2013	29,401	29,401
Carrying amounts	**$000**	**$000**
At 1 July 2011	6,600	6,600
At 30 June 2012	6,719	6,719
At 1 July 2011	6,719	6,719
At 30 June 2013	13,576	13,576

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 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	**$000**	**$000**	**$000**
Net Impairment of trade receivables	318	(1,088)	318	(1,088)
Audit fees for the audit of the financial statements	201	190	186	175
Audit related fees for assurance and internal audits	15	205	15	205
Board members' remuneration and expenses	356	360	356	360
Operating lease expenses	6,727	7,109	6,727	7,109
Koha and donations	11	18	11	18
	7,628	6,794	7,613	6,779

8: Finance costs

	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	**$000**	**$000**	**$000**
Interest and financing expenses	8,818	7,103	8,818	7,103
	8,818	7,103	8,818	7,103

9: Capital charge

	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	**$000**	**$000**	**$000**
Capital charge	14,202	13,732	14,202	13,732
	14,202	13,732	14,202	13,732

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 2013 was 8% (2012:8%).

10: Investment in associate

a: General information

Name of entity	Principal activities	Interest held at 30 June 2013	Balance date
Urology Services Limited	Provision of urology services	50%	30 June

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

2013 Actual	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
Urology Services Limited	1,108	1,047	61	6,017	1
	1,108	1,047	61	6,017	1
2012 Actual					
Urology Services Limited	997	936	61	5,827	(61)
	997	936	61	5,827	(61)

c: Share of profit of associate (50%)	Group 2013 Actual $000	Group 2012 Actual $000	Parent 2013 Actual $000	Parent 2012 Actual $000
Share of profit before tax	1	(31)	1	(31)
Less: Tax expense	-	-	-	-
Share of profit after tax	1	(31)	1	(31)

d: Investment in associate (50%)	$000	$000	$000	$000
Carrying amount at beginning of year	30	61	30	61
Share of total recognised revenue and expenses	1	(31)	1	(31)
Carrying amount at end of year	31	30	31	30

e: Share of associate's 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 2013	Balance date
HealthShare Limited	Provision of clinical audit services	20%	30 June

b: Carrying amount of investment	Group 2013 Actual $000	Group 2012 Actual $000	Parent 2013 Actual $000	Parent 2012 Actual $000
Opening Balance	38	38	38	38
Movement in share of HealthShare Limited (20%)	156	-	156	-
Closing Balance	194	38	194	38

c: Summary of Waikato DHB's interests in HealthShare Limited (20%)	$000	$000	$000	$000
Non-current assets	133	8	133	8
Current assets	500	402	500	402
Current liabilities	(439)	(372)	(439)	(372)
Net assets	194	38	194	38
Revenue	1,529	896	1,529	896
Expenses	(1,373)	(896)	(1,373)	(896)
Share of surplus of joint venture	156	-	156	-

12: Equity	Group				
	Trust Funds	Crown Equity	Revaluation Reserve	Retained Earnings	Total Equity
Reconciliation of movement in equity	$000	$000	$000	$000	$000
Balance at 1 July 2011	6,455	61,775	52,859	59,139	180,228
Total comprehensive income/(expense)	-	-	(129)	9,409	9,280
Capital contributions from the Crown	-	318	-	-	318
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Other movement	-	2	-	(2)	-
Trust funds movement	(705)	-	-	-	(705)
Balance at 30 June 2012	5,750	59,901	52,730	68,546	186,927
Balance at 1 July 2012	5,750	59,901	52,730	68,546	186,927
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	1	-	-	3	4
Trust funds movement	(136)	-	-	-	(136)
Balance at 30 June 2013	5,615	83,846	52,730	70,737	212,928

12: Equity (continued)	Parent			
	Crown Equity	Revaluation Reserve	Retained Earnings	Total Equity
Reconciliation of movement in equity	$000	$000	$000	$000
Balance at 1 July 2011	61,775	52,859	59,139	173,773
Total comprehensive income/(expense)	-	(129)	9,409	9,280
Capital contributions from the Crown	318	-	-	318
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	2	-	(2)	-
Balance at 30 June 2012	59,901	52,730	68,546	181,177
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

Trust funds
The Trust funds represent 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 the related party note.

13: Cash and cash equivalents	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Bank balances	(207)	3,206	(207)	3,206
Trust funds	5,901	5,764	-	-
	5,694	8,970	(207)	3,206

Unsecured bank facility

Waikato DHB had a working capital facility direct with Westpac, with a limit of $40.2 million which expired on 31 July 2012 and was not renewed.

14: Receivables and prepayments	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Ministry of Health trade receivables	2,339	7,505	2,339	7,505
Other trade receivables	4,537	1,900	4,520	1,899
Total trade receivables	6,876	9,405	6,859	9,404
Ministry of Health accrued income	10,195	8,865	10,195	8,865
Other accrued income	3,927	4,105	3,927	4,105
Prepayments	3,498	3,941	3,498	3,941
	24,496	26,316	24,479	26,315

Receivables and accrued income are shown net of impairment losses (provision for doubtful debts) amounting to $1.2 million (2012: $1.3 million). The carrying value of debtors and other receivables approximates their fair value.

14: Receivables and prepayments (continued)	Group 2013 Actual $000		Group 2012 Actual $000	
Trade receivables	Gross Receivable	Impairment	Gross Receivable	Impairment
The ageing profile of trade receivables and their impairment is:				
Not past due	3,841	-	5,123	-
Past due 0-30 days	2,322	-	3,302	-
Past due 31-120 days	648	223	545	164
Past due 121-360 days	324	231	661	174
Past due more than 1 year	891	696	1,096	984
	8,026	1,150	10,727	1,322

	Parent 2013 Actual $000		Parent 2012 Actual $000	
Trade receivables	Gross Receivable	Impairment	Gross Receivable	Impairment
Not past due	3,824	-	5,122	-
Past due 0-30 days	2,322	-	3,302	-
Past due 31-120 days	648	223	545	164
Past due 121-360 days	324	231	661	174
Past due more than 1 year	891	696	1,096	984
	8,009	1,150	10,726	1,322

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 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
Movements in provision for impairment of receivables	**$000**	**$000**	**$000**	**$000**
At 1 July	1,322	2,936	1,322	2,936
Provisions made/(reversed) during the year	318	(1,090)	318	(1,090)
Bad debts written off during the year	(502)	(563)	(502)	(563)
Bad debts recovered during the year	12	39	12	39
At 30 June	1,150	1,322	1,150	1,322

15: Inventories	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	**$000**	**$000**	**$000**
Pharmaceuticals	452	453	452	453
Surgical and medical supplies	6,669	6,446	6,669	6,446
Other supplies	762	722	762	722
	7,883	7,621	7,883	7,621

The amount of inventories recognised as revenue due to change in stock value during the year was $274,000 (2012: -$1.7million), which is included in the clinical supplies line item in the statement of comprehensive income.

Write-down of inventories amounted to $363,000 for 2013 (2012: $520,000). The provision for obsolete inventories adjustment recognised as expenses during the year ended 30 June 2013 was $Nil (2012: $130,000). No inventories are pledged as security for liabilities.

16: Assets held for sale

At 30 June 2013 Waikato DHB owned 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 Waikato DHB.

	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	**$000**	**$000**	**$000**
Land	40	70	40	70
Buildings	-	67	-	67
	40	137	40	137

17: Borrowings	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
Current	**$000**	**$000**	**$000**	**$000**
Unsecured bank facility	-	29,220	-	29,220
Loan from Health Benefits Limited	39,285	-	39,285	-
Loan from HealthShare Limited	977	431	977	431
Loan from Energy Efficiency and Conservation Authority	111	-	111	-
	40,373	29,651	40,373	29,651
Non-current	**$000**	**$000**	**$000**	**$000**
Crown loans	191,659	159,659	191,659	159,659
Loan from Energy Efficiency and Conservation Authority	221	-	221	-
	191,880	159,659	191,880	159,659
Loan facility limits	**$000**	**$000**	**$000**	**$000**
Crown loans	211,659	211,659	211,659	211,659
Unsecured bank facility	-	40,200	-	40,200

17:Borrowings (continued)

The interest rate terms are spread over a period between two to eight years from balance date to manage interest rate risk.

The fair value of Crown loan borrowings is $199.4 million (2012:$174.9 million). Fair value has been determined based on Government bond rate plus 15 basis points, which is based on mid-market pricing.

The Crown loans are secured by a negative pledge. Without the 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.

18: Employee entitlements

	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
Current	**$000**	**$000**	**$000**	**$000**
Liability for long service leave	2,524	2,204	2,524	2,204
Liability for retirement gratuities	2,495	2,365	2,495	2,365
Liability for annual leave	48,565	46,224	48,565	46,224
Liability for sick leave	823	777	823	777
Liability for continuing medical education leave and expenses	10,820	10,407	10,820	10,407
PAYE payable	5,736	4,022	5,736	4,022
Salary and wages accrual	10,778	11,311	10,778	11,311
	81,741	77,310	81,741	77,310
Non-current	**$000**	**$000**	**$000**	**$000**
Liability for long service leave	1,456	1,351	1,456	1,351
Liability for sabbatical leave	2,543	2,419	2,543	2,419
Liability for retirement gratuities	9,806	9,707	9,806	9,707
	13,805	13,477	13,805	13,477

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash 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 4.0% (2012:3.3%) and an inflation factor of 3.5% (2012:2.5%) was used.

19: Trade and other payables	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
	$000	$000	$000	$000
Trade payables and accruals to non-related parties	48,190	54,049	47,887	54,034
ACC levy payable	1,657	2,227	1,657	2,227
GST payable	6,087	6,870	6,087	6,870
Income in advance	897	177	897	177
Capital charge to the Crown	450	88	450	88
	57,281	63,411	56,978	63,396

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 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
Current	$000	$000	$000	$000
ACC Partnership Programme	648	744	648	744
Motor vehicle repairs on disposal	32	78	32	78
	680	822	680	822
Non-current				
Motor vehicle repairs on disposal	336	143	336	143
	336	143	336	143

Movements for each class of provision	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2011	878	546	1,424
Additional provisions made	356	77	433
Amounts used	(490)	(402)	(892)
Balance at 30 June 2012	744	221	965
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

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 its clams 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 implementations 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 caculated the ACC Partnership Programme liablity as at 30 June 2013. 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% (2012: 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 2.4% per annum (2012: 3%); and
- a discount factor of 3.5% for 30 June 2013 (2012: 3.5%).

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

	Note	Group 2013 Actual	Group 2012 Actual	Parent 2013 Actual	Parent 2012 Actual
		$000	$000	$000	$000
Net surplus/(deficit)		2,052	8,704	2,188	9,409
Add/(less) non-cash items:					
Depreciation	5	29,254	27,266	29,254	27,266
Amortisation	6	4,412	3,895	4,412	3,895
Impairment of intangible asset		1,191	-	1,191	-
Bad and doubtful debts	14	318	(1,089)	318	(1,089)
Share of associate (surplus)/deficit	10	1	31	1	31
Share of joint venture (surplus)/deficit	11	(156)	-	(156)	-
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	2	(12)	(52)	(12)	(52)
(Increase)/decrease in fixed asset creditor		(782)	(31)	(782)	(31)
Add/(less) movements in statement of financial position items:					
(Increase)/decrease in inventories	15	(262)	2,011	(262)	2,011
(Increase)/decrease in receivables and prepayments	14	1,820	11,206	1,836	11,206
(Increase)/decrease in investment in associate (non-cash)	10	(1)	31	(1)	31
(Increase)/decrease in investment in joint venture (non-cash)	11	156	-	156	-
Increase/(decrease) in employee entitlements	18	4,759	4,451	4,759	4,451
Increase/(decrease) in trade and other payables	19	(6,129)	(6,546)	(6,418)	(6,546)
Increase/(decrease) in other provisions	20	51	(459)	51	(459)
Net cash inflow from operating activities		36,672	49,418	36,535	50,123

22: Capital commitments and operating leases

Capital commitments	Group 2013 Actual $000	Group 2012 Actual $000	Parent 2013 Actual $000	Parent 2012 Actual $000
Property, plant and equipment	33,249	60,638	33,249	60,638
Intangible assets	2,552	-	2,552	-
	35,801	60,638	35,801	60,638

The capital commitments represent capital expenditure contracted for at balance date but not yet incurred, predominantly in relation to the current building programme at Waikato Hospital.

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

	Group 2013 Actual $000	Group 2012 Actual $000	Parent 2013 Actual $000	Parent 2012 Actual $000
Not more than one year	4,507	4,539	4,507	4,539
One to two years	3,557	3,769	3,557	3,769
Two to three years	3,093	2,788	3,093	2,788
Three to four years	2,354	2,553	2,354	2,553
Four to five years	539	2,237	539	2,237
Over five years	81	331	81	331
	14,131	16,217	14,131	16,217

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 increased every 1-5 years to reflect market rentals. None of the leases includes contingent rentals.

23: Contingencies

Contingent liabilities	Group 2013 Actual $000	Group 2012 Actual $000	Parent 2013 Actual $000	Parent 2012 Actual $000
Personal grievances	260	100	260	100
Legal proceedings and disputes by third parties	30	-	30	-
	290	100	290	100

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 2013 (2012: $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.

	2013 Actual $000	2012 Actual $000
Balance at 1 July	38	29
Receipts	127	124
Payments	(146)	(115)
Balance at 30 June	19	38

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 (31% at 30 June 2013). 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 tables 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 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 Health Benefits Limited	39,285	39,285	39,285	-	-	-	-
Loan from HealthShare Limited	977	977	977	-	-	-	-
Trade and other payables	57,281	57,281	57,281	-	-	-	-
	289,534	283,534	97,595	52	104	124	191,659

	Group 2012 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	159,659	159,659	-	-	-	-	159,659
Loan from HealthShare Limited	431	431	431	-	-	-	-
Unsecured bank facility	29,220	29,220	29,220	-	-	-	-
Trade and other payables	63,411	63,411	63,411	-	-	-	-
	252,721	252,721	93,062	-	-	-	159,659

25: Financial instruments (continued)

	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 Health Benefits Limited	39,285	39,285	39,285	-	-	-	-
Loan from HealthShare Limited	977	977	977	-	-	-	-
Trade and other payables	56,978	56,978	56,978	-	-	-	-
	289,231	289,231	97,292	52	104	124	191,659

	Parent 2012 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	159,659	159,659	-	-	-	-	159,659
Loan from HealthShare Limited	431	431	431	-	-	-	-
Unsecured bank facility	29,220	29,220	29,220	-	-	-	-
Trade and other payables	63,396	63,396	63,396	-	-	-	-
	252,706	252,706	93,047	-	-	-	159,659

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 2013, it is estimated that a general increase of one percentage point in interest rates would decrease the surplus by approximately $400,000 million (2012:$260,000 million).

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 2013 Waikato DHB had no forward foreign currency agreements outstanding (2012:$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 Waikato 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 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.

		2013 Actual	2012 Actual
Loans from related parties		**$000**	**$000**
HealthShare Limited		977	431
		977	431

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 $1.012 billion (2012:$982 million) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2013 was $2.3 million (2012:$7.5 million). Waikato DHB incurred a capital charge of $14.2 million (2012:$13.7 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 2013 of $8.8 million (2012:$9.3 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 2013 was $124.9 million (2012: $111.6 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2013 was $47.6 million (2012:$53.4 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 2013 totaled $20.5 million (2012:$20.7 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 2013 amounted to $156,380 (2012:$Nil).

During the year Waikato DHB received $20,723 (2012:$31,002) for administration fees from HealthShare Limited and a further $371,667 (2012:$403,952) for the provision of transport, accommodation, and information services personnel costs. Waikato DHB incurred expenses from HealthShare Limited of $4,722,088 (2012:$2,087,881) for services provided.

As at 30 June 2013 Waikato DHB owed HealthShare Limited $443,146 (2012:$442,503), and HealthShare Limited owed Waikato DHB $525,648 (2012:$38,126).

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 2013, HealthShare Limited had total assets of $3.285 million (2012:$1.957 million) and total liabilities of $2.314 million (2012:$1.766 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 2013 amounting to $30,615 (2012:$30,349).

No dividends have been received from Urology Services Limited. During the period Waikato DHB recieved inpatient urological services from Urology Services Limited of $5.7 million (2012: $5.7 million). Waikato DHB recieved facility and management service fees of $3.0 million (2012: $2.8 million) from Urology Services Limited. During the period Waikato DHB's share of revenue amounted to $2.7 million (2012:$2.9 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 2013 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 2013 the Waikato Health Trust had total assets of $5.92 million (2012:$5.76 million) and total liabilities of $0.3 million (2012:$0.01 million).

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $737,508 (2012:$970,063). There was $287,615 owing to Waikato District Health Board at 30 June 2013 (2012:$Nil).

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 Institute of Technology (Wintec) for the provision of clinical training services, Genesis Energy for Gas and Electricity, District Health Boards New Zealand for Professional Services, Nga Miro Charitable Trust for the provision of Maori health support services, Te Korowai Hauora O Hauraki (a non profit incorporated Society) for the provision of General Practitioner clinical services, Kaute Pasifika for the provision of health services, Midland Cardiovascular Services for the provision of clinical services, Waikato Heart Trust for professional services, Wintec for course fees, The Family Clinic for Clinical Services, Hamilton Residential Trust for the provision of clinical services, Southern Cross Hospital for the provision of clinical services, Wolstencroft and Associates Limited for project director services, the Hamilton City Council for the provision of water supplies, sewage disposal and refuse collection and Tairawhiti DHB whose current Board member Matt Todd is a former Board member at the Waikato DHB, the two DHB's have completed transactions at arms length over the daily course of business.

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, Waikato Health Trust for which Mary Anne Gill, Maureen Chrystall and Pippa Mahood are Trustees 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**	**2013 Actual**	**2012 Actual**	**2013 Actual**	**2012 Actual**
		$000	**$000**	**$000**	**$000**
Grame Milne	Genesis Energy (supplier)	2,344	1,549	-	-
Director	*Gas and electricity*				
Grame Milne	DHBNZ (supplier)*	-	138	-	-
Director	DHBNZ (client)*	-	139	-	11
	Professional services				
Grame Milne	Massey University (client)	2	-	-	-
Member of Advanced Engineering & Technolgy Advisory Board	*Staff development*				
Harry Mikaere	Te Korowai Hauora O Hauraki (supplier)	156	135	7	14
Chairman	*General Practitioner clinical services*				
Harry Mikaere	Hauraki PHO (supplier)	-	1	-	-
Chairman	Hauraki PHO (client)	5	-	-	-
	Staff development				
Harry Mikaere	Coromandel Marine Farmers Limited (client)	30	-	12	-
Shareholder	*Professional services*				
Clyde Wade	Midland Cardio Vascular (supplier)	3,991	4,744	-	367
Shareholder	Midland Cardio Vascular (client)	3	2	-	-
	Clinical services				
Clyde Wade	Waikato Heart Trust (client)	-	100	-	-
Trustee	*Clinical services*				
Deryck Shaw	Lakes District Health Board (supplier)	249	239	2	58
Chairman	Lakes District Health Board (client)	1,954	239	279	-
	Clinical services				

27: Related parties (continued)

Board members	Transaction	Transaction value year ended 30 June 2013 Actual $000	Transaction value year ended 30 June 2012 Actual $000	Balance outstanding as at 30 June 2013 Actual $000	Balance outstanding as at 30 June 2012 Actual $000
Martin Gallagher	Waikato District Council (supplier)	1	-	-	-
Chair of numerous portfolios	*Facilities*				
Martin Gallagher	Hamilton City Council (supplier)	2,842	1,016	-	-
Chairman	Normal duties of a city council				
Pippa Mahood	*Facilities*				
Ewan Wilson					
Councillors					
Gay Shirley	Braemar Hospital (supplier)	3,114	-	86	-
Husband is a Trustee of Braemar Charitable Trust**	Braemar Hospital (client)	7	-	-	-
	Clinical services				
Sharon Mariu	National Health Committee (client)	9	-	2	-
Member	*Professional services*				

Former Board members	Transaction	Transaction value year ended 30 June 2013 Actual $000	Transaction value year ended 30 June 2012 Actual $000	Balance outstanding as at 30 June 2013 Actual $000	Balance outstanding as at 30 June 2012 Actual $000
Matt Todd* **	Tairawhiti DHB (supplier)	N/A	61	N/A	-
Board Member	Clinical services				

*DHBNZ was acquired by Central Region's Technical Advisory Services Limited in 2012 and is now known as DHB Shared Services.
Grame Milne is no longer a director therefore transactions with DHB Shared Services are not shown for 2013.
**Braemar Charitable Trust (the Trust is the sole shareholder of Braemar Hospital Limited).
***Matt Todd resigned as Board Member on 29 February 2012 therefore transactions with Tairawhiti DHB are not shown for 2013.

27: Related parties (continued)

Executives	Transaction	Transaction value year ended 30 June 2013 Actual	Transaction value year ended 30 June 2012 Actual	Balance outstanding as at 30 June 2013 Actual	Balance outstanding as at 30 June 2012 Actual
		$000	$000	$000	$000
Neville Hablous	Hamilton Residential Trust (supplier)	2	94	-	-
Trustee	*Disability support services*				
Craig Climo	National Health Committee	9	-	2	-
Member	*Professional services*				
Craig Climo	Health Benefits Limited (supplier)	858	-	44	-
Director	Health Benefits Limited (client)	64	-	63	-
	Professional services				
Craig Climo	HealthShare Limited (supplier)	4,722	-	365	-
Director	HealthShare Limited (client)	482	-	49	-
Brett Paradine	*Professional services*				
Alternate Director					
Darrin Hackett	HIQ Ltd (supplier)	419	124	-	29
General Manager	HIQ Ltd (client)	183	53	-	-
	Professional services				
Ian Wolstencroft	Wolstencroft and Associates Limited (supplier)	449	380	32	-
Shareholder and Director	*Project Director services*				
Maureen Chrystall	Urology Services Limited (client)	3,133	-	483	-
Director	*Clinical services*				-

28: Key management personnel remuneration

Compensations

There were no loans to board members during the year ended 30 June 2013 amounted to $Nil (2012:$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 2013 (2012:$Nil).

Remuneration

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

	2013 Actual	2012 Actual
	$000	$000
Salaries and other short-term benefits	3,161	3,072
Contributions to superannuation schemes	56	57
	3,217	3,129

Board members	No. of meetings elligible to attend 2013	No. of meetings actually attended 2013	Remuneration 2013 Actual	Remuneration 2012 Actual
			$	$
Graeme Milne	35	28	54,750	55,688
Sally Christie	35	32	35,813	36,313
Andrew Buckley	25	24	28,250	28,250
Martin Gallagher	26	25	28,000	27,000
Pippa Mahood	16	13	26,250	26,563
Sharon Mariu	25	22	28,563	28,813
Harry Mikaere	15	11	25,750	26,000
Deryck Shaw	10	10	25,000	2,083
Gay Shirley	29	29	29,188	27,750
Clyde Wade	31	27	29,500	27,750
Ewan Wilson	21	18	27,250	27,500
Matt Todd	-	-	-	26,000
			338,314	339,710

28: Key management personnel remuneration (continued)

Non-board members who attended committee meetings	No. of meetings elligible to attend 2013	No. of meetings actually attended 2013	Remuneration 2013 Actual	Remuneration 2012 Actual
			$	$
Paul Malpass	5	5	1,250	1,000
Robyn Klos	5	4	1,000	1,250
Ross Lawrenson	6	6	1,250	750
John Macaskill-Smith	6	3	500	500
John McIntosh	6	5	1,000	250
Fungai Mhlanga	6	6	1,250	1,000
Tureiti Moxon	5	1	250	500
Ken Price	5	4	1,000	750
David Slone	6	6	1,250	1,000
Tipa Mahuta	3	2	250	-
Piki Taiaroa	3	3	250	-
Wayne McLean	1	-	-	1,500
Rachael Dean	-	-	-	250
Eileen Barker	-	-	-	250
Adri Isbister	-	-	-	250
Sue Wardill	-	-	-	250
			9,250	9,500

29: Employee remuneration

Employee remuneration over $100,000 ($10,000 bands)	2013 Actual	2012 Actual
100,001 - 110,000	125	101
110,001 - 120,000	91	81
120,001 - 130,000	59	42
130,001 - 140,000	53	46
140,001 - 150,000	33	29
150,001 - 160,000	28	15
160,001 - 170,000	21	15
170,001 - 180,000	23	20
180,001 - 190,000	21	19
190,001 - 200,000	24	24
200,001 - 210,000	17	20
210,001 - 220,000	17	15
220,001 - 230,000	17	12
230,001 - 240,000	18	19
240,001 - 250,000	27	17
250,001 - 260,000	21	18
260,001 - 270,000	14	18
270,001 - 280,000	13	12
280,001 - 290,000	15	16
290,001 - 300,000	14	13
300,001 - 310,000	11	8
310,001 - 320,000	10	10
320,001 - 330,000	10	6
330,001 - 340,000	5	3
340,001 - 350,000	4	5

29: Employee remuneration (continued)

Employee remuneration over $100,000 ($10,000 bands)	2013 Actual	2012 Actual
350,001 - 360,000	2	1
360,001 - 370,000	4	3
370,001- 380,000	1	2
380,001 - 390,000	3	2
390,001 - 400,000	1	1
400,001 - 410,000	3	2
430,001 - 440,000	-	1
460,001 - 470,000	-	1
480,001 - 490,000	1	-
530,001 - 540,000	1	-
540,001 - 550,000	-	1
630,001 - 640,000	-	1
680,001 - 690,000	1	-
	708	599

Of the 708 (2012:599) employees shown above, 85 percent or 603 (2012:533) 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 752 (2012:634), compared with the actual number of employees of 708 (2012:599)

The 2013 actual includes 27 fortnightly payruns for some employees, compared to the standard 26 fortnightly payruns in 2012.

The remuneration of the Chief Executive for the year ended 30 June 2013 was in the $480,001 to $490,000 band (2012:$460,000 - $470,000).

29: Employee remuneration (continued)

Termination payments
During the year the Board made the following payments in respect of the termination of employment with the Waikato DHB:

	2013 Actual	2012 Actual
Amount paid	$595,023	$479,537
Number of employees	31	9

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 $2.2 million against its annual plan budget of $1.0 million. Explanations for major variances are:

Variances in comprehensive income:
The Provider arm recorded a $5.9 million unfavourable variance to budget mainly due to:

- provisioning for a reduction of $5.0 million in revenue
- interest, depreciation and capital charge costs $5.4 million favourable due to slower than planned capital expenditure and consequent loan drawdowns
- personnel costs are $3.5 million unfavourable with some offset in outsourced services due to use of locums
- outsourced services are $7.9 million unfavourable with some offset in other areas of expenditure
- clinical supplies are $1.6 mllion favourable.

32: Explanation of financial variances from budget (continued)

The Funder arm recorded a $7.2 million favourable variance to budget mainly due to favourable MoH contracted revenue and revenue from other district health boards.

Variances in statement of changes in equity:

- The surplus was $1.2 million favourable to budget due to the statement of comprehensive income explanations provided above.

Variances in financial position:
Current assets are $16.5 million lower than budgeted due to:

- inventories $2.0 million lower than budgeted due to recent improvements in supply chain processes
- receivables and prepayments $14.5 million lower than budgeted due to improvements in credit controls and timing of revenue accruals.

Current liabilities are $3.5 million lower than planned due to trade and other payables being lower than budgeted, partly offset by higher short term borrowings. Fixed asset creditors' payments can be inconsistent throughout the year and balances have decreased.

Non-current assets $9.6 million lower than planned due to slower spend in the 2011-12 financial year after budgeting for 2012-13 was completed. The work in progress balance has decreased due to capitalisation of a major part of the hospital's building programme.

Non-current liabilities are $19.1 million lower than planned as draw downs on loan are slower than planned due to slower than planned capital spend.

Variances in cash flows:

- Net cash flows from operating activities are $12.6 million unfavourable to budget due to an increase in payments to suppliers partly offset by a decrease in payments to employees;
- Net cash flows from investing activities are $17.2 million lower 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.