Annual Report

for the year ended **30 June 2017**

Waikato District Health Board

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

This Annual Report has been prepared to meet the requirements of the Crown Entities Act 2004 (see Section 150 of the Act) and the Public Finance Act 1989 (see Section 43 of the Act). This report presents information on our performance over the 2016/17 year with ratings on the outputs and impacts we intended to deliver in terms of national, regional and local priorities and as stated in the Waikato DHB's 2016/17 Annual Plan.

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

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

www.waikatodhb.health.nz/key-publications

Statement of responsibility for the year ended 30 June 2017

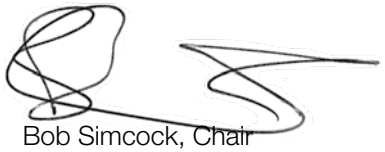
We are responsible for the preparation of the Waikato District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the District Health Board under section 19A of the Public Finance Act 1989.

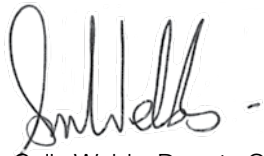
We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Waikato District Health Board group for the year ended 30 June 2017.

Signed on behalf of the Board



Bob Simcock, Chair
25 October 2017



Sally Webb, Deputy Chair
25 October 2017

Contents

Mount Pirongia and Lake Ngaroto.

Mihi

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

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

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

'Tūturu whakamaua kia tina!'
'Tina!'

'Haumi e; hui e!'
'Taiki e!'

A brief explanation of the mihi

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

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

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

'Pull it together [the report], so that is done properly!'
'It shall be done!'

'Gather it together; weave everything together!'
'It is accomplished!'

Foreword

It has been a challenging year for the Waikato DHB with ever more demand on our services, and our hospitals busier than ever. But our 6000 dedicated and hardworking staff have stepped up to that challenge - delivering more healthcare both in our hospitals and in the community and forging ahead with our vision of Healthy people Excellent care.

To help us cope with this increasing demand for health services, we need more care provided closer to people's homes in our large rural community. That's why this year we launched our joint proposal with the University of Waikato for a third medical school for New Zealand.

This medical school is being proposed in response to health workforce shortages in provincial and rural areas. We have an aging medical workforce, a preference for part time work among GPs and a reliance on overseas-trained doctors.

Being a graduate entry programme, and offering four years of training rather than five, it opens the doors wider for more people to train as doctors. We need people from our communities to train as doctors and return to their community, and provide the healthcare that's needed. We want a new breed of doctor who are more representative of the communities they serve, who focus on the healthcare of our high needs communities and are able to use the latest advances in technology.

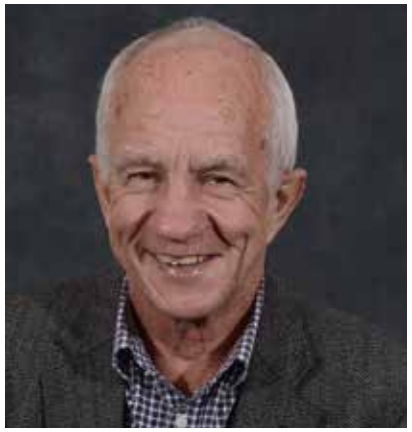
It's been 50 years since the last medical school was created in NZ, so this is a once in a lifetime opportunity to create a radically different education programme that meets our communities' needs.

Access to health services in our remote communities and for our large Maori population is key to keeping people healthy and reducing inequities. Our SmartHealth online health service that lets people talk to a doctor from their smartphone or home computer launched an out of hours doctor service this year. This lets people contact a doctor by video, voice or text chat on evenings and weekends when their own doctor is not available or they can't easily get to an A&M clinic.

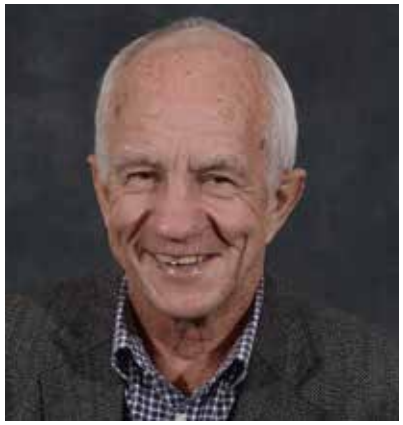
Getting our health messages out to our rural population was behind our attendance at the first ever Health Hub at Fieldays event. We showcased services from cancer detection and rural mental health and wellbeing through to children's oral health and a simulation manikin for people to practice CPR on.

Through all of these initiatives we have tried to remain true to our DHB values and keep 'people at heart.' By staying focused on what's important for our population and working closely with our partners in primary care, we have empowered people to live healthy lives and delivered safe quality health care.

Bob Simcock
Chair



Board profiles



Bob Simcock

Waikato DHB Chair

Re-appointed: December 2016

- Chairman, Orchestras
- Member, Waikato Regional Council
- Director, Rotoroa LLC
- Trustee, RM & AI Simcock Family Trust
- Wife is Trustee of Child Matters, Trustee Life Unlimited which holds contracts with the DHB, Member of Governance Group for National Child Health Information Programme, Member of Waikato Child and Youth Mortality Review Group.

Crystal Beavis

Re-elected: December 2016

- Director, Bridger Beavis & Associates Ltd, management consultancy
- Director, Strategic Lighting Partners Ltd, management consultancy
- Life member, Diabetes Youth NZ Inc
- Trustee, several Family Trusts
- Employee, Waikato District Council

Sally Webb

Deputy Chair

Appointed: December 2016

- Chair, Bay of Plenty DHB
- Member, Capital Investment Committee
- Director, SallyW Ltd

Andrew Buckley

Term concluded

- Company Director, “Crannog Ltd”
- Trustee, “Golden 8” Family Trust
- Chair, Alcohol & Drug Community Support Trust

Sally Christie

Re-elected: December 2016

- Partner, employee of Workwise

Martin Gallagher

Re-elected: December 2016

- Member, Hamilton City Council
- Board member Parent to Parent NZ (Inc), also provider of the Altogether Autism service
- Trustee, Waikato Community Broadcasters Charitable Trust
- Alternate Member, Waikato Plan Joint Committee
- Member, Hospital Advisory Committee, Lakes DHB
- Wife employed by Selwyn Foundation and Wintec (contracts with Waikato DHB)

Mary Anne Gill

Elected: December 2016

- Employee, Life Unlimited Charitable Trust
- Member, Public Health Advisory Committee, Bay of Plenty DHB
- Member, Disability Support Advisory Committee, Bay of Plenty DHB
- Member, Health Strategic Committee, Bay of Plenty DHB
- Son is an employee of Hong Kong and Shanghai Banking Corp Ltd (NZ)

Tania Hodges

Re-appointed: December 2016

- Director and Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)
- Trustee and Shareholder, Whānau.com Trust
- Director, Ngati Pahauwera Commercial Development Ltd
- Director, Ngati Pahauwera Development Custodian Ltd
- Director, Ngati Pahauwera Tiaki Custodian Limited
- Trustee, Ngati Pahauwera Development and Tiaki Trusts (Deputy Chair)

Dave Macpherson

Elected: December 2016

- Councillor, Hamilton City Council
- Deputy Chair, Western Community Centre, Inc
- Partner is Chair of Ngaruawahia Community House, Inc
- Member, Waikato Regional Transport Committee
- Member, Waikato Water Study Governance Group
- Member, Future Proof Joint Council Committee

Pippa Mahood

Re-elected: December 2016

- Life Member, Hospice Waikato
- Member, Institute of Healthy Aging Governance Group
- Board member, WaiBOP Football Association
- Member, Community and Public Health Committee, Lakes DHB
- Member, Disability Support Advisory Committee, Lakes DHB
- Husband retired respiratory consultant at Waikato Hospital

Sharon Mariu

Re-appointed: December 2016

- Director/Shareholder, Register Specialists Ltd
- Director/Shareholder, Asher Group Ltd
- Director, Hautu-Rangipo Whenua Ltd
- Owner, Chartered Accountant in Public Practice
- Daughter is an employee of Puna Chambers Law Firm, Hamilton
- Daughter is an employee of Deloitte, Hamilton

Gay Shirley

Term concluded

- Owner, Chartered Accountant in Private Practice
- Trustee of a number of Family Trusts
- Chair, Alandale Lifecare Ltd
- Chair, Alandale Foundation Board
- Husband is Trustee of Braemar Charitable Trust (the Trust owns all the shares in Braemar Hospital Ltd)

Clyde Wade

Re-elected: December 2016

- Shareholder, Midland Cardiovascular Services
- Trustee, Waikato Health Memorabilia Trust
- Trustee, Waikato Heart Trust
- Trustee, Waikato Cardiology Charitable Trust
- Patron, Zipper Club of New Zealand
- Emeritus Consultant Cardiologist, Waikato DHB
- Cardiology Advisor, Health & Disability Commission
- Fellow Royal Australasian College of Physicians
- Occasional Cardiology consulting
- Member, Hospital Advisory Committee, Bay of Plenty DHB
- Son is an employee of Waikato DHB

Ewan Wilson

Term concluded

- Hamilton City Councillor
- Director/Shareholder, MEW Developments Ltd
- Director, Grand Journey by Wilson Tours Ltd
- Director, Wilson Aviation Ltd
- CEO, Kiwi Regional Airlines
- Daughter is an employee of Waikato DHB

Board powhiri.

Part 1 Overview

A family day out at the park.

Cows grazing in Paterangi.

Introduction

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2017. In the Statement of Performance (part two), we present our actual performance results against the non-financial measures and targets contained in our Statement of Intent 2016/17.

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

We have both funded and provided health services this year. For the 2016/2017 year, we received approximately $1.3 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. The Ministry of Health 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 2016/17 approximately 62 percent of funding received by Waikato DHB was used to directly provide hospital and health services. The remaining 38 percent was used to fund contracted services provided by non-government organisations (NGOs), primary health care organisations (PHOs), Māori providers, Pacific providers, aged residential care, other DHBs, and pharmacies and laboratories. These services were monitored, audited, and evaluated for the level of service delivery.

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

Nevaan enjoying a swing at the farm near Matamata.

Diagram: Our performance story

National performance story

Health system future direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
Strategic themes	People-powered	Closer to home	Value and high performance	One team	Smart system

Regional performance story

Midland vision	All New Zealanders live well, stay well, get well					
Regional strategic outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional strategic objectives	Improve Māori health outcomes	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB performance story

Our vision	Healthy people. Excellent Care					
Our strategic imperatives	Achieving health equity for high needs populations	Ensuring quality health services for all	Providing people centred services	Delivering effective and efficient care and services	Becoming a centre of excellence in teaching, training and research	Developing productive partnerships

Service performance

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

Stewardship

Stewardship	Workforce	Organisational performance management	Clinical integration/ Collaboration/Partnerships	Information

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

Our organisational profile

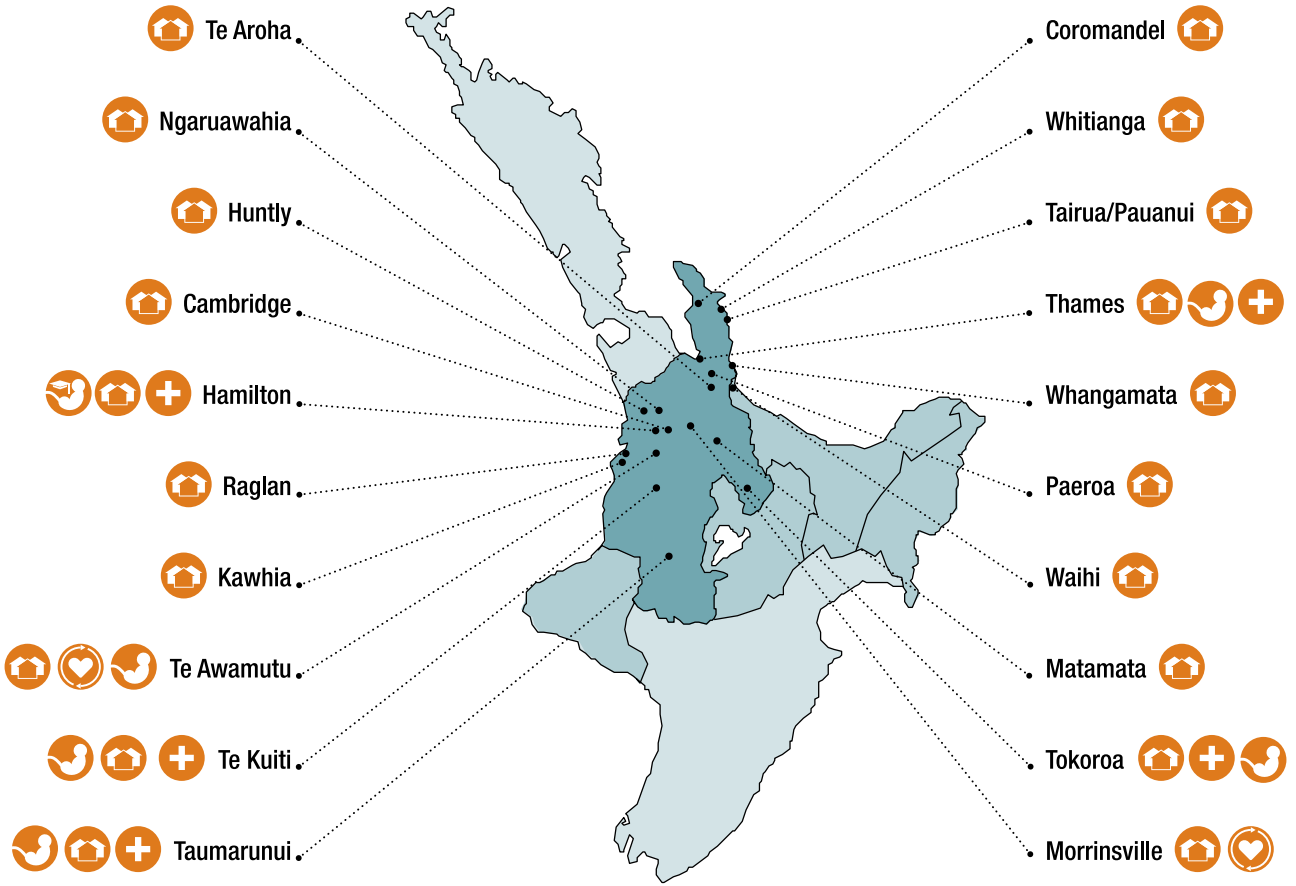
Waikato DHB
employs around
6763 people

Plans, funds and provides hospital and health services to around 400,820 people who live within the Waikato DHB boundaries

Provides tertiary services (such as highly complex surgery) to the Midland regional population of more than 898,300

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

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



Location and population

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

For 2016/2017, our population was 400,820. 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. 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 is estimated to be 23 percent of our population for 2016/2017 and is growing. The Māori population is significantly impacted by many chronic conditions such as diabetes and smoking related diseases and show up disproportionately in adverse health statistics. These facts, plus the acknowledgement of the status of iwi in the Waikato, gives us a strong commitment to include and engage Māori in health service decision making; and to deliver health information and health services in a culturally appropriate way.

Pacific people represent almost 3 percent of our population and are a group that requires targeted health initiatives.

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

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

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

Governance and accountabilities

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

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

Bob Simcock was reappointed Chair of the Board on in December 2016. The chief executive is Dr Nigel Murray, who began July 2014. Our Board and executive offices are located in Hamilton at the Waiora Waikato Hospital campus.

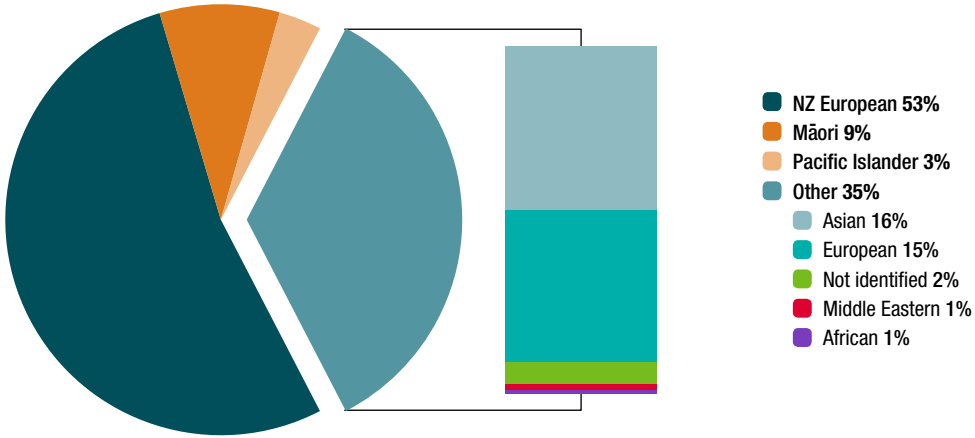
Our Board has four statutory committees; Audit and Risk Management Committee, Community Public Health Advisory Committee, the Hospital Advisory Committee, Disability Support Advisory Committee, which are made up of Board members and elected members from the community. The Performance and Monitoring Committee conducts the business of the Hospital Advisory Committee and the Heatlhy Strategy Committee conducts the business of the Community Public Health Advisory Committee and Disability Support Advisory Committee. To continue to maintain a high quality of clinical standards a Board of Clinical Governance supports the chief executive.

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

Our workforce at a glance

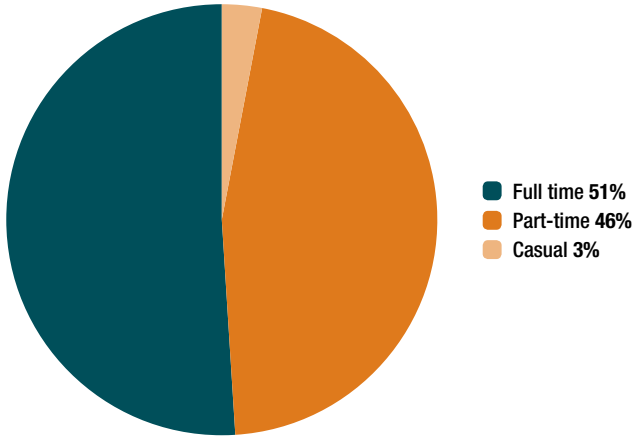
As at 30 June 2017, the DHB had 6763 employees with 5658 full-time equivalents.
These employees are central to the DHBs ability to plan, fund, and deliver health services to Waikato communities.

Employee ethnic diversity



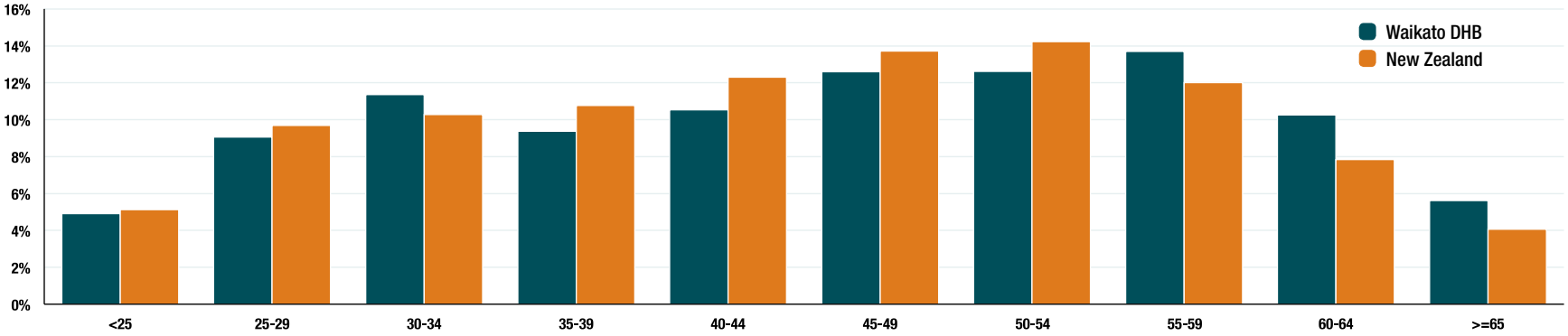
New Zealand European is 53 percent of the workforce and Māori is 9 percent.

Employee status



The majority of staff are full-time (51 percent), 46 percent are part-time, and 3 percent of the staff are casual employees.

Employee age comparison (years)



The average age of all Waikato DHB employees is 45 years. The age range distribution is shown above.

Waikato DHB Radiotherapy staff.

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 Ministry of Health and other DHB's
- 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 DHB's
- Promote, protect and improve our population's health and wellbeing through health promotion, health protection and education and the provision of evidence-based public health initiatives

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

Providing health and disability services

We are responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services. 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
- Taumarunui Hospital – rural hospital

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

Our rural hospitals form an important part of Waikato DHB's health service delivery. The hospitals works closely with all health service providers working in the area, some services provided at the rural hospitals include:

- Emergency Department providing 24 hour care for people with serious illness or injury
- X-ray and laboratory services for seriously ill patients 24/7 and for planned hospital visits Monday to Friday
- Inpatient unit, Maternity unit, Day unit
- Outpatient clinics for a wide range of services including orthopaedics, medicine, surgery, paediatrics and women's health

Strategy and Funding health and disability services

The Strategy and Funding (previously called Planning and Funding) division of our DHB is responsible for planning and funding health and disability services across our district. The core responsibilities are:

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

The Strategy and Funding division contracts services from a wide range of non-government organisation (NGO) providers, as well as other DHB's who often provide more specialist services.

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

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

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

National performance story

Waikato DHB is committed to being an active participant in delivering on national outcomes. The following diagram is part of our wider performance story (see pages 14 and 15) and shows the national strategic direction.

Health system future direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
Strategic themes	People-powered	Closer to home	Value and high performance	One team	Smart system

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

DHBs work with the Ministry of Health to help achieve our health systems future direction, with the aim to have a real impact on the lives of New Zealanders. The health and disability system is dynamic and integrated, and many activities contribute across a number of our long-term outcomes and impacts.

There are many mechanisms that DHBs can use to monitor their performance towards achieving the health systems future direction. The Health Targets provide a clear and specific focus for action to ensure that New Zealand's health care is of the highest quality and within the best possible time.

Health Target results
DHB's report their progress in the Health Targets to the Ministry of Health four times a year; the Ministry then reports their findings to the Minister and the public. Health Target results can be found on websites, in newspapers, newsletters, e-newsletters, annual reports, and publications or reports. The Health Target information is presented at the end of this section. We do not always meet the Health Targets, however we do ensure that we report on our results using a variety of mechanisms, including those listed above and in posters displayed throughout Waikato DHB hospitals and other facilities. Multi-methods for reporting our results is done so the public has various opportunities to see how we are performing. This helps us to work as hard as possible to excel at the targets and to show the public that we are accountable to them.

Shorter stays in emergency department

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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	91%	89%	89%	94%	92%	88%	93%	90%	88%	94%	91%	86%
All DHBs	93%	92%	93%	94%	94%	94%	95%	94%	94%	95%	94%	93%

More information about our results and performance is on page 55.

Improved access to elective surgery

Target: The volume of elective surgery will be increased by at least 4000 discharges per year (nationally)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	106%	119%	108%	115%	120%	106%	114%	120%	110%	116%	119%	114%
All DHBs	105%	104%	105%	107%	105%	103%	107%	106%	104%	107%	108%	106%

More information about our results and performance is on page 109.

Faster cancer treatment

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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	N/A	57%	81%	68%	68%	86%	65%	77%	86%	56%	73%	86%
All DHBs	N/A	69%	78%	66%	75%	82%	67%	75%	82%	68%	74%	81%

More information about our results and performance is on page 104.

Increased immunisation

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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	90%	90%	92%	91%	92%	92%	91%	91%	90%	91%	89%	89%
All DHBs	92%	93%	93%	94%	94%	93%	93%	93%	92%	93%	93%	92%

More information about our results and performance is on page 67.

Better help for smokers to quit

Target: 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	N/A	84%	87%	N/A	88%	87%	N/A	88%	86%	N/A	89%	88%
All DHBs	N/A	83%	87%	N/A	85%	86%	N/A	86%	86%	N/A	88%	89%

More information about our results and performance against both parts of this target is on page 64.

Raising healthy kids

Target: 95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017	2014/2015	2015/2016	2016/2017
Waikato DHB	N/A	N/A	47%	N/A	N/A	79%	N/A	N/A	84%	N/A	N/A	81%
All DHBs	N/A	N/A	49%	N/A	N/A	72%	N/A	N/A	86%	N/A	N/A	91%

More information about our results and performance is on page 46.

Regional performance story

Waikato DHB is committed to being an active participant in our regional planning process. The following diagram is part of our wider performance story (see pages 14 and 15) and shows the regional strategic direction.

Midland vision	All New Zealanders live well, stay well, get well					
Regional strategic outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional strategic objectives	Improve Māori health outcomes	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

To deliver on the regional strategic direction Regional Service Plans and regional outcome monitoring activities were developed.

Regional Service Plan objectives

The Midland DHBs produced a Regional Service Plan (RSP) for the 2016-19 period. The strategic intent for the Midland region is described in our RSP and is presented as part of our performance story diagram.

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

HealthShare is tasked with co-ordinating the delivery of regional planning and implementation on behalf of the Midland DHB region.

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

Waikato DHB is committed to being an active participant in our regional planning process. This is evidenced by both clinical and management representatives from our DHB being part of the various forums and networks that have been established to guide RSP implementation activities as well as directly funding regional work and positions. The RSP is a plan of action around specific areas that clinicians have identified as priorities as well as national priorities. Clinical networks are the primary vehicle through which change will be driven and delivered. Clinicians noted the need for clinical networks to lead service improvement through the use of integrated patient pathways, common clinical policies, and shared clinical audit programmes. These networks help small services to develop sustainable services plans to ensure quality and safety, with vulnerable local services transferred in a planned way to regional locations or supported regionally.

Regional population profile

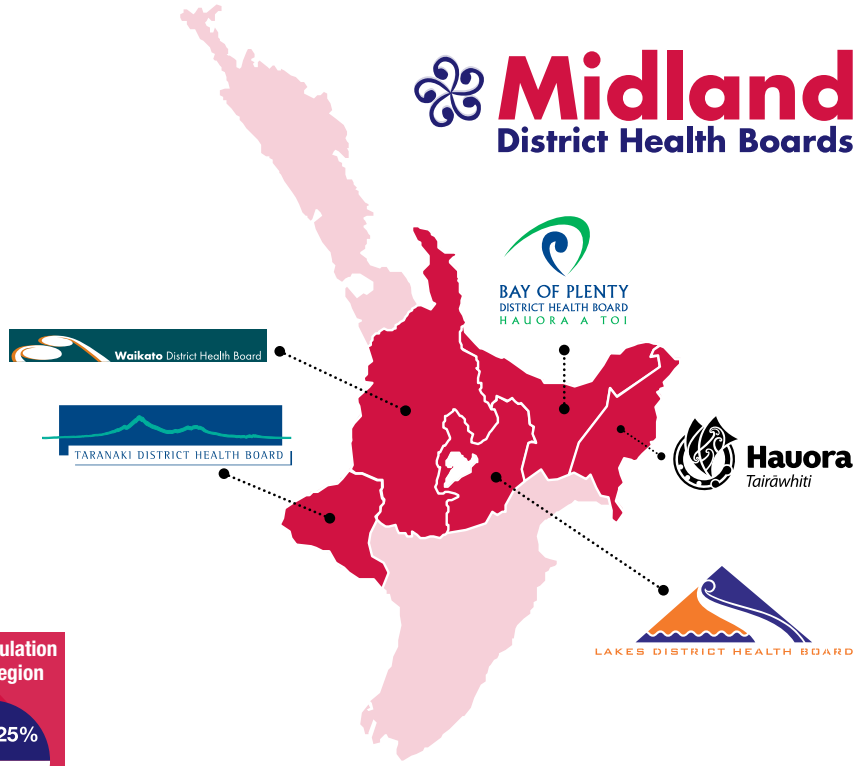
21% The Midland region covers an area of 56,728 km^2, or 21% of New Zealand's land mass.

Stretches from Cape Egmont in the West to East Cape and is located in the middle of the North Island.

5 DHBs: Five DHBs:
Bay of Plenty, Lakes, Tairawhiti, Taranaki, and Waikato.

Includes major population centres of New Plymouth, Hamilton, Rotorua, Tauranga and Gisborne.

898,310 people (2016/17 population projections), including 232,060 Māori (26%) and 43 local iwi groups.



Midland region Iwi

Māori population of DHB region

Bay of Plenty DHB: Ngai Te Rangi, Ngāti Ranginui, Te Whānau ā Te Ēhutu, Ngāti Rangitihi, Te Whānau ā Apanui, Ngāti Awa, Tūhoe, Ngāti Mākino, Ngāti Whakaue ki Maketū, Ngāti Manawa, Ngāti Whare, Waitahā, Tapuika, Whakatōhea, Ngāti Pūkenga, Ngai Tai, Ngāti Whakahemo, Tūwharetoa ki Kawerau — 25%

Hauora Tairāwhiti:
Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu, Ngā Ariki Kaiputahi, Te Aitanga-a-Hauiti — 50%

Lakes DHB:
Te Arawa, Ngāti Tuwharetoa, Ngati Kahungunu ki Wairarapa — 35%

Taranaki DHB:
Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngaruahinerangi, Ngāti Ruanui, Ngā Rauru — 19%

Waikato DHB:
Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Waikato, Tuwharetoa,Whanganui, Maata Waka — 23%

Local performance story

The following diagram is part of our wider performance story (see pages 14 and 15).

Our vision	Healthy people. Excellent Care					
Our strategic imperatives	Achieving health equity for high needs populations	Ensuring quality health services for all	Providing people centred services	Delivering effective and efficient care and services	Becoming a centre of excellence in teaching, training and research	Developing productive partnerships

Our vision

Healthy people. Excellent Care is our aspirational, long-term desired goal that states we will support people to stay fit and healthy in their community. However, if people do need health and care services, we treat them quickly, expertly and in a caring and fair way.

Waikato sunset, Maungakawa.

Our new strategic imperatives and priorities

The strategic imperatives are our long-term goals. Under each strategic imperative are four priorities, which connect strategy with day-to-day activity. For each priority a programme plan is being developed. These plans will detail the transformative innovation needed to create the health system that works best for the Waikato. A member or members of the Waikato DHB executive group will lead each of the priority programme plans. The plans will identify specific activity and actions that will contribute to the achievement of the strategic imperatives and the vision. The plans will identify indicators of performance that will be measured and monitored to assess progress. The priority programme plans will not be individual stand-alone developments, as they will need to link with other priority programmes.

Due to the priority programme plans being in development, this Annual Report will report on the previous year's strategic priorities, as these are still key focus areas for the Waikato DHB. The 2017/2018 Annual Report will report on the new strategic imperatives and priorities.

Monitoring the strategy

We will monitor delivery of the strategy by assigning performance and progress measures to each priority programme plan. The progress for each priority will be a factor when reviewing the priorities every three years. When a priority has been achieved, it will move out of the strategy's priority section and into a maintenance schedule. This will make room for new priorities to be included in the strategy when required. Progress measures will be assigned to each of the strategic imperatives, which will be reported on in the Waikato DHB's Annual Report. Progress of the strategic imperatives will provide an indication for how we are working in line with our mission and towards obtaining our vision.

Health equity for high need populations ***Oranga***	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services
Safe, quality health services for all ***Haumaru***	• Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation • Prioritise fit-for-purpose care environments • Early intervention for services in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives
People centred services ***Manaaki***	• Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whānau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy
Effective and efficient care and services ***Ratonga a iwi***	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and efficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services
A centre of excellence in learning, training, research, and innovation ***Pae taumata***	• Build close and enduring relationships with local, national, and international education providers • Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research • Cultivate a culture of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our population
Productive partnerships ***Whanaketanga***	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services

Accountability for results

In the end, the success of this strategy will be measured by the results that will be achieved. Every strategic imperative and associated priority will be monitored and the objectives required under the contracts of the people charged with delivering those results. In this way, by being accountable for what we say we are going to do, we will give confidence to everyone that we mean what we say.

Key focus areas

While the Waikato DHB has a new strategy, the previous year's strategic priorities are still relevant and remain key focus areas. These focus areas and a short description are outlined in the following table.

Strategic priority	Description
Financials	Ensuring delivery on agreed financial forecasts and the ability to live within our means
Regional collaboration	Improving clinical services, quality, and viability across the Midland region and reducing duplication of effort and bureaucracy
Quality improvement	Constantly seeking opportunities to get better at how we function and improve effectiveness
Addressing chronic conditions	These conditions are the leading cause of ill health and premature death in New Zealand. They disproportionately affect low-income earners, Māori, and Pacific people
Organisational and workforce development	Building a sustainable health workforce to serve future generations
Integrated care	Health systems need to be rebalanced to respond better to the changing pattern of need generated by long-term conditions and the technological opportunities becoming available
Rural	A significant number of our people live in areas we consider as rural. We are planning for clinical sustainability in rural health services and exploring opportunities to get the workforce better joined up

Financials

Cost of Service Statement by Group	Parent	Parent	Parent
For the year ended 30 June 2017	**2017 Actual**	**2017 Budget**	**2016 Actual**
Revenue	**$000's**	**$000's**	**$000's**
Funder	1,274,020	1,279,305	1,220,234
Governance and Planning	5,294	5,289	5,357
Provider	851,832	838,897	793,510
Eliminations	(772,617)	(766,493)	(715,828)
	1,358,529	1,356,998	1,303,273
Expenditure			
Funder	1,236,335	1,236,417	1,172,902
Governance and Planning	5,686	5,606	4,936
Provider	888,191	876,969	837,817
Eliminations	(772,617)	(766,493)	(715,828)
	1,357,595	1,352,499	1,299,827
Share of associate surplus/(deficit)	(59)	-	28
Share of joint venture surplus/ (deficit)	56	-	(40)
Surplus/(deficit)	931	4,499	3,434

Regional collaboration

Regional collaboration has continued to be a focus over the 2016/17 year. Continual effort for regional collaboration is evident in the development and implementation of the 2016-19 Midland Regional Services Plan (RSP).

This collaborative work has resulted in a number of initiatives, such as:

Midland Faster Cancer Treatment Patient Information Project 2016-2018

This work supports the implementation of the national tumour standards. A 2014/15 stocktake of Midland DHB specific patient information for cancer patients identified that there was limited and inconsistent regional patient information resources.

The project is set down in two tranches over an 18-month period, which began in late 2016. The region is making good progress on reviewing and redeveloping leaflets.

Midland Bowel Screening Regional Centre

The Minister announced the national staged roll out of the bowel screening programme. Waikato DHB was agreed to be the lead DHB for the Bowel Screening Regional Centre (BSRC) in partnership with Midland Cancer Network. Waikato DHB and BSRC are due to be established in 2018/19 with remaining Midland DHBs in 2019/20.

Midland Stroke Network

The Midland Stroke Network has been busy this last year. All of the roles in the network have been recruited to. A lead stroke physician and a lead stroke nurse from each of the five Midland DHBs are actively taking part in the work of the network. This work has included:

- reviewing the evidence based models of care for rehabilitation services for stroke patients. A suite of key national and international documents for DHBs was identified and it was recommended that DHBs use these to evaluate their rehabilitation services against.
- monitoring the progress of the Telestroke pilot which started in March this year. The pilot includes Waikato, Thames and Rotorua hospitals.
- providing data for HealthShare to create quarterly reports monitoring key indicators agreed by the network, as well as those determined by the Ministry of Health.

Quality improvement

Waikato DHB is committed to improving the quality of services provided to our patients, family /whanau and carers. Quality and Patient Safety continue to engage and work closely with providers and consumers and to 'Listen, Learn and Improve' in order to provide the services that best meet their needs. Quality improvement programmes often continue from year to year, as they are areas of ongoing need and challenge. Some of the work is driven by national requirement and some are local priorities and all are reported on in the annual Quality Account. The National Health targets and the Quality and Safety markers continue to influence improvement work in 2016/2017 and these are reported on quarterly with the ability to benchmark against other DHBs. The national medication safety programme continues and a new 5-year programme started in mid-2016 focussing on the early detection of the deteriorating patient. The key parts of this programme include the launch of a national early warning score chart and a programme to improve recognition and management of sepsis. We are working increasingly with our community partners to provide continuity of care, to keep patients safe in their homes and to improve health outcomes.

Our focus for 2016/2017 continues to build on previous work with three focus areas under which there are five streams of work, which include:

Patient safety

- Continue to keep patients safe in our care
- Improve end of life care for patients and their family/whānau

Patient outcomes

- Reduce the number of people dying from preventable conditions

Patient experience

- Listening to our patients and community – ensuring a safe and welcome environment in DHB services
- Continue to improve care around deteriorating patients

Our progress against the key priority areas is reported against quarterly to the Board through the quality report and annually within the quality account. This account will form part of the Annual Report process as an adjunct report. A standard quality performance dashboard is provided monthly for Board meeting, to assure Board members that the services provided across the DHB are safe and effective.

Addressing chronic conditions

Public Health – Five key public health areas

The priority public health issue areas identified as a service are based on national, regional and local direction and data. The five key public health issues areas in which the Public Health unit have prioritised include:

- Alcohol
- Physical activity / Nutrition
- Tobacco
- First 1000 days
- Mental Health

Internal strategy groups have been established for three of the five public health priorities alcohol, physical activity/nutrition and tobacco. These strategic groups provide public health leadership and co-ordination to develop, implement and monitor the key public health service priorities and response across the core functions. These strategic groups evolve in response to changing needs, priorities, evidence and organisational structure.

The Public Health unit recognises the importance of the first 1000 days (from conception to two years of age) laying the foundations for health and wellbeing; and equally the importance of mental wellbeing for a flourishing population and acknowledges there is no health without mental health. For the 2017/2018 contract year two additional priorities, first 1000 days and mental health will be explored by the Public Health unit to determine and develop a public health response, which aligns to best practice.

Rheumatic Fever

Waikato DHB joined forces with telecommunications firm Spark to trial a new way of helping young people with rheumatic fever to receive their vital medication called 'Top up 4 yr top ups'.

The trial, done in partnership with the University of Waikato, Waikato Medical Research Foundation and Waikato DHB's SmartHealth online healthcare service, aims to encourage young people to continue with their treatment by providing mobile phones and ongoing monthly top ups each time they return for their often painful monthly penicillin injections.

Ongoing treatment is essential for those with rheumatic fever to stop them developing rheumatic heart disease. Young people need the antibiotic injections to keep strep throat away and stop their heart valves becoming more damaged.

Young people usually need the injections every month for about 10 years and sometimes feel that when they start getting better they no longer need their medication, but it's really important that they finish their course of antibiotics.

Project Energize

Project Energize is a programme delivered to primary and intermediate schools in the Waikato and has been running since 2005. Funding for the programme comes from the Waikato DHB in partnership with Sport Waikato and is delivered by Sport Waikato. The aims of the programme are to teach healthy eating and physical activity to children between 5 and 12 years old. Relationships are well established with the DHB, Alliance PHOs as well as the Auckland University of Technology and Waikato University. Results for Project Energize continue to be outstanding through the 2016/2017 years.

Organisational and workforce development

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

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

- Provide an Equal Employment Opportunities environment
- Provide an environment which is healthy and safe
- Appropriately accommodate employees with known disabilities
- Impartially select suitably qualified people
- Recognise aspirations, cultural differences of Māori and non-Māori
- Support teaching and learning
- Review and update policies and procedures that support good employer aims

- Proactively address claims of harassment and bullying
- Enable flexibility of work where ever feasible that progresses the organisations aims
- Review post entry and exiting data
- Proactively influence organisational culture

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

Leadership, accountability and culture

Royal Australasian College of Medical Administrators (RACMA)

RACMA is a specialty medical college preparing medical practitioners and those with another specialty to understand health systems. Its aim is to improve leadership and management capability for medical professionals with a view to them administering within or managing a hospital or other health service.

The programme is structured to give insights into issues not covered by medical training, including medico legal, contracts, budget, resource management, and leadership.

Vocational trainees can access information through their Clinical Director of Training for the area.

Harassment and bullying prevention

Waikato DHB fosters a zero tolerance approach towards harassment and bullying. Its policy around harassment and bullying aligns with the Worksafe Best Practice Guidelines. A training programme with an emphasis on management behaviours is offered, managers are encouraged to attend.

Recruitment, selection and induction

Manager orientation

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

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

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

Registrar orientation

Registrars change-over twice a year – the second Monday in December and the second Monday in June; the December change-over is by far the largest change-over of RMOs for the DHB, with up to 40 percent of our registrars moving on, mainly due to training programmes. For all new arrivals, an email notices are sent out which provide links to the webpage which contains generic information including orientation manuals. A link to complete e-learning modules is also sent.

When the registrar orientation was introduced it was for a full day, but feedback over the last year has resulted in the programme being refined to a generic half-day, then a service-specific orientation and ward orientation.

PGY1 orientation

Most compliance modules such as quality and risk, fire training, venepuncture, adult deterioration detection system, and smoking cessation are available on line and can be accessed before they start, and many other topics are covered during the three-day orientation programme using an interactive case study to reinforce learning.

The benefits are that PGY1s begin orientation before they start, information is available when they want it, and learning is experiential which makes the session relevant and interesting.

Pre-employment health screening

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

Vaccinations for health care workers policy

Systems are utilised by Waikato DHB to ensure that staff, prospective new employees, other clinical personnel, including locums and health care students are assessed, screened and vaccinated against infectious diseases prior to commencing employment or clinical placement.

Children's worker checks

Children's worker safety checks are now completed prior to commencement for all new children's workers as required by the Vulnerable Children Act 2014. Initially, police vetting timeframes were causing concern around commencement dates for new employees; however, an effective urgent process is now in place with the police vetting service, which has minimised the need for deferral of start dates.

Safety checking of existing staff has also commenced in order to meet the requirement for all core children's workers to have been fully safety checked by 1 July 2018, and non-core children's workers by 1 July 2019. At 30 June 2017, approximately 50 percent of children's workers have been safety checked.

Employee development, promotion and exit

Resident Medical Officer (RMO) health careers event

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

The event brings DHB and primary health sector senior doctors and the junior medical staff and students in a fair like atmosphere, where they can have informal discussions. This year it was held in the concourse in the Meade Clinical Centre. It attracted 76 participants, last year there were 65 participants.

Hamilton Careers Expo

Waikato DHB had a stand at the Hamilton Careers Expo on 11-12 June. Partnering with NZ Institute of Rural Health, and using the national Health Careers material, this was a great opportunity to showcase the wide variety of career opportunities available in health and then connect attendees to the relevant tertiary training providers. The Careers Expo is open to the public, with free admission, and is well attended by many of the secondary schools in the region, as well as parents, whānau, and members of the public considering new career paths.

Smart Waikato: FutureForce

Waikato DHB provided a career advertising feature for Smart Waikato's FutureForce publication 2016/2017. The publication has a distribution of 15,000 (which includes attendees at the Hamilton Careers Expo, as well as senior secondary school students throughout the Waikato region). The publication is widely used as a classroom resource by careers teachers. Specific careers profiled this year were Theatre Nursing, Medical Radiation Technology, Dental Therapy.

Kia Ora Hauora

The regional programme coordination function for each DHB has been devolved along with the funding from February 2017. The devolution is so that local DHBs can connect with candidates from their districts to facilitate a smoother transition to work after completion of tertiary education. The funding for this programme is being reviewed by the ministry of health.

Waikato DHB has a 32 percent share of the total midlands Kia Ora Hauora candidates or 341. 27 percent of candidates live in rural towns.

The Kia ora Hauora programme data is currently being cleansed. Once this has been completed it will be possible to provide more specific information about where candidates are on the pipeline so that DHBs can provide more support into employment.

Gateway programme

Each year the DHB facilitates access to a number of clinical and non-clinical placements for Year 12 and 13 students in the Gateway programme. The gateway programme consists of a one-day placement per week for approximately 10 weeks for students to experience the work environment so that they can make a decision about their future career.

In 2017, we are providing placements in nursing, midwifery, attendant, and some trades occupations for approximately 40 students.

Dedicated education units

Dedicated Education Units continue to provide the student model for nursing student with continuation of specific units within Orthopaedics, OPRS, Internal Medicine, and two aged care facilities being Tamahere and Cascades. Development of the model for the student contexts of Midwifery and Mental Health continues jointly with our undergraduate education partners at Wintec and Te Whare Awanuiarangi. The principles of dedicated preceptorship and structured reflection to develop practice and clinical reasoning are also being applied to student placements in our other clinical environments.

Nursing and Midwifery have an intentional workforce plan that is based on Learning Needs Analysis to determine the workforce need of the next five

to ten years acknowledging our aging workforce and population need. This generates a pipeline of student activity and placement refinement (using the DEU model), progresses to graduate entry and postgraduate modelling. For both the Nursing and Midwifery workforces the percentage of graduate to make this effective is 5-6 percent, which has been achieved this year for both nursing and midwifery. Next year planning is in place to increase both.

Another aspect of our workforce plan is to align our Māori population to be represented within the Nursing and Midwifery Workforce. Our last graduate nurse programme intake achieved 23% which meets this population alignment goal.

Ongoing development with postgraduate education supports specific learning and specialty development identified by the service as part of the Learning Needs Analysis process.

This year we have secured four places on the Ministry of Health's pilot streamed programme for the Nurse Practitioner Development and have another five in progress within the usual route. The clinical placement of these roles is across the continuum and includes primary, rural, aged care and acute settings.

Exiting information

Waikato DHB's exit form allows us to capture exiting data from employees who have more than one reason for leaving (or transferring from one service to another). During the capture period a count of 133 registrars completed the exiting form. This may have been due to rotation.

The top five reasons for why people left over 2016/2017 are similar to the reasons stated for 2015/2016. The top five reasons people left the Waikato DHB for 2016/2017 are:

Top reasons	Number
Relocation	205
End Employment Agreement	197
More Time With Family	122
Better Career Prospects	116
Retirement	94

Total number of staff who left the DHB for 2016/2017 was approximately 960.

Remuneration, recognition and conditions

Staff Service Recognition Programme 2017

The Staff Service Recognition Programme is designed to formally recognise the loyal service contributions of our staff members who have reached continuous service milestones. In this programme, service is recognised at five yearly intervals commencing with 10 years of service. For 2017, there is a total of 594 staff celebrating 10 years or more continuous service. This number includes 70 staff working in rural locations.

Due to the unavailability of the Bryant Education Centre auditorium, the celebrations are being held in the meeting room in the Waiora building at Waikato Hospital. The size of the venue has necessitated the event being held over four days. For the two Waikato presentations in 2017 there are 166 staff that have been invited to celebrate 20 years continuous service and over. We have one staff member celebrating 50 years' service with the Waikato DHB in 2017 who has been invited to participate in the programme.

The chief executive, members of the Waikato District Health Board, members of the executive groups, supporting managers and colleagues attend the presentations. Family and friends are also welcome. Special thanks go to the Board and chief executive who attend and support this worthwhile programme.

Salary and conditions

The Waikato DHB applies remuneration and rewards fairly and equitably within the boundaries of the Collective Agreements for the vast majority of employees. These agreements are typically multi-employer across all or some of the other district health boards. The DHB has regular meeting with unions at which views are exchanged and information shared. The DHB supports the bipartite action group.

Safe and healthy environment

FThe DHB continues to support its employees to participate in DHB health and safety systems. There are currently 27 employees from across the DHB who have completed the organisation's own comprehensive Health and Safety Representative training and approximately 38 more enrolled for the latter part of the year. Health and Safety education has been reviewed and models of delivery expanded to include on line were appropriate.

Safety culture

A Safety Culture Working Group work plan to address the findings from the 2015 staff survey, has achieved a number of outcomes:

- New values developed by staff were adopted as part of Waikato DHBs strategy, and are now being embedded and used by staff and managers
- A new staff safety programme of work is being implemented DHB wide
- The Workplace Support Person (WSP) programme is a new intervention (along with other measures) to manage uncivil behaviour; the perception of bullying.
- The WorkWell programme, which supports the wellbeing of staff, has a division prepared for accreditation after the first twelve months of work.

ACC Partnership

The annual ACC workplace safety management audit will be undertaken in September 2017. The audit covers policy and practices across the organisation.

Director responsibilities for Health and Safety

The Health and Safety at Work Act came into force on 4 April 2016. It has brought new responsibilities for everyone in the workplace. Greg Peploe, director people and performance presented to the Board a review of Health and Safety systems which provided key updates, responsibilities and recommendations including:

1. Board members who may not have done so undertake the Institute of Directors on-line Health and Safety governance training and that this training is provided to any future new members.
2. Endorse the Draft Policy subject to going it for wider consultation as per usual process.
3. When setting the chief executive's key performance measures ensure that that the Board set Health and Safety objectives.
4. That Work Safe Management Audit be presented to Audit and Risk when undertaken.

Integrated care

Regional pathways of care

The finalised regional pathways of care are published on the Map of Medicine tool that is accessible across the region by all parties involved in patient care. The pathways:

- develop a collaborative clinical best practice approach across primary and secondary care
- improve equity, quality of care and increase consistency across the region
- enable the exploration of service reconfiguration, integrated care services and direct access to diagnostics
- improved patient care pathway for a better patient experience

Integrated regional hepatitis C service

The new regional hepatitis C community based service is now available. The purpose of the service is to provide:

- Clinically led services delivered within the regionally agreed clinical pathway of care, eg Map of Medicine and Bay Navigator
- Quality liver elastography scans (Fibroscan) delivered by skilled experienced staff
- Fibroscan and patient education in the community and closer to the patient's home
- Geographical coverage across the five Midland DHBs
- Clinical oversight within the service
- Reduction in health disparity

Rural

One of Waikato DHB's priorities is planning for clinical sustainability in rural health services and exploring opportunities to get the rural health workforce better joined up.

The 21,220 square kilometre district covered by Waikato DHB includes extensive rural areas, rural communities and small towns. In fact, 60 percent of Waikato's population lives outside the main city of Hamilton.

For many years, Waikato DHB has worked with local communities and other health organisations to find models of rural health care that are sustainable and provide rural communities with access to health services.

As the funder of services, and as a provider of hospital and health services in all communities across the district, Waikato DHB has a key role to play in making rural health services sustainable and integrated.

Different communities are taking different approaches, but the common goal is modern, integrated health service delivery for rural people. Examples of approaches to rural health integration include:

- There is a strong focus on connecting up secondary (hospital based) and primary (community based) services, wherever they are, so that; patients have a more continuous path through the health care system; there is less duplication of health sector resources; there is a focus on prevention and early intervention, rather than waiting until a health condition is in a serious stage
- The DHB's continues to deliver the community health forums, which provide regular opportunities for communities to know about plans and to raise issues.
- Developments in technology are providing opportunities to link rural facilities and rural health professionals with their colleagues in secondary and tertiary hospitals.
- South Waikato Health Centre
  - Co-location of a number of primary health providers in two totally refurbished ward areas at Tokoroa Hospital, creating a foundation for further integration in future.
- Taumarunui integrated health care model
  - Primary and secondary health providers working together to develop agreed principles of collaboration and pathways of care in the north Ruapehu district.
- North King Country health workforce development
  - In the Northern King Country/Te Kuiti area, health providers from secondary, primary and voluntary organisations have been working together for many years to recruit and retain health professionals.

Some highlights for the year

New Medical School proposed

Waikato DHB and the University of Waikato launched a bid for a third medical school in New Zealand. The new Waikato Medical School will be a community-engaged, graduate entry medical school based in the Waikato and at regional clinical education sites in 12-15 locations throughout the central North Island. The medical school was proposed in response to health workforce shortages, and in particular shortages of primary care doctors and specialists in provincial and rural areas. It will focus on selecting graduate students who are committed to meeting the health care needs of New Zealanders living outside the main centres, and in particular high-needs communities.

REACH for success

An initiative helping unemployed people overcome their challenging health issues and return to work went from strength to strength this year. REACH (Realising Employment through Active Co-ordinated Healthcare), supports clients to manage their health condition or disability so they can find suitable work. This gives them confidence and independence and improves their wellbeing. The Waikato DHB staff, in partnership with the MSD case manager, work with their local GP and other agencies to help solve problems and use cognitive behavioural therapy to clear blocks that could be getting in the way of them being independent. They also help establish healthy behaviour and an activity plan that helps them prepare for a return to work if possible. This year REACH has engaged with 61 clients, with eight of those getting a job and back into employment and three being helped into a training course to help them get back to work. The programme is a great example of a cross agency approach – instead of working in isolation with clients, agencies like MSD, Corrections, the DHB and the patient's GP all work together to support them. This reduces the impact of long term unemployment on everyone.

Research projects win grants

Three research projects were recipients of major grants from the Health Research Council funding round. Ross Lawrenson, Waikato University professor of population health and Waikato DHB's clinical director of strategy and funding, leads the research to examine ways of improving early diagnosis of lung cancer among Māori and rural communities. A second project will focus on finding ways to avoid delays in diagnosis in colorectal cancer. Another project led by Waikato DHB public health physician Dr Nina Scott and involving a group of Waikato health

professionals, will examine the effectiveness of a health screening tool Harti Hauora Tamariki, designed to improve Māori children's wellbeing. The tool has been piloted at Waikato Hospital, and the study will be based at the hospital and conducted over three years. Dr Scott will be working with public health physician and associate professor Dr Polly Atatoa Carr and community psychologist Dr Bridgette Masters-Awatere

Health hub at Fieldays

The DHB showcased some of the innovative and lifesaving servcies we are providing to communities at the first Waikato Health Hub at Fieldays in June. Covering topics from cancer detection and treatment, rural mental health and wellbeing through to a simulaton manikin for people to practice CPR on and our SmartHealth online doctor service – the HealthHub was visited by tens of thousands of people over four days. Being able to talk to some of the thousands of people who came to Fieldays about healthcare services available to them, in a really fun and interactive way, was invaluable.

SmartHealth out of hours service launched

SmartHealth, the DHB's online health service, started an out of hours doctor service for people who find it difficult to see a doctor on evenings and weekends. The SmartHealth doctor can provide self management advice, prescribe medication in certain situations and fax the prescription to their local pharmacy, advise whether they need to visit a hospital Emergency Department, urgent care clinic or refer them to their GP the next day. The Waikato DHB's SmartHealth service was launched last year as a way for patients to connect online with health professionals from their smartphone, tablet or home computer. SmartHealth also linked up with Healthline to expand the support it offers patients. When someone from the Waikato DHB catchment area calls the nurse-led Healthline service for health advice on an evening or weekend and the nurse deems it clinically appropriate, they will be offered the opportunity to talk to an online SmartHealth doctor.

Changes to south Waikato maternity services

The board reviewed maternity services in South Waikato, Ruapehu and King Country to ensure that women and their whanau in the region can have a healthy birth and as healthy a baby as possible. Changes include a primary maternity hub service model to help women navigate access to services like smoking cessation, lactation, parenting education and specialist services like diabetes; the closure of the Te Kuiti Birthing Unit; a move to a Lead Maternity Carer model for Te Kuiti and Tokoroa; an enhanced facility contract for the two birthing units in Tokoroa and Taumarunui.

New maternity day assessment service opens

The Maternity Day Assessment Unit opened at Waikato Hospital in April catering for high-risk women who require increased surveillance during their pregnancy. The new maternity service was another step on the journey to transform the Women's Health service at Waikato Hospital into one of the best in the country, and improve our maternity, obstetric and gynaecological services to women in the Waikato.

Launch of Youth Intact

A new Waikato wide youth drug and alcohol service Youth INtact was launched in March. Funded by the Waikato District Health Board and delivered by Odyssey to the wider Hamilton region, the service has delivered a new look and approach for how youth with alcohol and drug problems and their whānau/families receive the help they need. Youth INtact has been developed with lots of feedback from clinicians, communities, rangatahi/young people and family/whānau.They wanted quick and easy access to youth friendly and youth specific services that are professional, holistic and culturally responsive. They also wanted the ability for early intervention and assertive follow up when there is a problem

Lucy Sim joins the team

Lucy Sim joined the Waikato DHB's midwifery education team – the $145,000 very realistic wireless childbirth simulator helps train midwives and others involved in childbirth on all the stages of delivery and on rare emergency scenarios. One of Lucy's main tasks has been participating in training days that ensure midwives, nurses and other health professionals know what to do and how to work together if a maternity emergency arises. In the past they had to rely on willing participants to role play, and obviously there were severe limitations on what they could show or do. With the Lucina Childbirth Simulator, it allows a much more realistic scenario and a lot more realistic detail for staff to practice with. The morning clinic is designed for women who are not requiring admission, but need more care and monitoring than a lead maternity carer or GP can provide in the primary setting. The unit provides a better experience for women we care for and allows midwives to work at the top of their scope, providing them the opportunity for leadership in their area of expertise.

Part 2 Statement of performance

Te Puna Oranga staff and Iwi Māori Council member supporting SmartHealth for our patients

Our service performance

In order to assess information on how well we have delivered our outputs, and if we have made the impact we intended to, we have identified a set of performance measures against which we could evaluate our performance for the 2016/2017 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 2015/2016 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 2016/2017.

The information presented in this section demonstrates that we have a responsibility across the whole of the continuum of health and disability, from keeping people well, to services for people with an advanced progressive disease which is no longer responsive to curative treatment.

The following table shows our long-term and intermediate goals. The measures reported on in this section of the report will all align to an intermediate impact and a long-term impact.

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

✓ **Achieved**

✗ **Not achieved**

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

Our service performance – funding

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

The budget figures are based on the Ministry of Health data dictionary definitions that were used to calculate the budget as presented in the Waikato DHB Annual Plan for 2016/2017. Output class allocations are based on specific costing system rules to separate and assign costs resulting in total revenue and total expenses that will be different to the statement of comprehensive revenue and expense.

Output class reporting is a different way of slicing information. We do not have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2016/2017 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code. The outer years are based on the same cost and revenue ratios being applied to total cost and revenue.

Cost of service statement by output class for the year ended 30 June 2017

	Parent	Parent	Parent
Revenue	**2017 Actual**	**2017 Budget**	**2016 Actual**
	$000's	$000's	$000's
Intensive assessment and treatment services	929,452	886,974	890,575
Early detection and management	265,255	297,222	258,374
Prevention	31,047	28,148	29,198
Rehabilitation and support	132,775	144,654	125,126
	1,358,529	1,356,998	1,303,273
Expenditure			
Intensive assessment and treatment services	947,063	920,299	905,518
Early detection and management	258,179	266,437	251,524
Prevention	23,034	25,765	21,976
Rehabilitation and support	129,319	139,998	120,809
	1,357,595	1,352,499	1,299,827
Share of associate surplus/(deficit)	(59)	-	28
Share of joint venture surplus/(deficit)	56	-	(40)
Surplus/(deficit)	931	4,499	3,434

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.

Critical Care team demonstrate patient care.

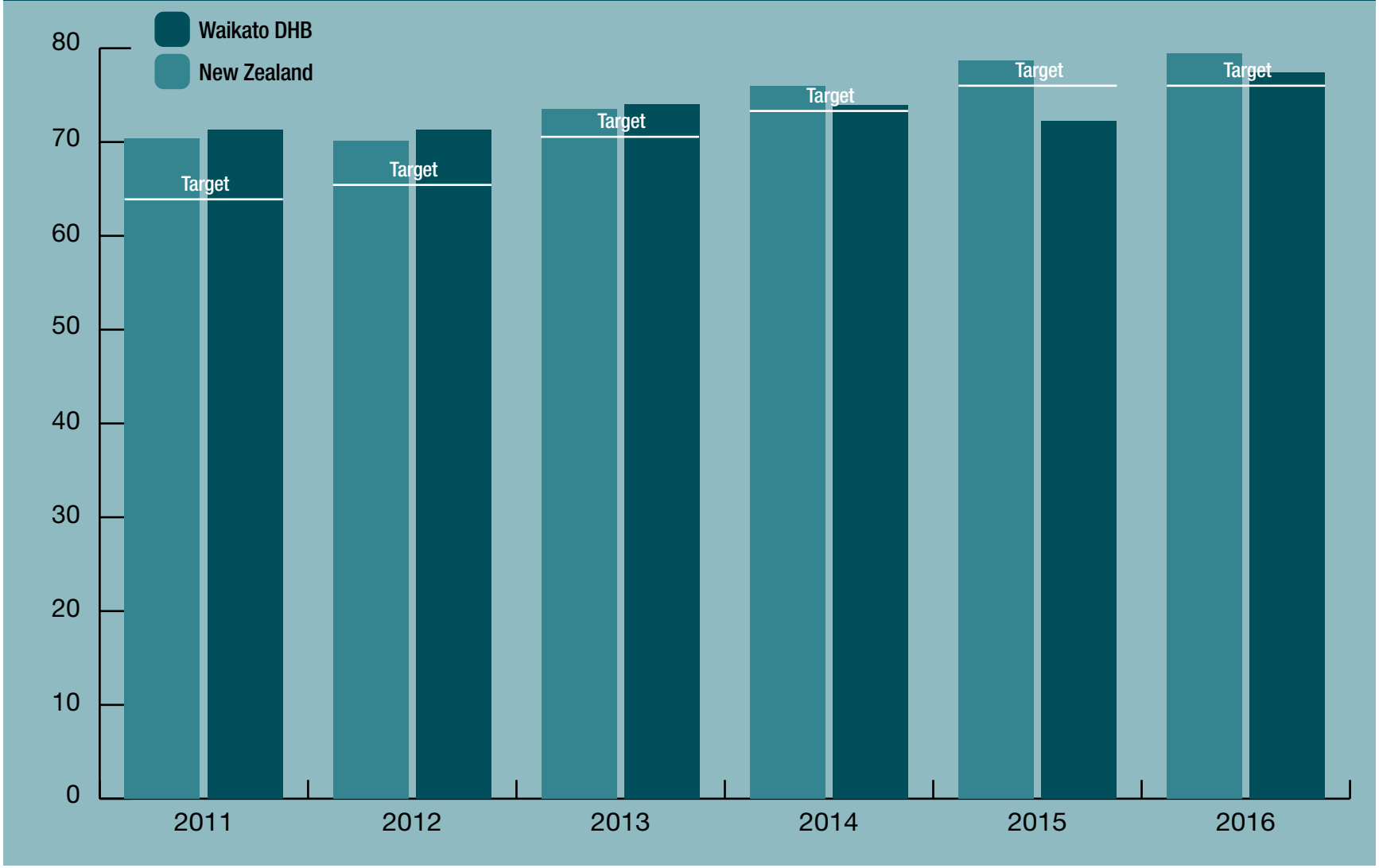
Long-term impact	**People are supported to take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Impact measures	• Percentage of Year 10 students who have never smoked	• Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	• 95 percent of obese children identified in the B4 School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)

Impact measure

People are supported to take greater responsibility for their health

Fewer people smoke

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



People are supported to take greater responsibility for their health

Fewer people smoke

Impact measure

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of year 10 students who have never smoked	74%	77.2%	>75.7%	✓ 77.4%

Significance of measure

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

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

Waikato DHB performance

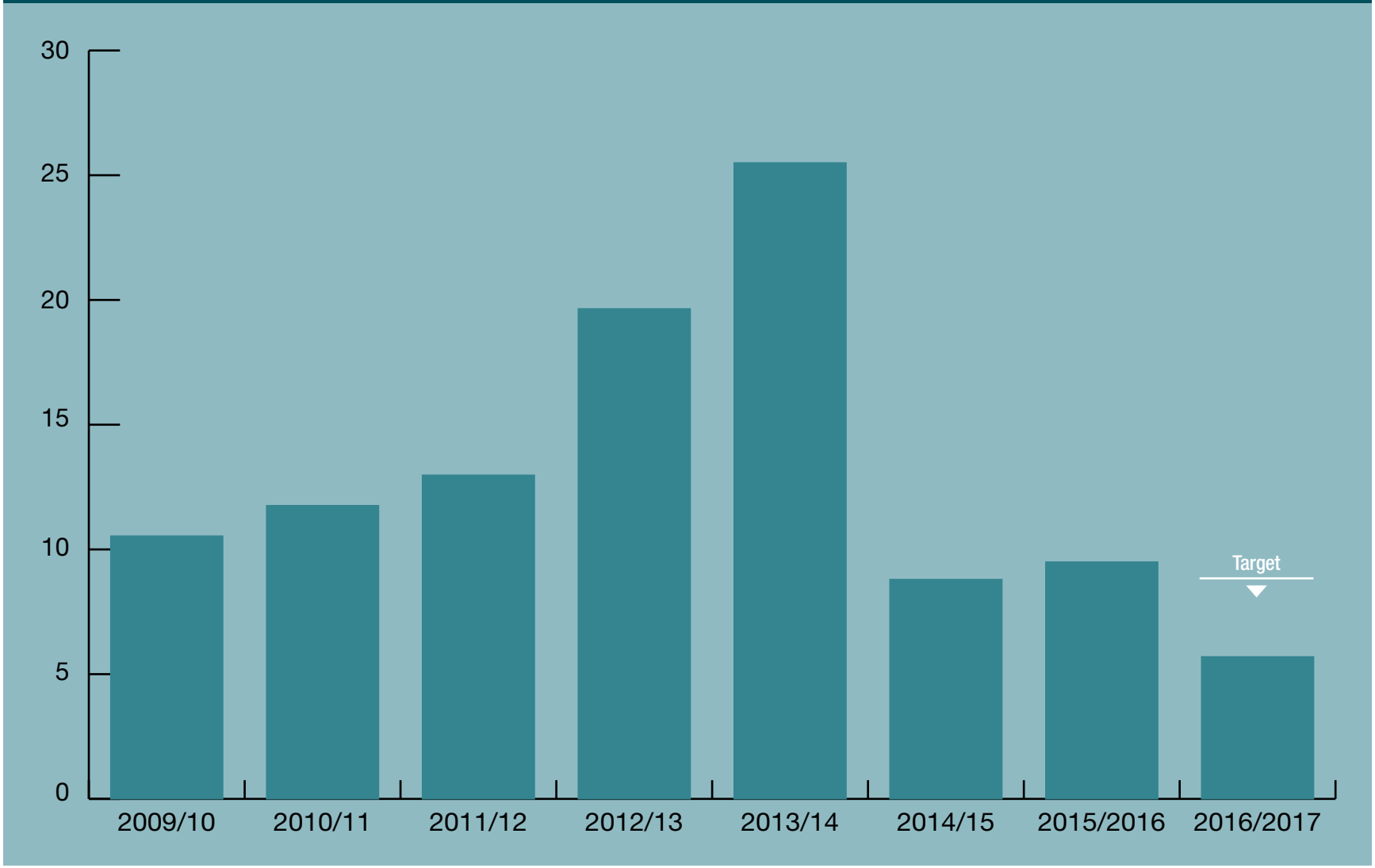
The result is for the 2016 calendar year to line up with the school calendar. The result for 2016 continues the improving trend against this performance measure. While the result is an improvement from the previous year, we still sit below the national percentage of 79.4 percent. Overall, we see that although the gap is closing female students still have a higher daily and regular smoking rate than male students do; and Māori smoking remains disproportionately high. These factors will be taken into consideration in terms of targeting interventions to reduce the levels of smoking in our district.

Impact measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

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



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	8.8	9.49	<8.8	✓ 5.66

Significance of measure

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

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

Waikato DHB performance

The Waikato DHB achieved the target for the 2016/17 year. The result for this measure shows the three year average per 100,000, for the 2016/17 year there were only three events compared to eight events in the 2015/16 year.

Activities delivered for the year included:

- Updating the Waikato Immunisation Action plan with new tasks as agreed by the Immunisation Steering Group
- Leadership in primary and secondary care
- Early enrolment in Primary Health Care
- Service relocation of the National Immunisation Register team back to Waikato DHB with the team leader contacting all general practices to get new-borns enrolled and referring any non-enrolled babies to Outreach Immunisation Service at 7 weeks
- Integrating immunisation outreach services with Primary Health Organisations
- Establishing a "missing events service"

These tasks have been implemented through engagement with Primary Health Organisations and negotiating a full Full-Time Employment Agreement for the Waikato Child Health Coordination Service with Midlands Health Network alongside NCHIP

For the 2017/18 year the areas of focus will be:

- Increasing activity on trialling a new Outreach Immunisation Enrolment Form
- New agreements in place for free general practitioner extended consultations for unenrolled mothers with the expectation that this will create an opportunity promote childhood vaccinations and enrol their newborns
- Reporting from Primary Health Organisations front line services on why families/whānau are 'delaying vaccine events'
- Lead Maternity Carer education both at funded workshops and on Midwifery Collaborative teleconferences

Impact measure

People are supported to take greater responsibility for their health

Improving health behaviours

Measures	Baseline	Previous year 2015/16	Target 2016/17	Result 2016/17
95 percent of obese children identified in the B4 School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017	New measure	New measure	95%	81%

Significance of measure

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

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

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

This is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

The Waikato DHB is tracking well to meet the 95 percent target for December 2017.

Activities delivered for the year included:

- Referral process in general practice is through Map of Medicine pathways developed and promoted at Continuing Medical Education meetings
- Engaging with Midlands Health Network (which has the B4 School coordinator and data reporting contract to ensure all referrals to a health professional are recorded correctly

For the 2017/18 year the areas of focus will be:

- Referral pathway in place
- Working with our key partners Primary Health Organisations and public health nurses to have a steady increase performance
- Developing a Raising Healthy Kids proposal for sign off by the Ministry of Health and implementing that with our Active Families provider in Waikato. The proposal will include:
- Workforce development and training inclusive of the Map of Medicine pathway
- Increased access to the BeSmarter tool
- Qualitative research and evaluation on declines and implementation
- Expansion of Active Families arrangements

Long-term impact	**People stay well in their homes and communities**			
Intermediate impacts	An improvement in childhood oral health	Long-term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	More people maintain their functional independence

Impact measures	• Mean decayed missing and filled teeth score of Year 8 children	• Measure to be developed	• Ambulatory sensitive hospitalisation rate per 100,000 for the following age group:
			  • 45-64 year olds
				• Average age of entry to aged related residential care:
				  • Rest home
				  • Dementia
				  • Hospital

Madison is learning some top tips to keep her teeth healthy using a pink dental dye that identifies plaque to help guide her teeth brushing.

People stay well in their homes and communities

An improvement in childhood oral health

Impact measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Mean decayed missing and filled teeth score of Year 8 children	1.08%	0.96%	1.05%	✓ 0.92%

Significance of measure

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

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

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

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

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

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

Waikato DHB performance

This measure is for the 2016 school and calendar year. The 2016 target was an average of 1.05 decayed, missing and filled permanent teeth for 12-13 year olds. Waikato DHB achieved an average of 0.92 teeth affected by decay, achieving the target. In addition, 72 percent of this group had never experienced decay in their permanent teeth, which is the highest achievement recorded for the Waikato DHB.

There remains an ongoing service focus to prevent and minimise decay. This includes digital x-rays for diagnosis, and taking steps to reverse the early stages of decay with fissure sealants and/or regular applications of fluoride varnish. An inequality focus remains as tamariki and those in high deprivation areas have poorer oral health.

Early in 2017 Titanium, an electronic patient record integrated with other DHB patient information systems, was commissioned. Titanium provides the infrastructure to manage recalls based on risk and will greatly assist with achieving health improvements.

The areas of focus are:

- All patient records will be loaded into the Titanium system during 2017. The service will be paperless for patient records and paper-light in other processes.
- Regular six monthly fluoride varnish applications for at-risk children
- Fissure sealants applied to permanent molar teeth
- Use of digital x-ray for monitoring decay and avoiding intervention where it can be managed preventively
- Automated SMS messaging of appointments from Titanium
- Encourage parents to attend appointments with their children to better understand their child's oral health and home environment influencers.

Cyclist enjoys The Timber Trail, Pureora Forest.

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Impact measure

Measure	Baseline: year ended March 2016	Previous year 2015/16	Target 2016/17	Result 2016/17
Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: • 45-64 year olds	4,154 per 100,000 of population	4,115	3,936 per 100,000 of population	✗ 4,386

Significance of measure

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

The results are expressed as a standardised rate with the national level being 100,000 with results under that level being positive.

Waikato DHB performance

The Waikato DHB did not meet the target for the 2016/17 year. For this age group, the increase is driven by admissions for congestive heart failure, cellulitis and stroke. For Māori ethnicity in this age group, the increase is driven by admissions for stroke, congestive heart failure, gastroenteritis/ dehydration, diabetes and myocardial infarction.

For the 2017/18 year the areas of focus will be:

- Maintaining the Demand Management Advisory Group with representation from secondary and primary clinicians
- Increasing volume of primary options for acute care delivered by all Primary Health Organisations
- Engaging with both the primary and secondary care sectors to achieve a chronic obstructive pulmonary disease (COPD) programme in Primary Health Care with the aim of saving bed days

Impact measure

People stay well in their homes and communities

More people maintain their functional independence

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Average age of entry to age related residential care (years) – **Rest home**	85	84	>84	✗ 84
Average age of entry to age related residential care (years) – **Dementia**	83	82	>80	✓ 82
Average age of entry to age related residential care (years) – **Hospital**	86	85	>85	✗ 84

Significance of measure

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

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

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

Waikato DHB performance

The target for entry to secure dementia facilities has been achieved with results remaining consistent with the target.

Although close to the target, the rest home and continuing care targets were not achieved. It is possible that age-of-entry data is skewed by the increased use of age-related residential care facilities for the provision of end-of-life care in the younger old (65+) – where these people do not die within six weeks as expected, they are then transferred to the age-related residential care funding stream; and therefore are counted in respect of this target. We have seen an increase in demand for this level of care with the change to hospice/palliative care services changing their focus away from access to hospice-funded extended residential support.

The younger age groups of older people skew the overall data on age of entry into long-term residential support. The increased demand for residential support for people 65yrs + with limited life expectancy, but who are not 'actively dying', is a current service gap as the focus has been on developing community models of palliative care where the person stays in their own home. However this is not always possible.

We will continue to review the target to test this possibility. It is difficult to extract specific NHIs from overall data collection and will require specific work.

Long-term impact	**People receive timely and appropriate specialist care**		
Intermediate impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improved health status for people with severe mental illness and/or addictions

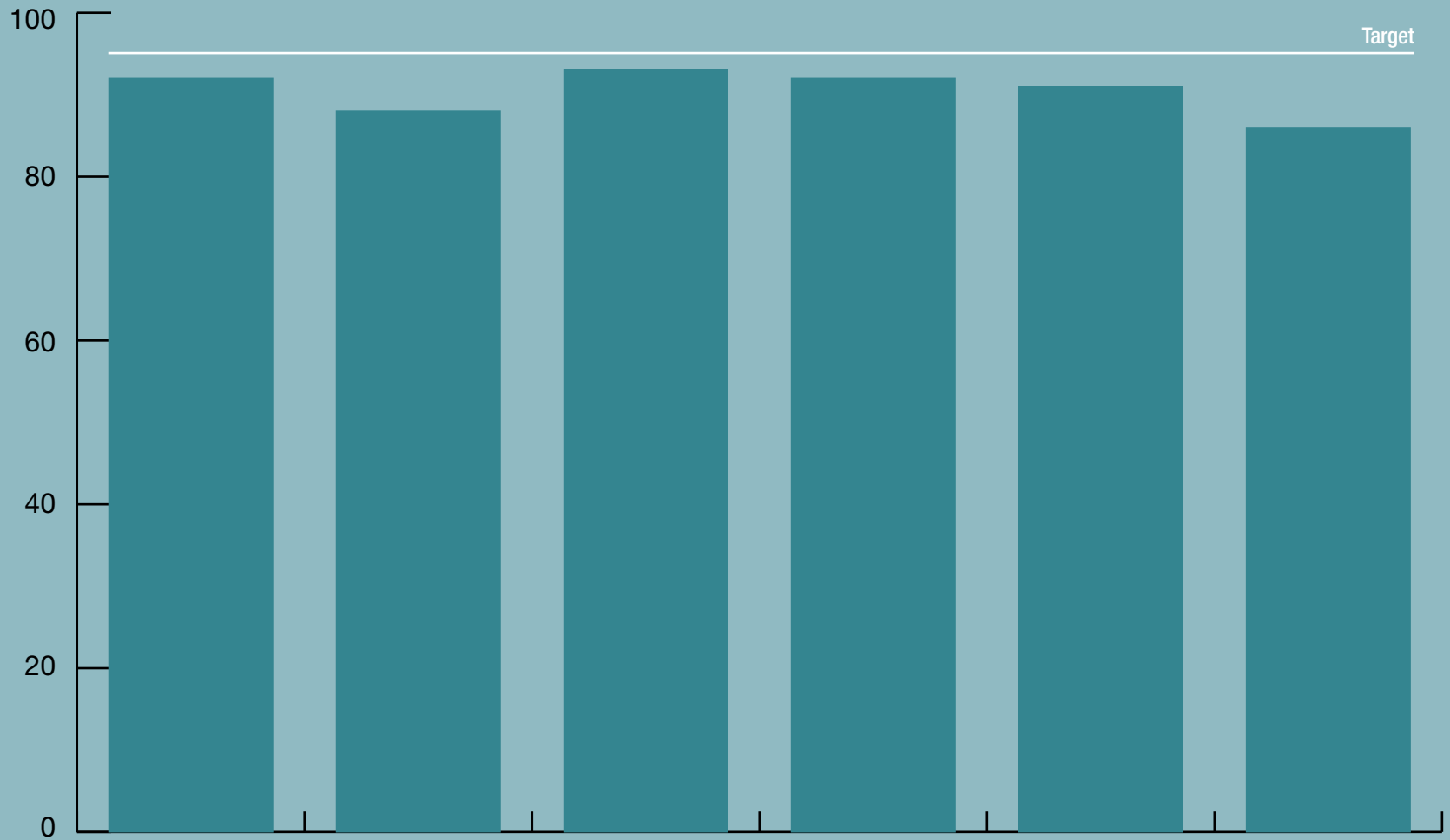
Impact measures	• Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	• Standardised intervention rates (per 10,000):
		  • Major joint replacement procedures
		  • Cataract procedures
		  • Cardiac surgery
		  • Percutaneous revascularization
		  • Coronary angiography services
			• 28 day acute readmission rates

Impact measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

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



People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Impact measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	94%	91%	95%	✗ 86%

Significance of measure

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

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

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

This is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

The Waikato DHB has not met the target for 2016/17.

There were a number of initiatives undertaken during 2016/17 they included:

- Recruitment to trauma and orthopaedic fellow positions, to increase the medical coverage out of hours was agreed in 2016/17 and orthopaedic fellow employed and commenced in 2016/17. Trauma fellow will commence once employed in Quarter 3 2017/18 and recruitment process is underway.
- Co-design work with ACC and mental health
- Approval of a budget increase of $4 million for additional staffing for the Emergency Department

The 2017/18 year will focus on:

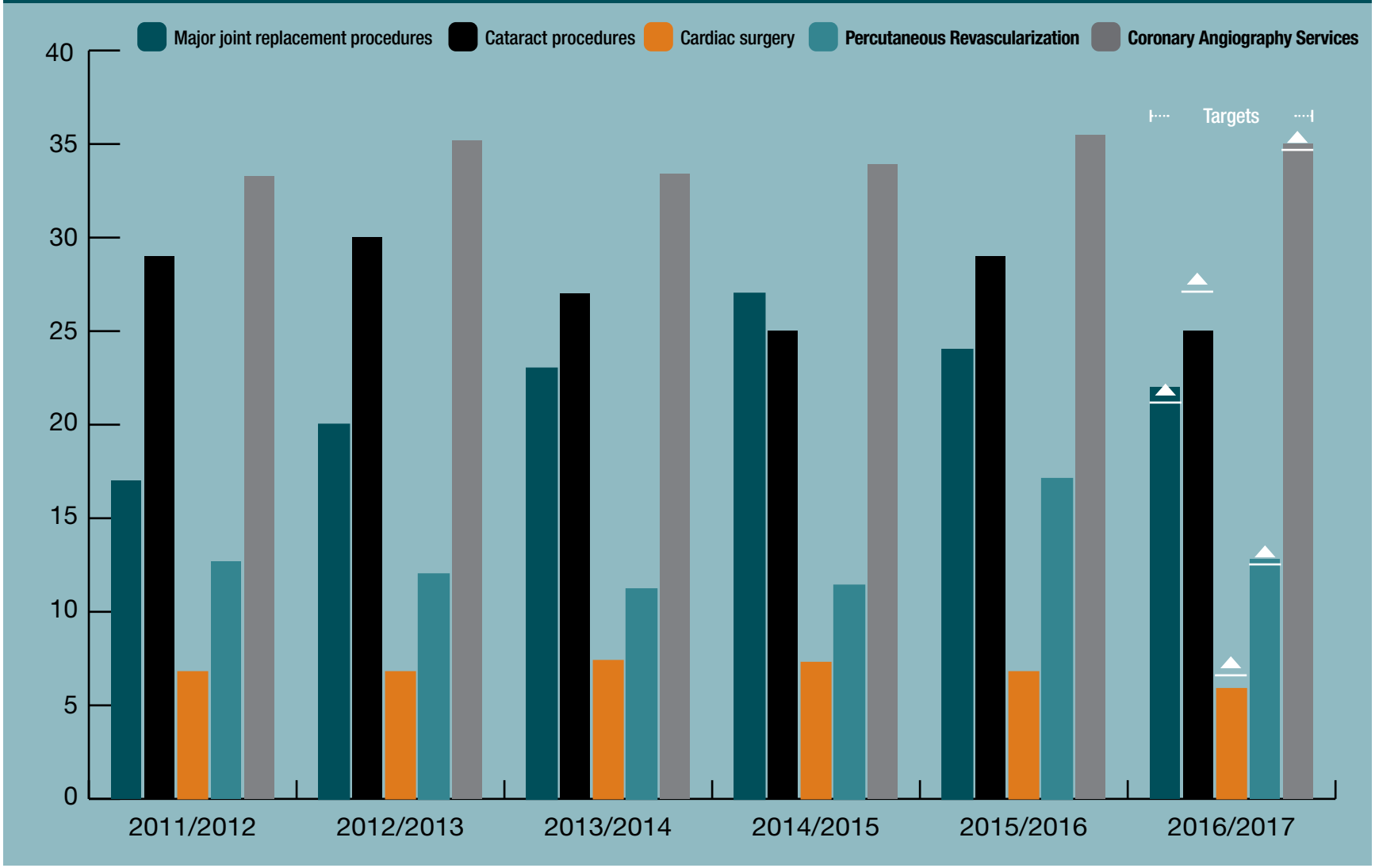
- Agreeing the streaming process from triage for all patient groups
- Review the updated referral from primary care to ED process
- Update escalation of overload guidelines
- Initiate the estate changes to increase the short stay facility (additional 5 spaces)
- Open an additional 27-bedded ward to assist with the current bed constraints. Business case approved with goal to open the Older Persons and Rehabilitation ward OPR5 in September 2017 and aligned with Waikato Hospital bed plan requirements.

Impact measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

Standardised intervention rates (per 10,000)



People receive timely and appropriate specialist care

People have appropriate access to elective services

Impact measure

Measures		Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Standardised intervention rates (per 10,000):	Major joint replacement procedures	27	24	>21	✓22
	Cataract procedures	25	29	>27	✗ 25
	Cardiac surgery	7.3	6.8	>6.5	✗ 5.9
	Percutaneous revascularization	11.4	17.1	>12.5	✓12.8
	Coronary angiography services	33.9	35.5	> 34.7	✓35.0

Significance of measure

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to elective services is a measure of the effectiveness of the health system. Meeting standard intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives. Knowing that access to services is equitable will improve the public's trust and confidence in the public health system. Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

Waikato DHB performance

The Waikato DHB has met the target for three out of the five service areas for 2016/17. There were a number of initiatives undertaken during 2016/17 they included:

- Pre hospital Preparedness (PHP) project advanced in 2016/17
- More patients being encouraged to phone to make an appointment at a time that suits them within the appointment times available
- The relative under delivery of cataract procedures for the reporting period is due a number of reasons. One reason is a change in the skill mix of registrars with a new intake. The second reason is issues with availability of anaesthetists. Productivity is reduced when no anaesthetist is allocated for surgery resulting in up to 200 less discharges per year. Cardiac surgery results were also impacted by being a surgeon down for the greater part of the year.

The 2017/18 year will focus on:

- Open an additional 27-bedded ward to assist with the current bed constraints. Business case approved with goal to open the older person rehabilitation (OPR) ward 5 in September 2017 and aligned with Waikato hospital bed plan requirements
- Engage a consultancy with expertise on production planning process to improve surgical patient journey including theatre scheduling and production plan end-to-end process improvement, project to commence in Quarter 1

Actions being undertaken to increase productivity to ensure the target rate is achieved, include resolution of the anaesthetists availability and outsourcing of more cataracts in the 2017/18 financial year. Productivity is expected to increase in the second half of 2017 and continue through.

Impact measure

People receive timely and appropriate specialist care

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

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
28 day acute readmission rates (mental health and addictions)	12%	11%	≤15%	✓ 12%

Significance of measure

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

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

Waikato DHB performance

Whilst Waikato DHB has met the target for 2016/2017 there has been a very slight increase in the rate of readmissions from 2015/2016 figures.

This is in some way reflective of the continued increase in occupancy and the number of service users who present with multiple co-morbidities and social, as well as mental health issues.

The 2017/18 year will focus on:

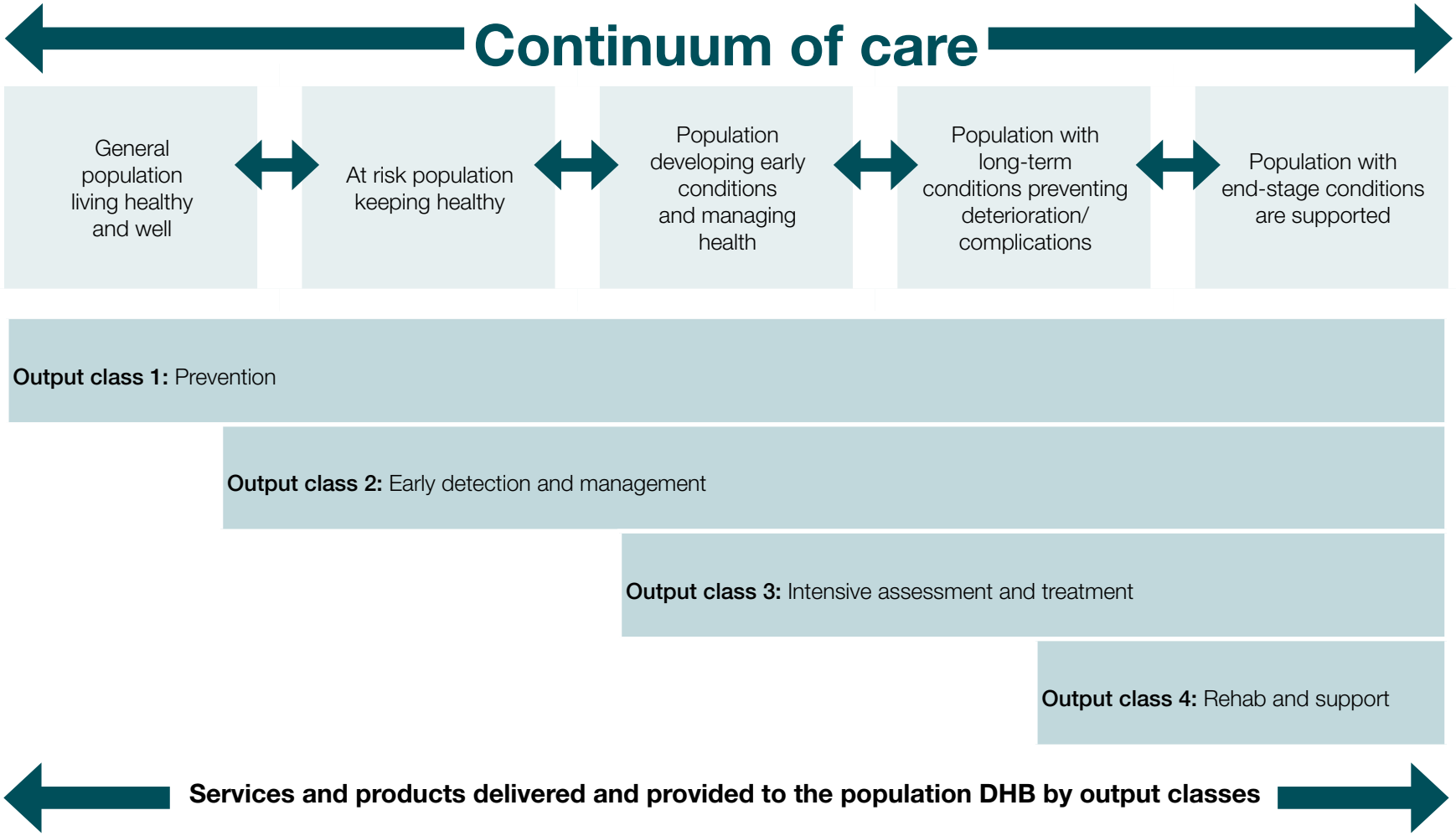
- flow through community services
- models of care
- single plan
- linking clients to primary care

Puna Poipoi staff and service users in their tie-dyed pink t-shirts to show their support for Pink Shirt Day NZ.

Output measure

Our outputs

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



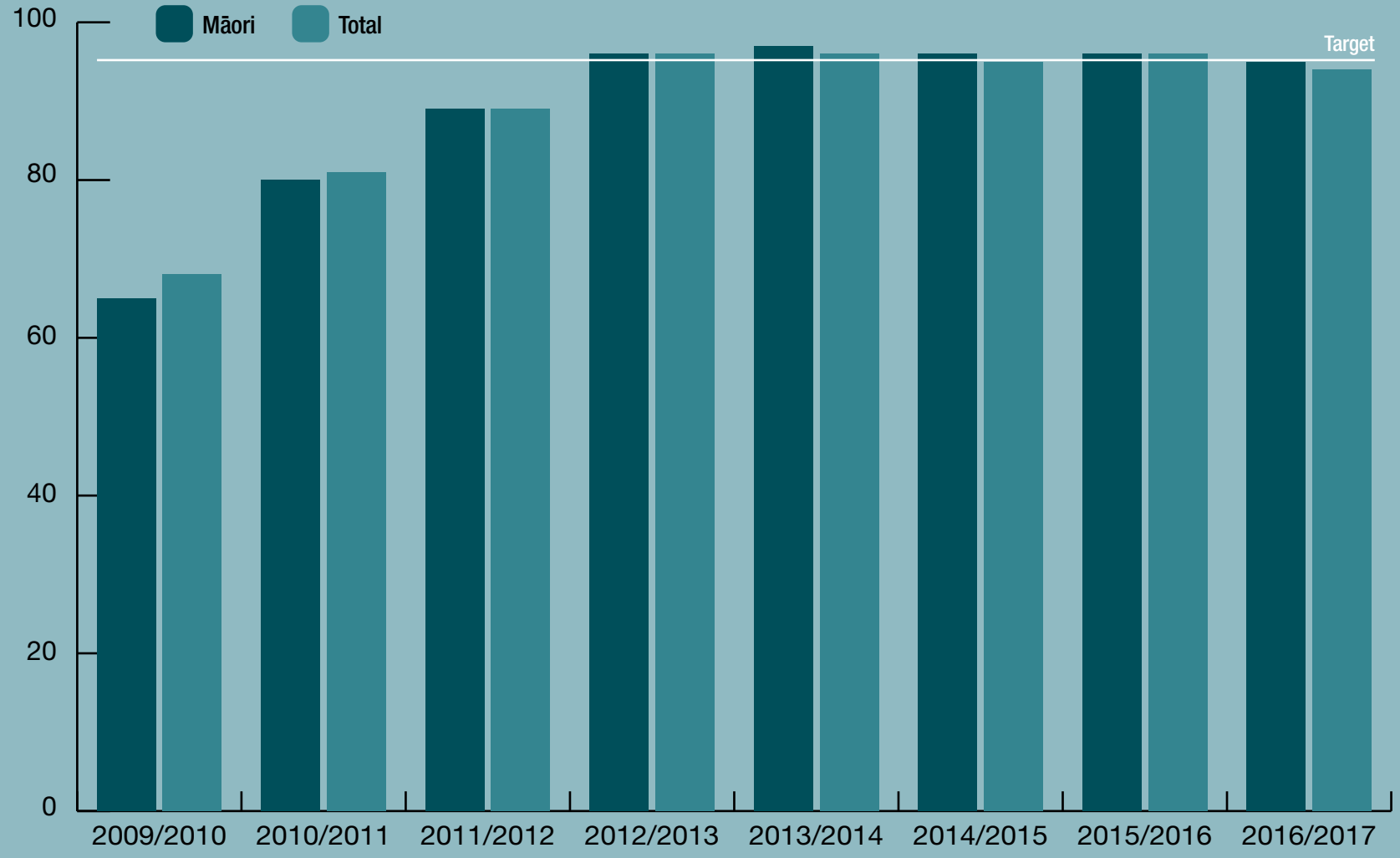
Long-term impact	**People are supported to take greater responsibility for their health**		
Intermediate impacts	Fewer people smoke	Reduction in vaccine preventable diseases	Improving health behaviours
Output Performance Measures	• Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking • Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	• Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time • Percentage of two year olds are fully immunised and coverage is maintained • Percentage of eligible children fully immunised at 5 years of age • Percentage of eligible 12 year old girls have received HPV dose three • Seasonal influenza immunisation rates in the eligible population (65 years and over)	• Exclusive or fully breastfed at Lead Maternity Carer discharge (4-6 weeks) • Exclusive or fully breastfed at 3 months • Receiving breast milk at 6 months • The number of people participating in Green Prescription programmes • Percentage of Kura Kaupapa Māori primary schools participating in Project Energize • Percentage of total primary schools participating in Project Energize

Output measure

People are supported to take greater responsibility for their health

Fewer people smoke

Percentage of hospitalised smokers offered advice to quit



People are supported to take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	Total 94% Māori 94%	Total 96% Māori 96%	Total 95% Māori 95%	✗ Total 94% ✓ Māori 95%

Significance of measure

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

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

Waikato DHB performance

The Waikato DHB achieved the target for the Māori population but not for the total population.

Activities delivered for the year included:

- Monthly monitoring of Health Target with results sent out to inform clinicians of areas where improvement needs to be made
- A new subjective Admission Assessment Form for clinical use was developed with smoke status and interventions prompts and documentation options improved
- new and novel ideas were encouraged to keep practice current and clinicians engaged. These included: monitors in maternity services, smokefree health messages on kiosks, stickers for nicotine products in medication charts, nicotine products available for non admitted family members and regular feedback from audits

For the 2017/18 year the areas of focus will be:

- Further development of the Smokefree Policy through the Rapid Action Plan will include;
- Identification of staff smoke status, where a staff member smokes and is not able to be smokefree while at work, a Smokefree Health Care Plan will be developed and will be discussed by the manager at Annual Performance Appraisal. A variety of options to ensure better support for staff to be smokefree at work will be developed.
- Patients and visitors will be requested not to smoke on DHB grounds and a variety of actions are planned to ensure staff are not exposed to second hand smoke while at work. These will include free nicotine replacement therapy for visitors and the offer of referral for support. All patients will be given nicotine inhalator on admission and long stay patients will be offered alternatives to going outside to the road
- Better signage and messages to remind people to respect our places and not smoke while on DHB grounds

Output measure

People are supported to take greater responsibility for their health

Fewer people smoke

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%	89%	90%	✗ 88%

Significance of measure

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

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

This is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

Primary health care organisations within Waikato DHB area achieved 88 percent in the work towards Better Help for Smokers to Quit target.

Activities carried out in primary care to achieve this target included:

- Clinical leadership is provided by primary health organisations and champions are established in each general practice. Primary health organisations also have access to national clinical leadership for advice when required.
- Systems and processes that include IT reminder, prompting and audit tools ensure all health professionals are supported in working towards achieving this target.
- Training for practice staff to carry out ABCs (ask, brief advice, offer cessation) is provided by champions who are also supported by primary health organisation champions.
- Primary health organisation representatives attend Waikato DHB's Smokefree Steering Group bi-monthly meetings to identify and share examples of best practice.

People are supported to take greater responsibility for their health

Fewer people smoke

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	95%	94%	90%	✓ 95%

Significance of measure

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

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

This is one of the National Health Targets.

Waikato DHB performance

The target has been achieved for the 2016/17 year.

To increase the number of pregnant women being offered advice and support to quit smoking by their midwife (independent and DHB-employed), as early in pregnancy as possible there has been a focus on:

- Introductions between local stop smoking services and primary birthing facilities in the community (where many lead maternity carers are based).
- Midlands Health Network stop smoking service has also increased their incentives for pregnant women to set a quit date and remain smokefree for 4 weeks.

For 2017-2018 Waikato DHB plans to increase the number of pregnant women being offered advice and support to quit smoking by their midwife (independent and DHB-employed) as early in pregnancy as possible by focusing on:

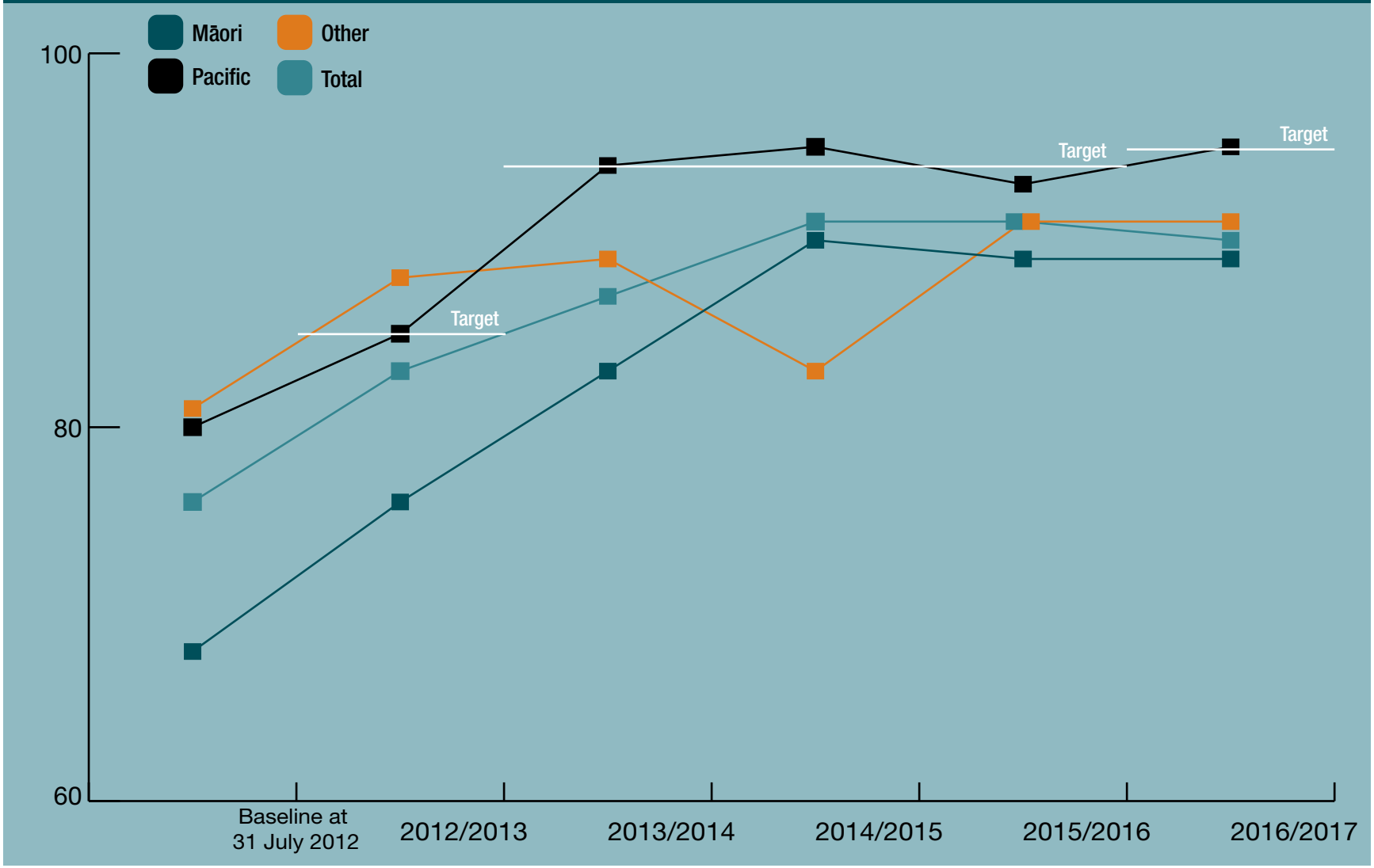
- Continuing to connect local stop smoking support service with the midwifery community.
- Communicating the incentive scheme for pregnant women to the midwifery community
- Communicating the incentive scheme for pregnant women to the general practitioners sector to encourage engagement with stop smoking services following pregnancy testing at general practices
- Midlands Health Network stop smoking service data sharing

Output measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Percentage of eight month olds fully immunised



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Māori 90% Pacific 95% Other 83% Total 91%	Māori 89% Pacific 93% Other 91% Total 91%	Māori 95% Pacific 95% Other 95% Total 95%	✗ Māori 89% ✓ Pacific 95% ✗ Other 91% ✗ Total 89%

Significance of measure

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

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

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

This is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

The Waikato DHB did not achieve the target for the 2016/17 year for Māori, other, and total population although the Pacific population target was achieved. Early enrolment of newborns to primary care is a high priority for Waikato Child Health Coordination Service and all Primary Health Organisations.

In development is a generic newborn enrolment form for use by Outreach Immunisation Service (OIS) providers.

New agreements are in place with Primary Health Organisations to offer a free extended consultation as part of the enrolment process for unenrolled mothers of newborns to ensure their babies are enrolled and immunised.

The NIR team has been relocated to Waikato Hospital campus.

As requested by the MoH we are working with Hauraki Primary Health Organisation to amalgamate subcontracted OIS providers to the Primary Health Organisations to reduce fragmentation and overheads and have one team focusing on hard to reach babies. Hauraki has appointed an administrator to support the OIS team.

Annual training for health professionals with best practice embedded has been continued with a focus on reducing delays due to non-related medical concerns where delay to a vaccination is NOT contraindicated. Meeting held with Plunket to discuss ongoing health education with all families and whānau is respect to improving immunisation coverage. NIR team leader contacts all general practices which decline newborns with view to get them enrolled or refer to another practice.

Output measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of two year olds are fully immunised and coverage is maintained	90%	91%	95%	✗ 92%

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.

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children. This equates to longer and healthier lives. The changes which are required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better coordinated.

Waikato DHB performance

Waikato DHB failed to reach the target of 95 percent.

The following results were recorded across 2016-2017:

- Quarter 1 92 percent of two year olds fully immunised
- Quarter 2 91 percent of two year olds fully immunised
- Quarter 3 93 percent of two year olds fully immunised
- Quarter 4 92 percent of two year olds fully immunised

We are steadily increasing our annual percentage result of two year olds who are fully immunised (with coverage maintained), although the increase is not as fast as we would like. We continue to focus on immunisation as a priority.

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of eligible children fully immunised at 5 years of age	73%	83%	95%	✗ 88%

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.

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children. This equates to longer and healthier lives. The changes which are required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better coordinated.

Waikato DHB performance

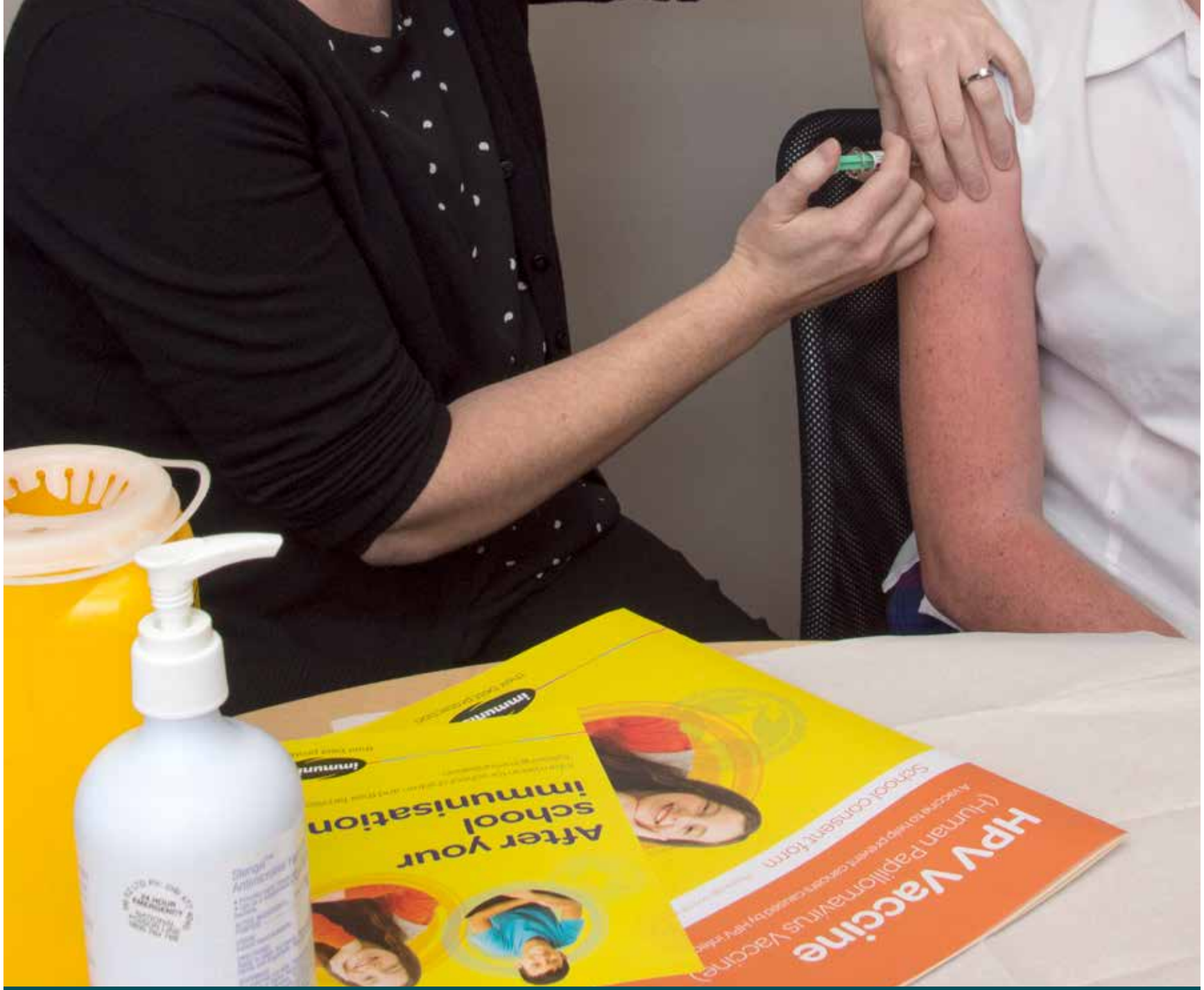
Immunisation Waikato DHB failed to reach the target of 95 percent.

The following results were recorded across 2016-2017:

- Quarter 1 86 percent of five year olds fully immunised
- Quarter 2 87 percent of five year olds fully immunised
- Quarter 3 89 percent of five year olds fully immunised
- Quarter 4 88 percent of five year olds fully immunised

Results for this measure are trending upwards from 83 percent last year to 88 percent this year. We expect this is due to the continued focus the Waikato DHB has committed to for ensuring children are immunised. Activities to increase performance will continue to be:

- Working with Midlands Health Network and other alliance partners
- The National Immunisation Register team provides every general practice with the lists of under immunised four year olds turning five in each quarter
- Aligning the B4 School dataset for immunisation activity to ensure the National Immunisation Register is not missing any immunisation events



Adminstering HPV immunisation.

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of eligible 12 year old girls have received HPV dose three ***for 2015/16 it is the 2002 birth cohort measured at 30 June in 2016**	68%	69%	70%	✗ 67%

Significance of measure

This immunisation is available to girls and young women in New Zealand to help protect them from cervical cancer. The immunisation is expected to provide long-lasting protection.

The vaccine causes the body's immune system to produce its own protection. It protects against infection from four types of the human papillomavirus:

- Two high-risk types that cause 7 out of 10 cervical cancers
- Two low-risk that cause 9 out of 10 cases of genital warts

The vaccine also helps to protect against a number of less common cancers that are caused by human papillomavirus infection.

Waikato DHB performance

Waikato DHB did not meet the 2016/17 target of 70 percent.

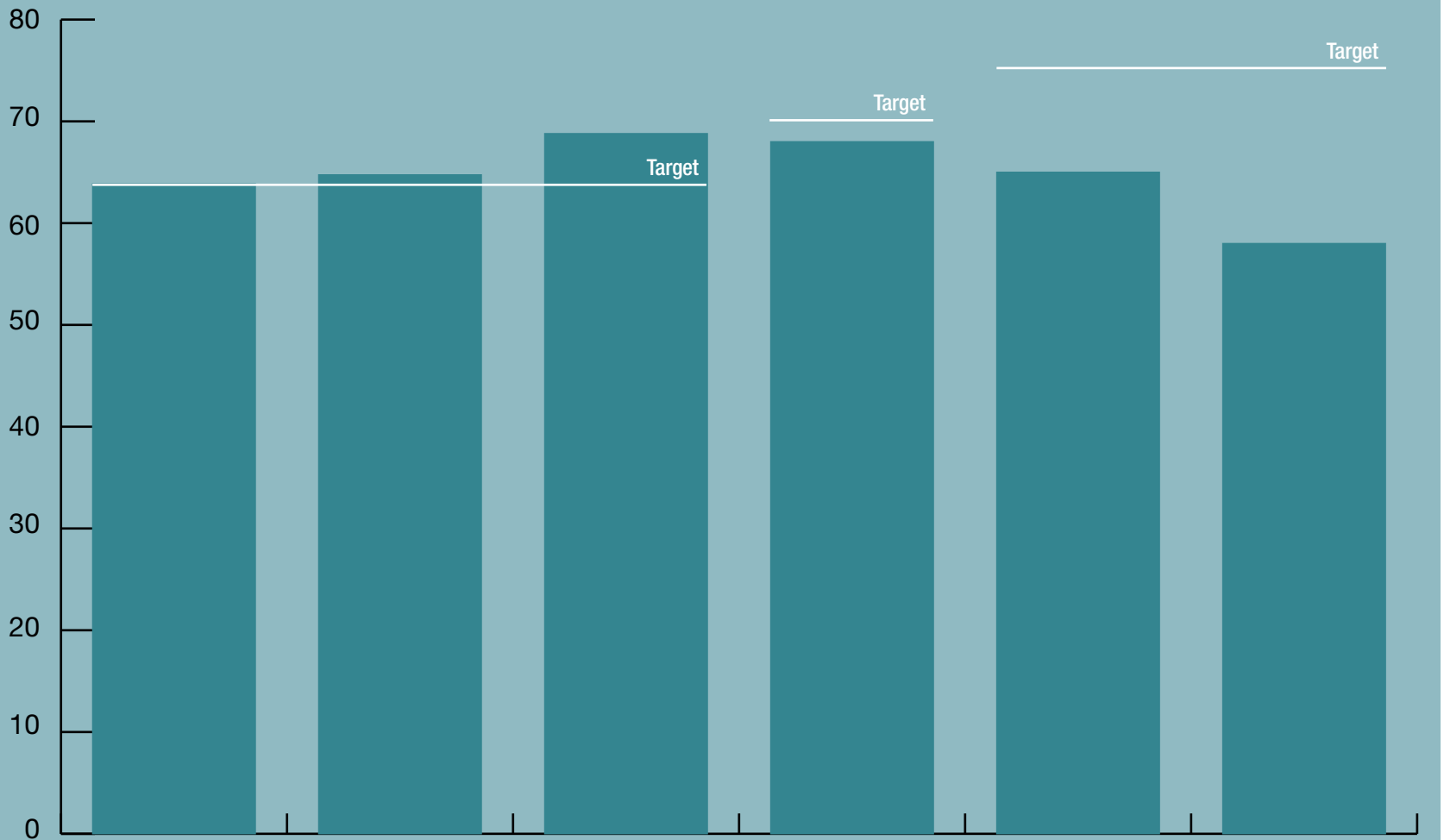
Girls who have declined school based immunisation but not the vaccine itself have been referred to general practitioners. Communications through an immunisation newsletter to primary care focussed on HPV vaccination and the important role practice nurses and general practitioners have in HPV vaccination this year.

Output measure

People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

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



People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Seasonal influenza immunisation rates in the eligible population (65 years and over)	68%	65%	75%	✗ 58%

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.

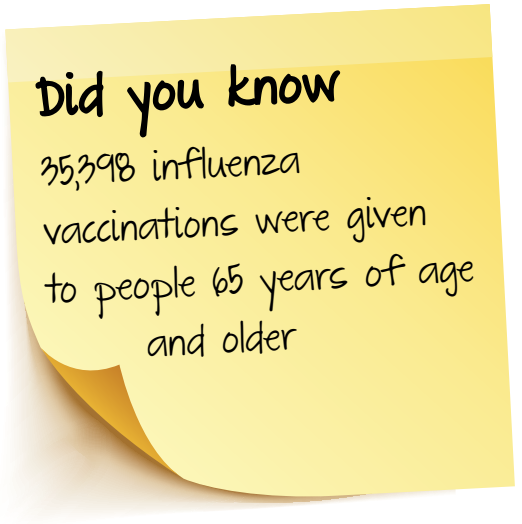
The eligible population for this measure is New Zealanders aged 65 years and over.

In relation to the measure, the period over which the vaccination programme runs is mid-March to July each year.

Waikato DHB performance

Seasonal influenza immunisation rates in the eligible population (65 and over) are lower in the baseline and against target despite spotlights on immunisation such as vaccination kaumātua and pharmacy services

We are concerned this is largely a data reporting issue as Primary Health Organisations now report through to the National Immunisation Register and not directly to the Ministry of Health as in previous years. We will investigate if the National Immunisation Register is recording all influenza events from Primary Health Organisations and pharmacies as it is our expectation that the rate reported is inaccurate.



Rebecca and her baby, Harry, enjoy some skin-to-skin time.

People are supported to take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Exclusive or fully breastfed at Lead Maternity Carer discharge – 4-6 weeks	Māori 60% Pacific 68% Other 73% Total 68%	Māori 62% Pacific 69% Other 71% Total 68%	Māori 75% Pacific 75% Other 75% Total 75%	No data available
Exclusive or fully breastfed at 3 months	Māori 43% Pacific 47% Other 60% Total 54%	Māori 44% Pacific 49% Other 60% Total 55%	Māori 60% Pacific 60% Other 60% Total 60%	No data available
Receiving breast milk at 6 months	Māori 54% Pacific 57% Other 64% Total 61%	Māori 52% Pacific 62% Other 68% Total 63%	Māori 65% Pacific 65% Other 65% Total 65%	No data available

Significance of measure

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

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

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

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

Waikato DHB performance

The results for this measure are not available at this time due to a change in data collection and reporting methods. Plunket now report via NHI to the Ministry of Health, However there are delays in receiving this data from the Ministry of Health

Please note the implementation of the new electronic Plunket record is still in its infancy in regards to data reporting. This is constantly being worked on and improved. Plunket is hoping to have more data such as your request, readily available in the future.

Work to increase the numbers of babies being breastfed is still a priority and will continue to be a focus.

Output measure

People are supported to take greater responsibility for their health

Improving health behaviours

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
The number of people participating in Green Prescription programmes	5,802	5,848	6,030	✗ 5,868

Significance of measure

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

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

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

Waikato DHB performance

The agreed target has been set at 6030 for Waikato and 670 for Lakes a total of 6700 for 2016/17. The annual target has not been achieved.

Waikato DHB has delivered 5868 out of the 6030 target for Waikato (162 shortfall) and 561 out of the 670 target for Taupo (109 shortfall).

Waikato DHB is working with Sport Waikato to ensure achievement for the 2017/18 year. Future delivery will ensure that the target achieved is better aligned with the contracted volume.

People are supported to take greater responsibility for their health

Improving health behaviours

Output measure

Measures	Baseline 2009	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	93.8%	100%	93.8%	✓ 100%
Percentage of total primary schools participating in Project Energize	98.8%	100%	98.8%	✓ 100%

Significance of measure

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

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

Waikato DHB performance

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

100 percent of primary schools and kura kaupapa Māori in our district participate in Project Energize. The project is focused around increasing children's physical activity, improving nutrition and ultimately making a positive impact on health and wellbeing.

A team of Energizers deliver the programme and provide practical 'hands on' support and assistance to schools and teachers.

In 2017/18 we intend to undertake further work with Sport Waikato and Population Health to evolve their approaches as the Raising Healthy Kids target is implemented. This work will be alongside schools as they implement Ministry of Educations guidelines to move from clusters of schools working together to community of leaders engaged with each other.

Te Puea (left) and Rangi (right) with their children.

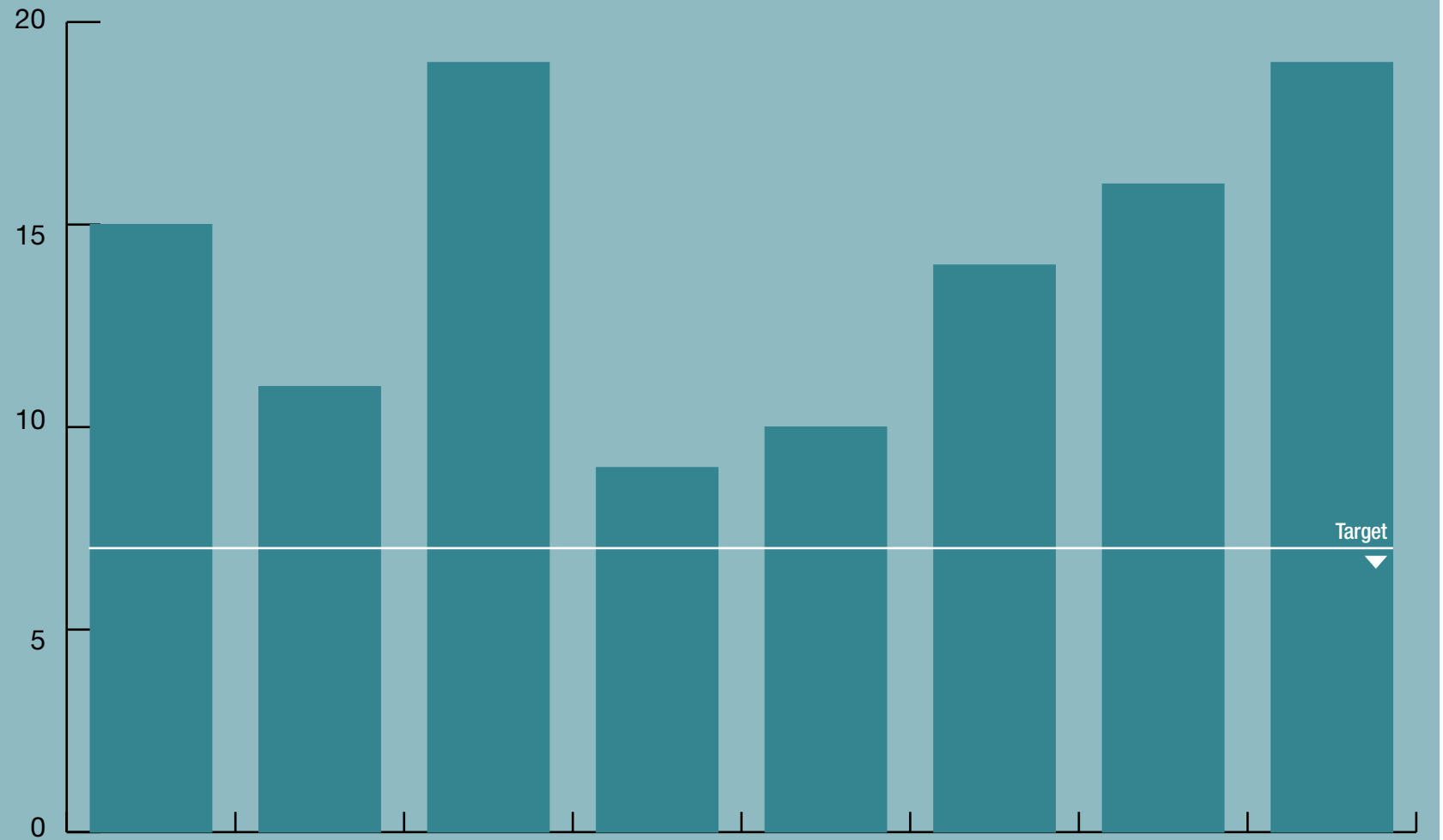
Long-term impact	**People stay well in their homes and communities**			
Intemediate impacts	An improvement in childhood oral health	Long term conditions are detected early and managed well	Fewer people are admitted to hospital for avoidable conditions	People maintain their functional independence
Output Performance Measures	• Percentage of children (0-4) enrolled in DHB funded dental services • Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination • Percentage of adolescent utilisation of DHB funded dental services	• Percent of the eligible population who have had their cardiovascular risk assessed in the last five years • Percentage of women aged 25 to 69 years who have had a cervical screening event in the past 36 months • Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years	• Percentage of eligible population who have had their B4 school checks completed • Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	• Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan • Percentage of people enrolled with a Primary Health Organisation • Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days

Output measure

People stay well in their homes and communities

An improvement in childhood oral health

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



People stay well in their homes and communities

An improvement in childhood oral health

Output measure

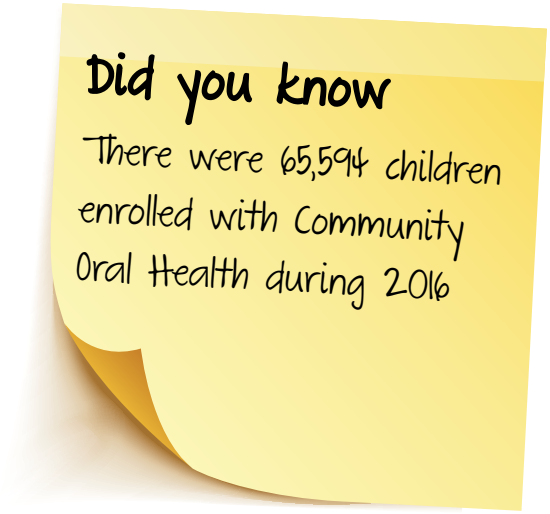
Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	14%	16%	< 7%	✗ 19%

Significance of measure

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

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

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



Waikato DHB performance

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

The Waikato DHB has not met this target for the 2016/17 year.

Activities delivered for the year included:

- Titanium (an electronic record system) was implemented at the start of 2017. It required significant staff release time during 2016/2017 to test, train, problem solve and implement the solution into clinics and mobiles. A resultant increase in arrears was anticipated based on the experience of other district health boards
- Several graduates joined the oral health workforce for 2016/2017. They require more time for all aspects of patient care when compared to the experienced staff they replace, as they build their clinical skills. Their patient loading is about half of that of an experienced therapist. The environment is that of a national shortage of registered dental therapists
- Many low risk patient groups are recalled on a 15-month rotation thereby freeing time and resource for high-risk patients
- The service is continuing its focus on prevention and evidence-based quality care

The focus for the 2017 school year includes:

- Efforts to reduce appointments not attended through increased use of SMS messaging, enabled by Titanium
- Transfer of 65,000 paper-based patient records into the electronic system Titanium. Note that there is additional time required for staff to learn the system and to enter base-line patient information. Once all patients are seen, the follow-up will be less time-consuming and targets will be easier to achieve
- Build and utilise Titanium-based reports to provide information for all aspects of service delivery and staff management
- Encourage under-graduate placements to help develop a workforce for the future
- Train dental assistants in some aspects of prescribed patient care so that dental therapists and dentists have more time for skilled aspects of patient care
- Automatic enrolment for pre-schoolers by using a data feed from the hospital management system. This will increase the number pre-schoolers known to the service, enrolled and offered appointments
- Preschool coordinator and service kaitiaki visits to kohanga reo and groups in high deprivation areas to improve knowledge and utilisation of services
- Kaitiaki ward visits and follow-up on referred patients

Output measure

People stay well in their homes and communities

An improvement in childhood oral health

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of children (0-4) enrolled in DHB funded dental services	70%	73%	85%	✗ 72%

Significance of measure

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

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

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

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

Waikato DHB performance

The Waikato DHB has not met the target for the 2016/17 year.

Activities delivered included:

- Many low-risk patients have been placed on a 15-month recall thereby freeing time and resource for high-risk patient groups and 6 monthly fluoride applications
- The service continued to provide opportunities for undergraduates to gain work experience at Waikato DHB in an effort to attract them back after they graduate to build a potential workforce in future years
- A focus on productivity and achieving targets, but with a strong emphasis on prevention to achieve positive health outcomes
- Implementation of a call centre to assist with appointment scheduling and appointment changes
- Commencement of work with Under Five Energisers through Sport Waikato to help raise awareness of oral health service availability and key health messages in 124 early childhood centres throughout the Waikato district

For 2017/18, we will continue the programme of work with Under Five Energizers through Sport Waikato to raise awareness of oral health services and key health messages in 124 early childhood centres across the Waikato district.

People stay well in their homes and communities

An improvement in childhood oral health

Output measure

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of adolescent utilisation of DHB funded dental services	70%	70%	85%	✗ 70.8%

Significance of measure

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

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

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

Waikato DHB performance

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

The Waikato DHB did not meet the target for the 2016/17 year.

Activities delivered for the year included:

- Written advice to all secondary school principals about mobile dental service delivery and how to deal with approaches from new providers
- Increasing access for adolescents by working closely with dentists especially in rural areas to take on the agreements. We now have the first dentist in PioPio which means all our small rural towns have access to a local dentist or mobile service
- Improving enrolment forms in use by one mobile dental service provider
- Reviewing and working with providers where there appears to be duplication across providers for the same service.

For the 2017/18 year the areas of focus will be on:

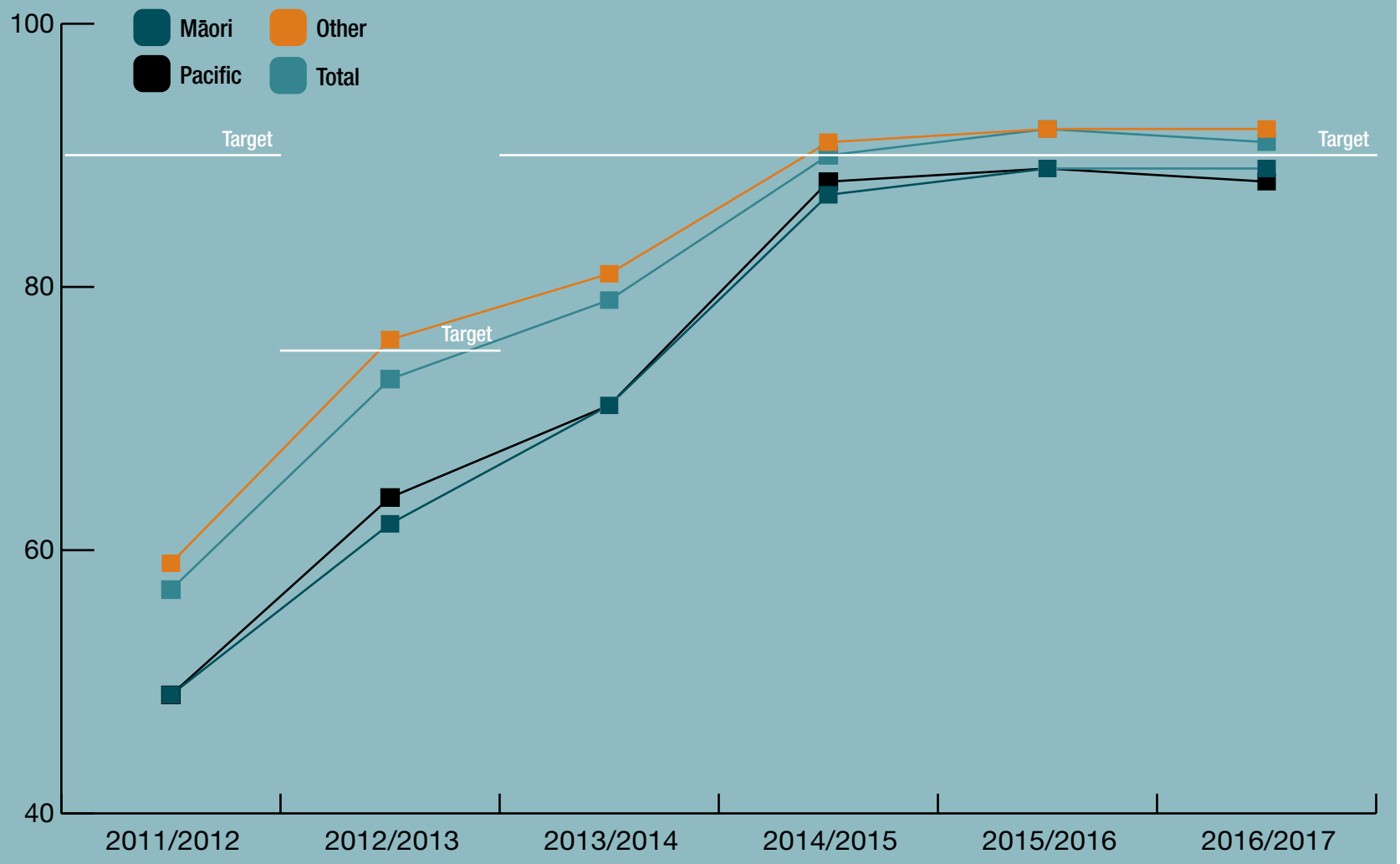
- Reducing gaps in service coverage through more effective intervention by mobile dental services; this includes mitigating risks associated with duplication of annual check-ups and subsequent risk of duplicated claiming by dentists
- Increasing access to oral health services for adolescents on the Rheumatic Heart Disease register
- Increased health promotion and use of SMART technology to increase uptake

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

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



People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	Māori 87% Pacific 88% Other 91% Total 90%	Māori 89% Pacific 89% Other 92% Total 92%	Māori 90% Pacific 90% Other 90% Total 90%	✗ Māori 89% ✗ Pacific 88% ✓ Other 92% ✓ Total 91%

Significance of measure

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

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

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

Waikato DHB performance

The Waikato DHB has met the target for the 2016/17 year at the total population level but were slightly under target for Māori and Pacific .

Activities delivered for the year included:

- Development of a Māori dashboard by Midland Health Network to identify at risk populations
- On going nurse education days for Hauraki PHO throughout the year
- Health stalls at the Pacific Nesian Festival in Hamilton

For the 2017/18 year the areas of focus will be:

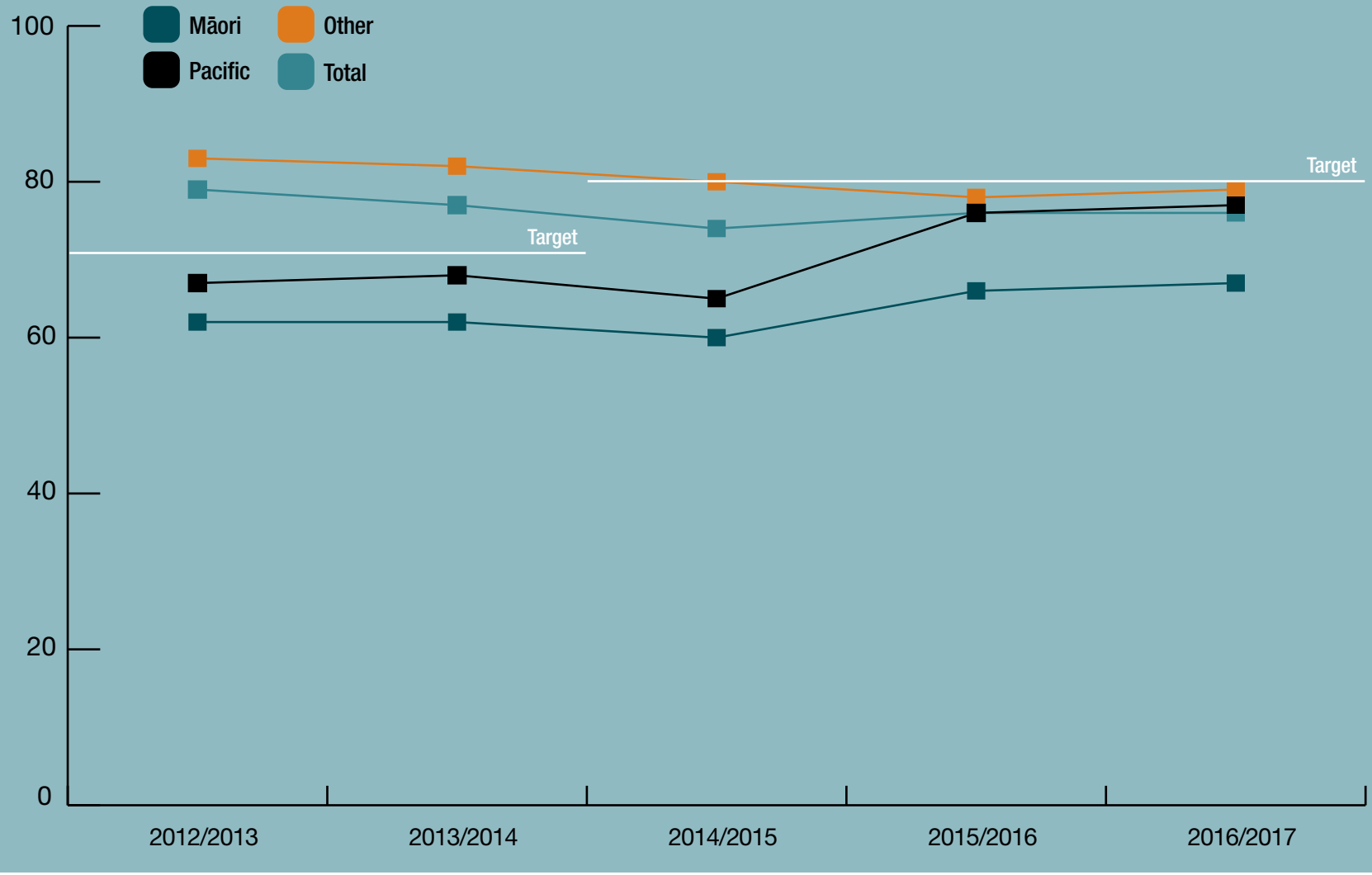
- Cardiovascular disease risk assessments for Māori men aged 35-44 years
- Identifying activities to modify risk
- Post event medication counselling

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of eligible women who have had a cervical cancer screen every 3 years



People stay well in their homes and communities

Long term conditions are detected early and managed well

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of women aged 25-69 who have had a cervical screening event in the past 36 months	Māori 60% Pacific 65% Other 80% Total 74%	Māori 66% Pacific 76% Other 78% Total 76%	Māori 80% Pacific 80% Other 80% Total 80%	✗ Māori 67% ✗ Pacific 77% ✗ Other 79% ✗ Total 76%

Significance of measure

A cervical smear test that looks for abnormal changes in cells on the surface of the cervix (the neck of the uterus or womb). Some cells with abnormal changes can develop into cancer if they are not treated. Treatment of abnormal cells is very effective at preventing cancer. There is a choice of providers for a smear test. A doctor or practice nurse will usually be able to provide this service, the Family Planning Association can offer this service and the Waikato DHB Sexual Health service will also provide this service as part of a sexual health clinical assessment.

Waikato DHB performance

The Waikato DHB did not meet the target for the 2016/17 year.

Activities delivered for the year included:

- Support to services, 112 completed
- Cervical screening update organised attended by 240 nurses May 2017
- Cervical Screening Awareness month display competition organised
- Attended and presented two smear taker training sessions at WINTEC, attended meeting to review NZQA standards for smear takers
- Three cervical screening education sessions provided to Raukawa – Tokoroa, one session to the Māori Women's Welfare League in Kihikihi. Supported Te Kohao Medical Centre with two Saturday sessions
- Cervical screening newsletters for primary health organisations to distribute to their practices
- 39 Annual practice visits
- 29 data match report training sessions completed for primary care

For the 2017/18 year the areas of focus will be:

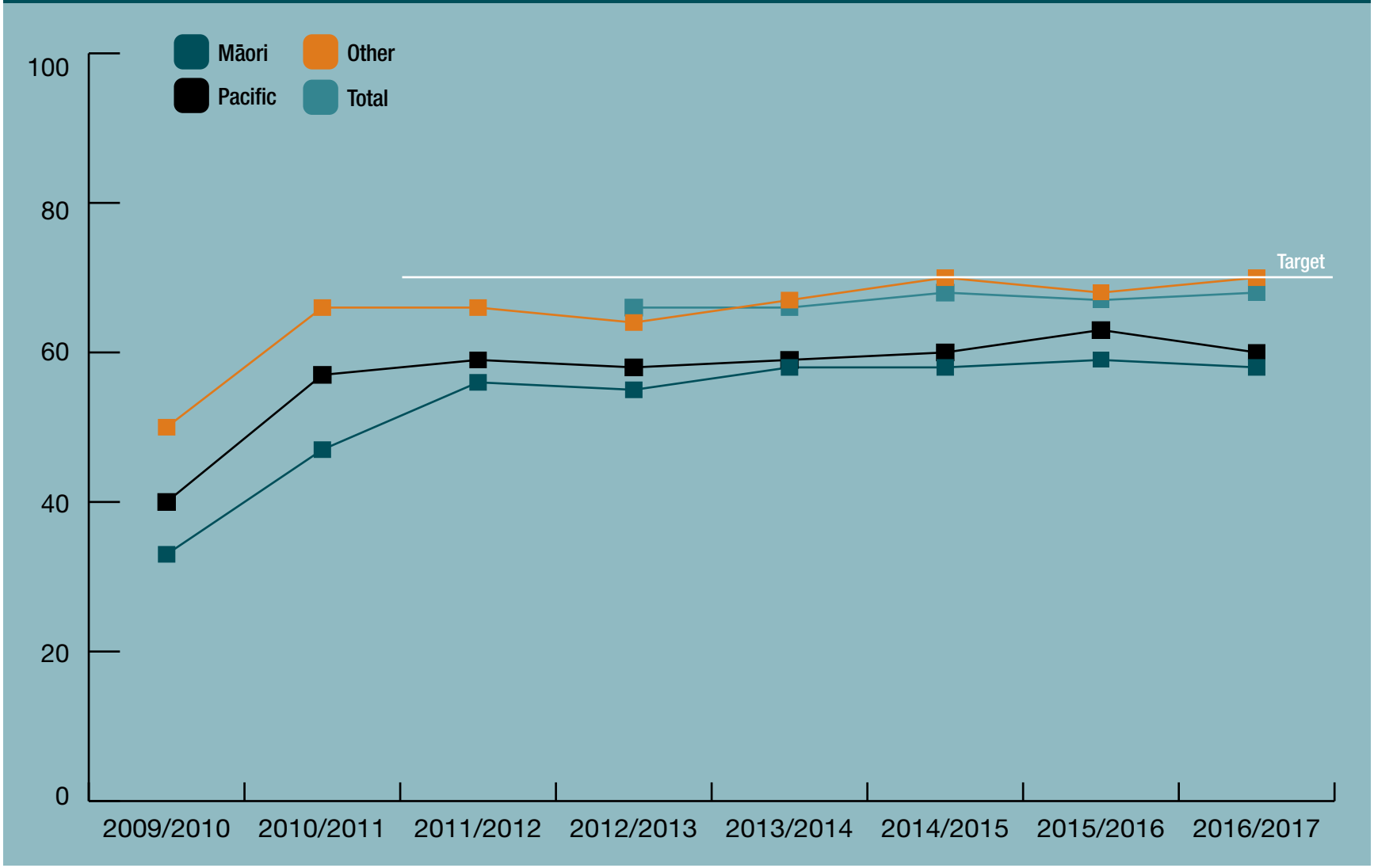
- Completing annual practice visits
- Continued awareness campaigns
- Collaborative meetings with primary health organisations with focuses on ways to improve screening coverage
- Annual information evening to be organised for primary care

Output measure

People stay well in their homes and communities

Long term conditions are detected early and managed well

Percentage of eligible women who have had a breast screen in the last 2 years



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People stay well in their homes and communities

Long term conditions are detected early and managed well

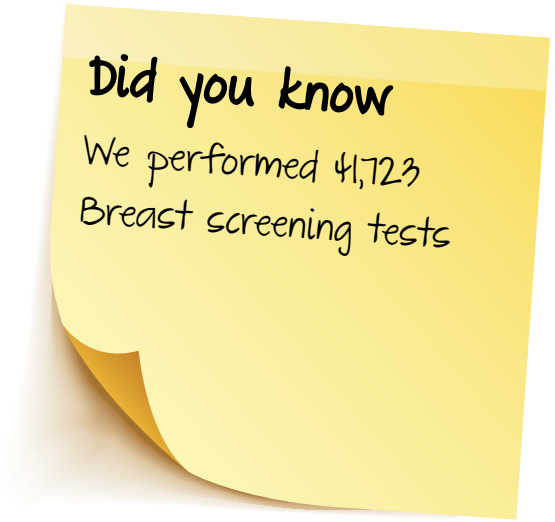
Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years	Māori 58% Pacific 60% Other 70% Total 68%	Māori 59% Pacific 63% Other 68% Total 67%	Māori 70% Pacific 70% Other 70% Total 70%	✗ Māori 58% ✗ Pacific 60% ✓ Other 70% ✗ Total 68%

Significance of measure

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

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



Waikato DHB performance

The target was not met for all populations in this measure. Breast Screening Midland (BSM) will continue focus on the rescreen timeliness to get rescreens completed within the 24 month timeframe.

Eligible population continues to increase, so screening numbers need to increase in at least the same proportion to maintain equitable coverage. This is a challenge due to capacity of screens and resources available.

There were no projects specifically targeting older women. All did-not-attends were processed in-house until November 2016 when the contracts changed. However, it took some time for the new providers to employ full-time staff, and undertake BSM training. They are now established and doing well.

Other activities delivered for the year included:

- Māori first timers - providing texts is continuing.
- Short notice bookings were accepted at all sites.

For the 2017/18 year the areas of focus will be:

- Process refining and evaluation of Maori first timers text
- Evaluation of did-not-attends process to look for trends
- Focus of reducing rescreen timeliness – need to look at capacity issues that may feed into this issue
- Developing a communications and engagement plan with Waikato DHB Comms team.
- Working on a pilot to increase uptake by priority women, particularly Māori, at targeted mobile sites. Pilot will be run during the Kirikiriroa visit in December 2017
- Participating in the DHB-wide Heart Hauora Kaupapa event

Jade helps out at her check-up.

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Output measure

Measures	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of eligible population who have had their B4 school checks completed – High needs	90%	90%	90%	✓ 90%
Percentage of eligible population who have had their B4 school checks completed – Total	90%	90%	90%	✓ 90%

Significance of measure

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

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

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

Waikato DHB performance

Waikato DHB has continued to meet the target for high-needs and total population for the 'B4 school checks'.

The effective engagement and collaboration between the Waikato DHB, Primary Health Organisation partners, and the Ministry of Health has been a significant contributing factor for achieving the target.

We will continue the collaborative relationships to ensure achievement of this target for 2017/18.

A selection of community resources developed for rheumatic fever awareness.

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Output measure

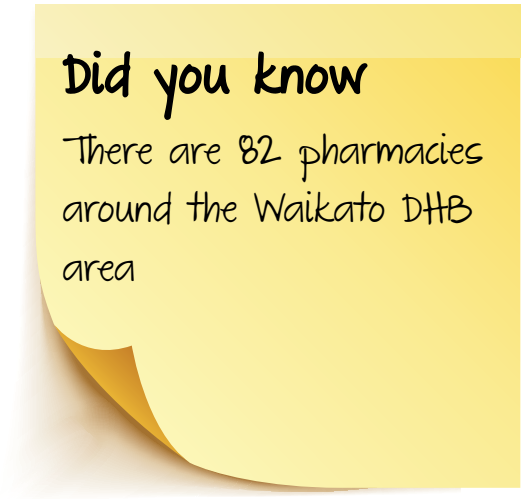
Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Acute rheumatic fever initial hospitalisation target rate (per 100,000)	3.9	1.5	1.2	✗ 2.5%

Significance of measure

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

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

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



Waikato DHB performance

The Waikato DHB did not meet the target for the 2016/17 year. During the 2016-2017 year, there have been 10 cases of acute rheumatic fever. Waikato DHB continues to work towards the target and have implemented various actions to facilitate this. These include:

- The establishment of the Waikato Rheumatic Fever Governance Group
- Agreements in place for five community based Māori and Pacifica (rural and urban) providers to maintain community awareness activities and engage with Healthy Homes programme of work
- Working with Media and Communications team to increase community awareness
- Continued maintenance of the Waikato DHB Rheumatic Fever website as a single point of reference
- Free sore throat swabbing services in primary care, schools and pharmacies
- Education on adherence to completing antibiotics
- Healthy homes initiative

Charles gets some advise at his home in Thames from Colleen, his district nurse.

People stay well in their homes and communities

People maintain functional independence

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and a completed care plan	100%	100%	100%	✓ 100%

Significance of measure

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

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

Waikato DHB performance

The Waikato DHB has met the target for 2016/17 maintaining the target of 100 percent of clients have a care plan based on the outcome of an International Residential Assessment Instrument (InterRAI) with the minimum data set- homecare assessment tool (MDS-HC) .

Waikato DHB has worked with Central Tas to develop both regional and local algorithms based on assessed data which inform the functional profiles of our older population. In addition we have undertaken collaborative research with both the University of Waikato and University of Auckland using interRAI MDS-HC Data to identify the cohort of older people 'at-risk' of avoidable admissions. This will inform the reassessment frequency of this cohort to ensure changes / decline is identified and managed within the community.

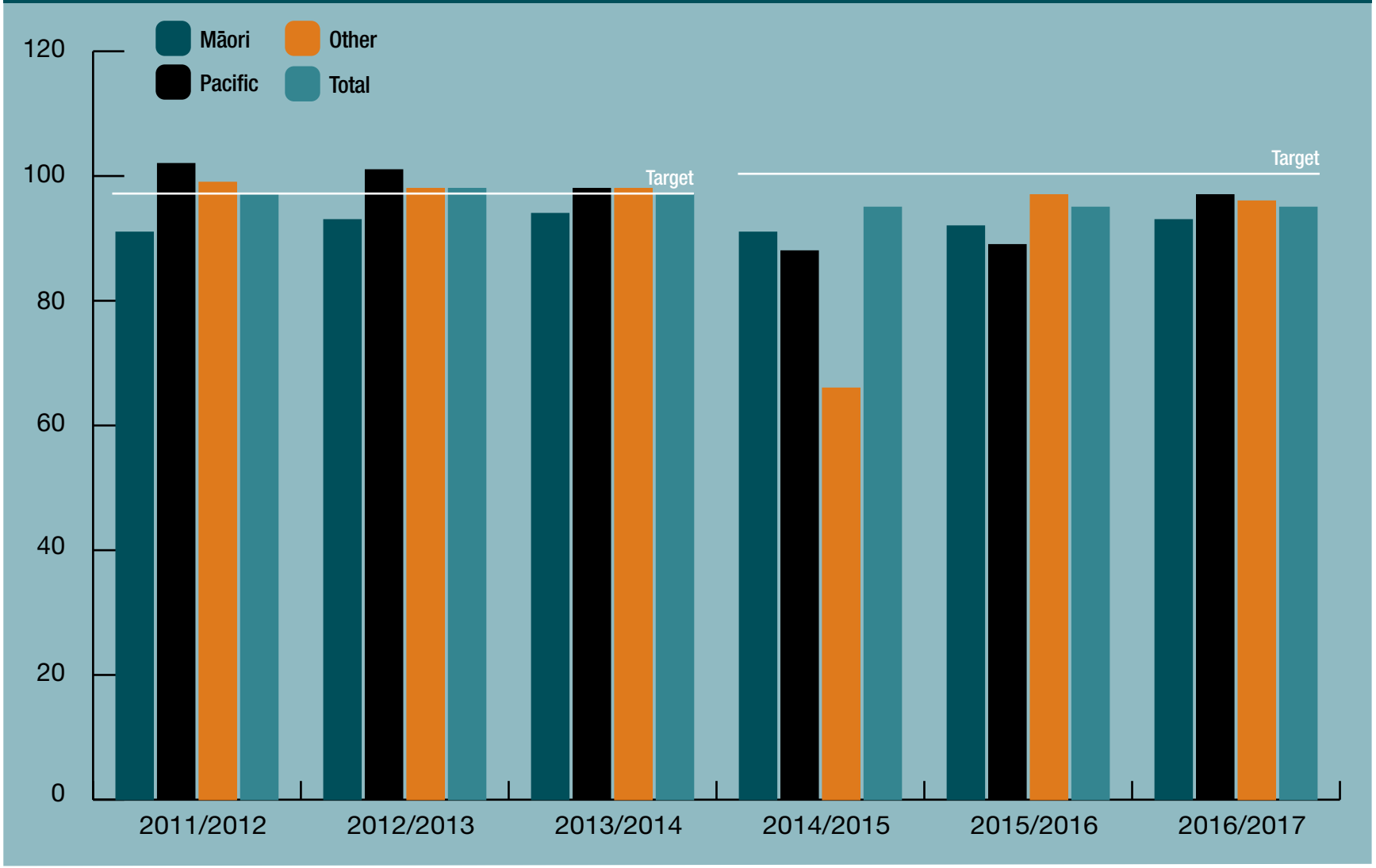
A service plan developed to meet the needs identified on the assessment reassessment.

Output measure

People stay well in their homes and communities

People maintain functional independence

Percentage of population enrolled with a Primary Health Organisation



People stay well in their homes and communities

People maintain functional independence

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of people enrolled with a Primary Health Organisation	Māori 91% Pacific 88% Other 66% Total 95%	Māori 92% Pacific 89% Other 97% Total 95%	Māori 100% Pacific 100% Other 100% Total 100%	✗ Māori 93% ✗ Pacific 97% ✗ Other 96% ✗ Total 95%

Significance of measure

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

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

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

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

Waikato DHB performance

The Waikato DHB has not met the target for 2016/17. There were a number of initiatives undertaken during 2016/17 to increase the percentage of people enrolled with a primary health organisation.

Activities to increase enrolment have included:

- Referral from Waikato Hospital Emergency Department for unenrolled Waikato patients presenting in Emergency Department to be have a free first visit to a General Practice of choice

The 2017/18 year will focus on:

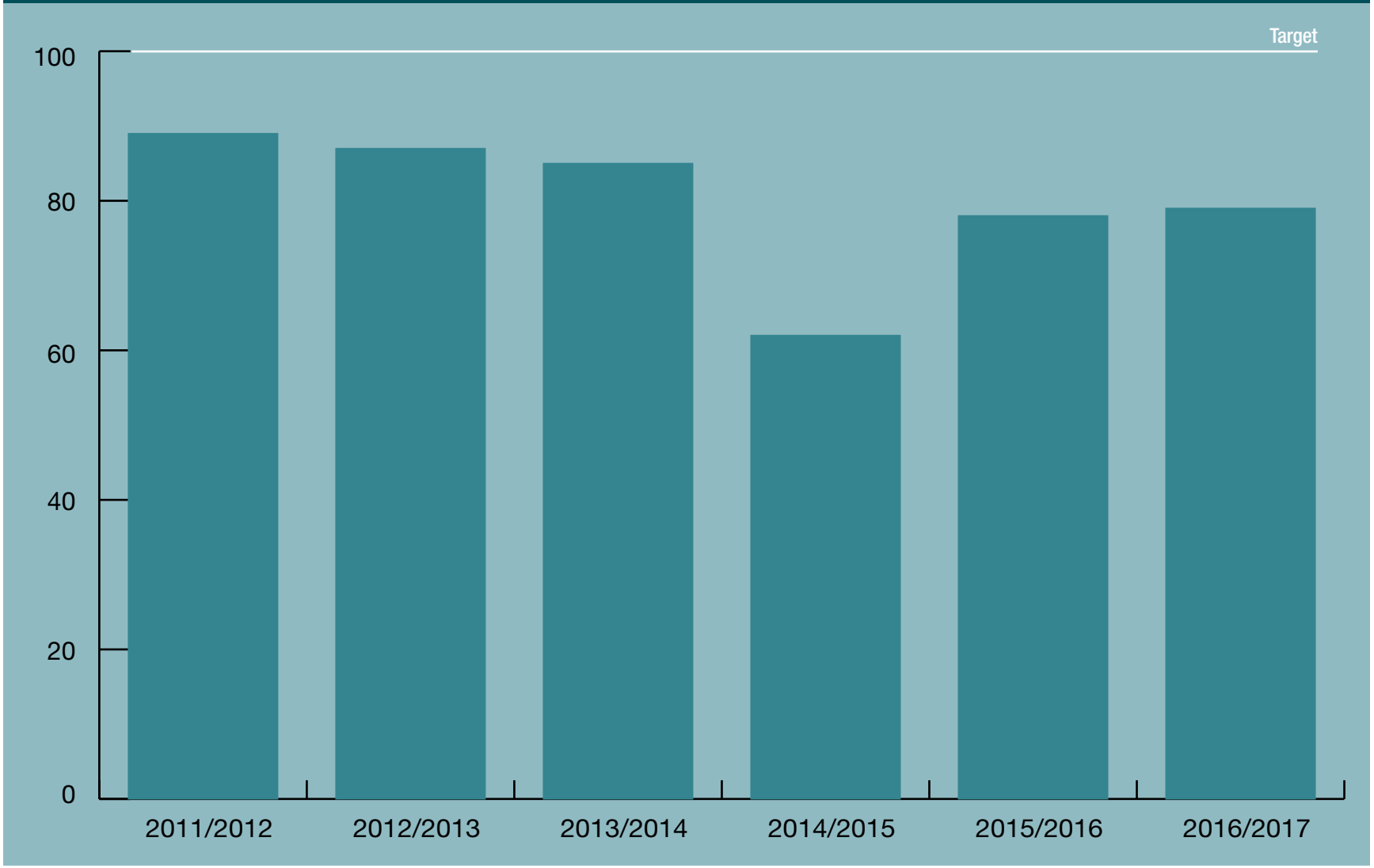
- Reviewing uptake of the above new unenrolled free visits programme
- Working with the National Immunisation Register and the Waikato Child Health Coordination Service to make every effort to get new-borns enrolled in primary health care prior

Output measure

People stay well in their homes and communities

People maintain functional independence

Percentage of Needs Assessment and Service Coordination (NASC) waiting times for new assessment within 20 working days



People stay well in their homes and communities

People maintain functional independence

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of Needs Assessment and Service Coordination (NASC) waiting times for new assessment within 20 working days	62%	78%	100%	✗ 79%

Significance of measure

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

Waikato DHB performance

The target for the 2016/17 year was not achieved. The Waikato DHB NASC agency is making gains against achieving this target, such as:

- Disability Support Link Health of Older People team completed a total of 2124 initial assessments over the 2016/17 period (compared to 1865 initial assessments in 2015/16)
- An increase in annual reviews and three yearly face-to-face reassessments; In 2015/16 Disability Support Link completed 7542 interventions; In 2016/17, this figure was 10305 interventions – a 36 percent increase
- 100 percent high-risk/urgent clients are seen and have services allocated within 5 days. All high-risk clients are triaged as urgent. The early assessment and review of complex/high-risk clients has been a notable success of the change to date
- In 2016/17 a further 2868 referrals were received for a reassessment of the client's level of care/allocated package; and of these referrals 92 percent were seen within 20 days

Whilst the improvements against meeting timeframes for low-risk initial assessment have been modest, this needs to be considered alongside other service demands and service improvements, such as:

- In an inpatient setting, the team has reduced its time to assess from 5 working days to an average of 1.2 working days, saving approximately 200-300 bed days per month
- The service is now reviewing and reassessing clients on a more regular basis as part of a pro-active admission avoidance model. The service is now completing nearly twice as many interventions compared with 2015

Jack Bhana with cellsaver unit.

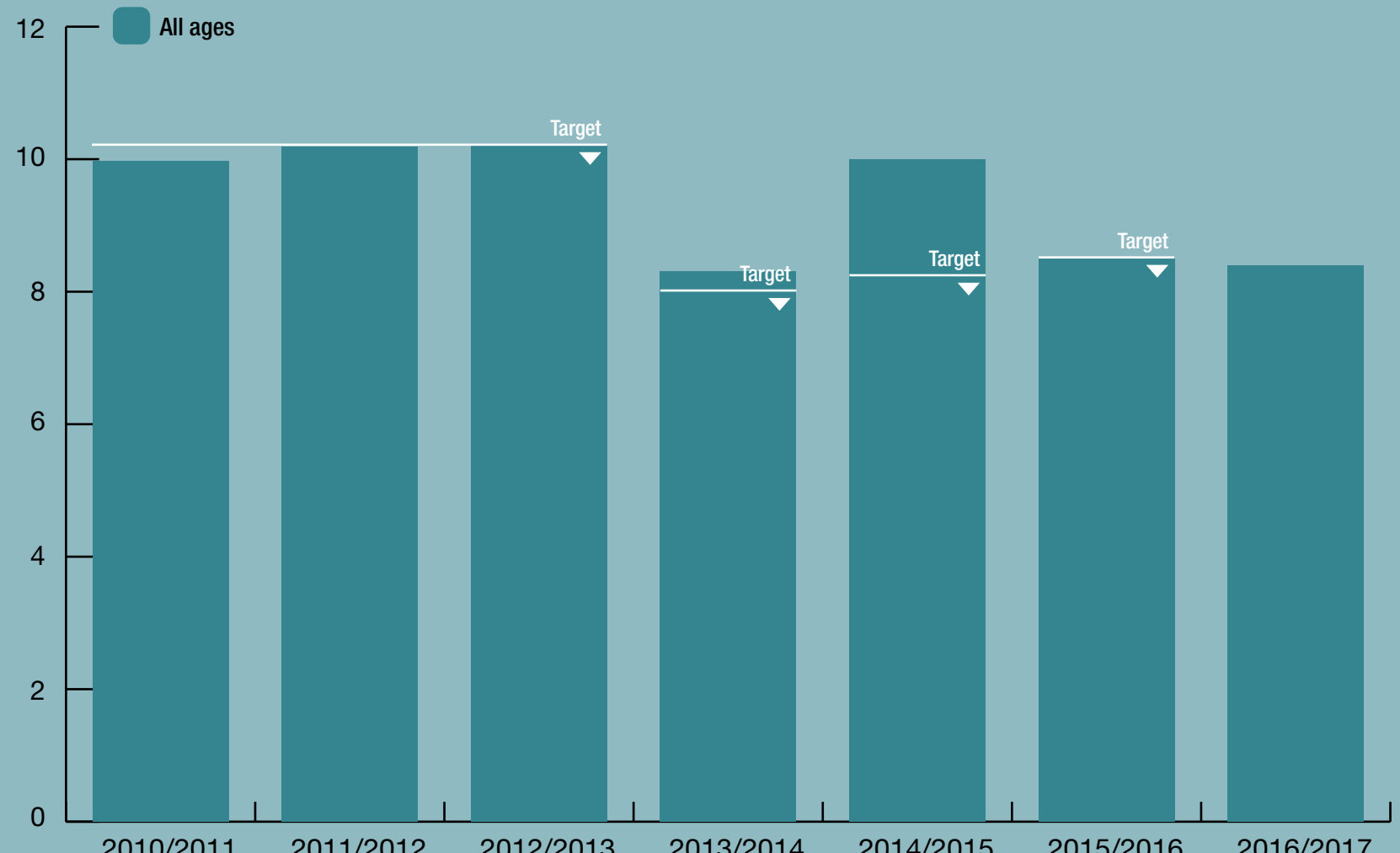
Long-term impact	People receive timely and appropriate specialist care				
Intermediate impacts	People receive prompt and appropriate acute and arranged care	People have appropriate access to elective services	Improved health status for those with a severe mental illness and / or addictions	More people with end stage conditions are supported appropriately	Support services
Output Performance Measures	• Acute re-admission rate • 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks • Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	• Percentage of patients waiting longer than four months for their first specialist assessment • Improved access to elective surgery, health target, agreed discharge volumes • Did-not-attend percentage for outpatient services • Elective surgical inpatient average length of stay • Acute inpatient average length of stay	• Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks • Percentage of child and youth with a transition (discharge) plan • Average length of acute inpatient stay • Rates of post-discharge community care • Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	• Percentage of aged residential care facilities utilising advance directives • Number of new patients seen by the Waikato hospital palliative care service	• Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) • Percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42days) • Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), and percentage within 30 days • Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 42 days, and percentage within 90 days • Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date, and percentage within 120 days • Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt • Pharmaceutical measure to be developed

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Acute re-admission rate



People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Acute re-admission rate	10%	8.5%	No target set	8.4%

Significance of measure

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

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

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

This result is taken from Ministry of Health reports, year ending March 2017.

Waikato DHB performance

The measure definition for performance measure Reducing Acute Readmissions to hospital' was under review by a sector working group during 2016/17. As it was anticipated that the revised definition would become operational during the 2016/17 year, DHBs were asked to include a holding statement in their accountability document so that a performance target could be agreed during the year. However, the review of the measure definition took longer than expected, therefore no DHB performance targets were agreed for 2016/17. The revised measure is in place for 2017/18 and it is expected that the first six months of the 2017/18 year will be used to establish formal DHB baselines.

There were a number of initiatives undertaken during 2016/17 they included:

- Pre hospital Preparedness (PHP) project advanced in 2016/17 with the following outcomes:
- Creating a pre-anaesthetic phase (Anaesthetic Assessment Clinic – AAC) and a pre-procedure preparation phase (Pre Hospital Care – PHC)
- Additional anaesthetist, nursing and administrative resource was outlined in business case to support the overall PHP process
- All elective procedure patients receive consistent pre hospital assessment, based upon defined criteria for urology, endoscopy, gynaecology, maxillo-facial, dental, ear, nose and throat, orthopaedics, obstetrics, general surgery, vascular, specialist paediatrics, plastic surgery
- Waikato DHB adopted the NHS SAFER programme that included the early identification of the expected discharge date for all inpatients. Project commenced in 2016/17 for rollout in quarter 1 2017/18

Output measure

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Measure	Baseline 2014	Previous year 2015/16	Target 2016/17	Result 2016/17
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	56%	72%	90%	✗ 86%

Significance of measure

Prompt treatment is more likely to ensure better outcomes for patients. Lengthy waiting times can add to the stress on patients and family at an already difficult time, so it is important that people have a clear expectation of how quickly they will receive treatment.

Work in this area is designed to reduce waiting times for appointments, tests and treatment and standardise care pathways for cancer patients, wherever they live. The activity links with the whole range of initiatives designed to improve the prevention, diagnosis and treatment of cancer and support for patients and their families.

This measure is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

Although Waikato DHB has not met this 90 percent target for 2016/17, it should be noted that it has delivered 86 percent performance, thus ensuring that Waikato DHB was the second strongest performer nationally for Quarter 4 2016/17. There were a number of initiatives undertaken during 2016/17 they included:

- Monitoring the implementation of a lung cancer one stop model for high suspicion of cancer (HSCAN) lung cancer patients, ensuring patients have first specialist assessment and initial diagnostics within 14 days of referral
- Rolling out of HSCAN red stamps across services for requesting diagnostics.
- Weekly urology waitlist meetings to discuss any patients triaged onto 62 day pathway
- Liaising with interventional radiology to ensure patients receive CT biopsy in timely manner

The 2017/18 year will focus on:

- Monitoring faster cancer treatment (FCT) achievement of health target for patients on lung cancer pathway ensuring gains of the one stop shop model are embedded and maintained
- Management and clinical leadership to continue to work together to implement service improvement initiatives to ensure women meet the FCT health target and indicator wait times
- Transitioning urology service to fully utilise DHB management system and embed FCT business rules into urology business as usual
- Monitor fast tracking process to identify all FCT referrals for diagnostics with a high suspicion of cancer with red stamp on referral form
- To engage with Te Puna Oranga to minimise inequity in cancer service, including and addressing did not attends and identifying barriers

People receive timely and appropriate specialist care

People receive prompt and appropriate acute and arranged care

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	10%	10%	<16%	✓ 10%

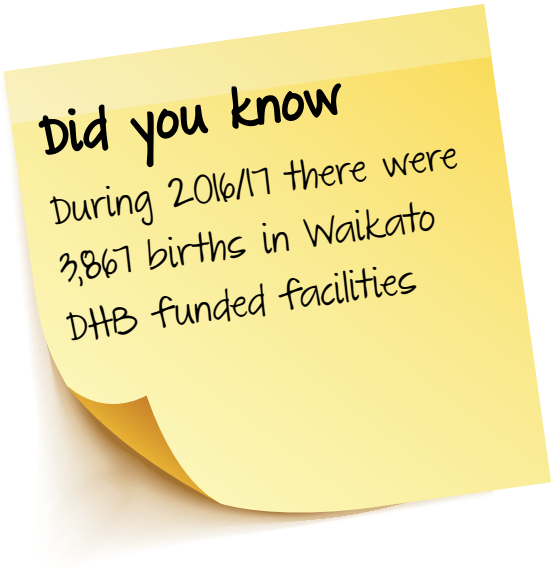
Significance of measure

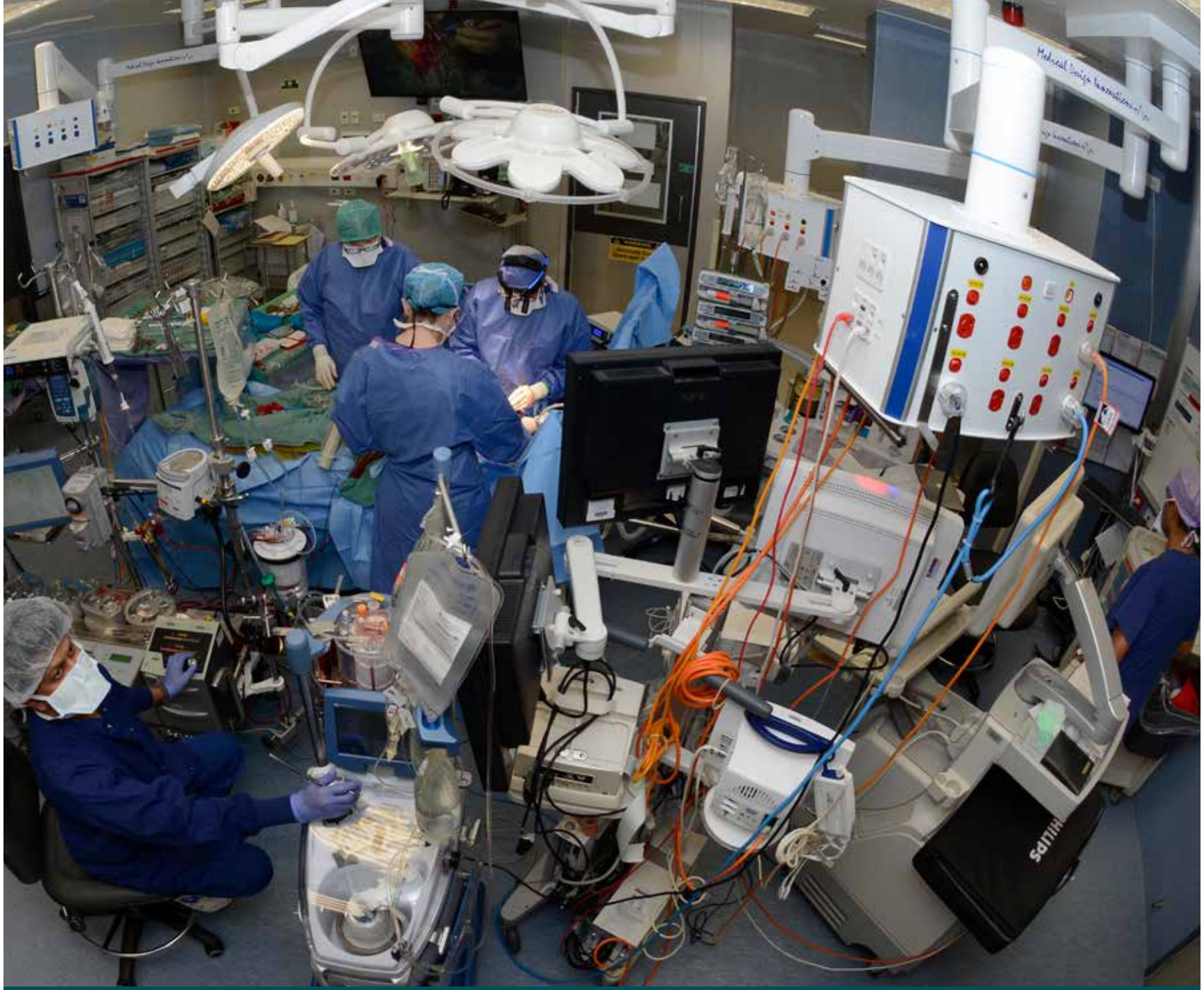
Caesarean deliveries have a higher risk of operative complications (infections, haemorraghia, visceral injury, thromboembolism). Caesarean sections have some significant associated risks including, increased maternal mortality, maternal and infant morbidity, and increased complications for subsequent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

Waikato DHB performance

The target for this year has been achieved.

While arranged caesareans are a necessary procedure for some woman, any surgery comes with risk and the Waikato DHB is committed to ensuring mother, baby, and the family and whānau receive the highest quality of care throughout the process. We will continue to work towards reducing complications related to caesarean delivery.





Perfusion views in Cardiac Theatre.

People receive timely and appropriate specialist care

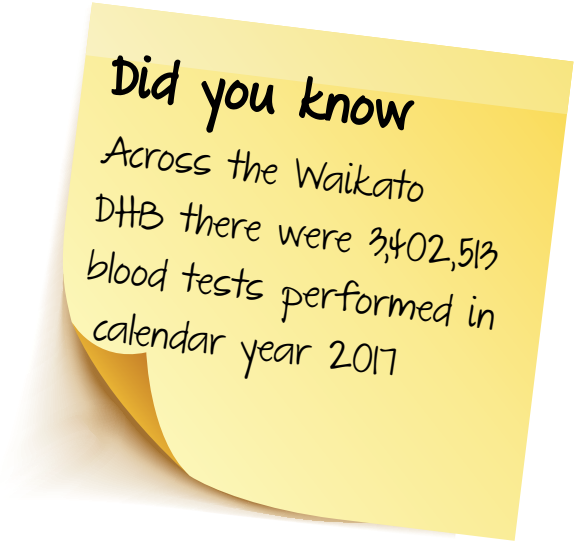
People have appropriate access to elective services

Output measure

Measure	Baseline 2010/2011	Previous year 2014/15	Target 2015/16	Result 2015/16
Percentage of patients waiting longer than four months for their first specialist assessment	0%	2.7%	0%	✗ 0.4%

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

The Waikato DHB has not met the target for 2016/17 but improved on the previous year's result of 2.7 percent. There were a number of initiatives undertaken during 2016/17 they included:

- Weekly meetings to better monitor progress resulted in 99.6 percent of patients being booked within the recommended timeframe
- Additional clinics being held when waitlists occurred
- Having clear prioritisation criteria

The 2017/18 year will focus on:

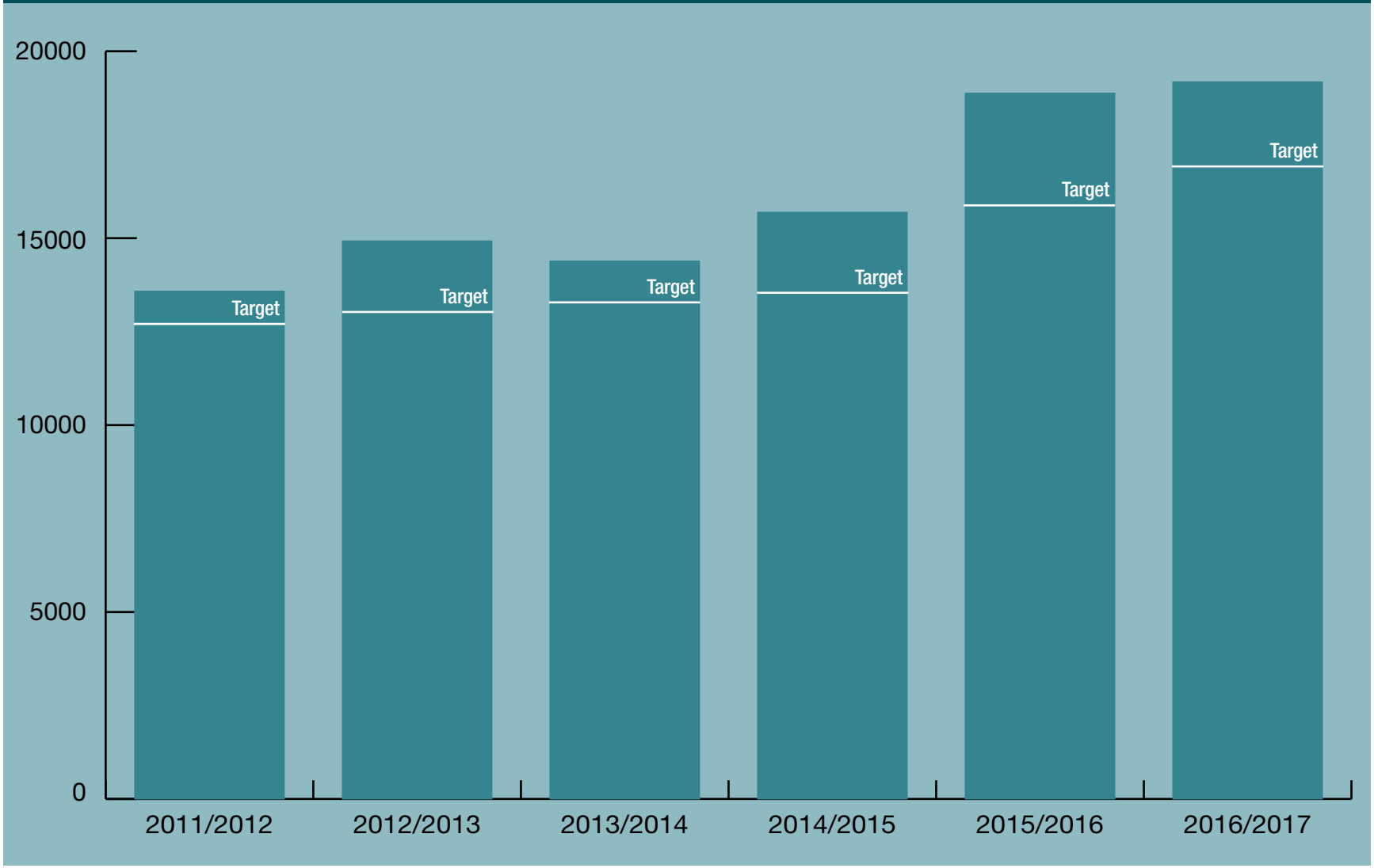
- Having improved clarity on roles and responsibilities in relation to outpatient clinic management
- Increasing the number of clinics held via telemedicine or SmartHealth
- Increasing the number of non-contact first specialist assessments

Output measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

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



People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Improved access to elective surgery, health target, agreed discharge volumes	15,693	18,876	16,805	✓ 19,179

Significance of measure

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

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

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

This measure is one of the National Health Targets.

This result is for the fourth quarter, refer to page 23 for all four quarter results.

Waikato DHB performance

The Waikato DHB has met the target for 2016/17. There were a number of initiatives undertaken during 2016/17 they included:

- Elective Service Commissioner appointed for a one year term to guide Waikato DHB compliance to elective patient flow indicators (ESPIs) and as well requirement to meet provider arm full delivery plan
- Overall performance to this target assisted by the Pre hospital Preparedness project to ensure steady flow of fit to operate on patients ready to book for a procedure
- Addressed gap in number of registered nurse and anaesthetic technicians full-time equivalent in an approved business case in 2016/17

The 2017/18 year will focus on:

- Rollout of use of national prioritisation tools
- Increase us of non-contact and virtual first specialist assessment appointments
- Address the gap in anaesthetist full-time equivalent to ensure all resourced theatre lists can go ahead as required to meet production plan volumes

Output measure

People receive timely and appropriate specialist care

People have appropriate access to elective services

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Did-not-attend percentage for outpatient services	Māori 21% Pacific 18% Other 7% Total 10%	Māori 20% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	✗ Māori 19% ✗ Pacific 18% ✓ Other 7% ✗ Total 10%

Significance of measure

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

Waikato DHB performance

While the DHB achieved the target for our 'other' populations, we continue to miss meeting the target for our total, Māori and Pacific populations.

There were a number of initiatives undertaken during 2016/17 they included:

- More patients being encouraged to phone to make an appointment at a time that suits them within the appointment times available
- Sending text reminders

The 2017/18 year will focus on:

- Establishing an Outpatient Administration Forum to better support administrators and standardise outpatient booking systems and processes across the DHB
- Enabling more services to use text reminders
- Investigating a patient centred booking system that mitigates sending patients letters to book appointments

People receive timely and appropriate specialist care

People have appropriate access to elective services

Output measure

Measures	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Elective surgical inpatient average length of stay	1.71 days	1.67 days	1.65 days	✓ 1.62 days
Acute inpatient average length of stay	3.89 days	2.54 days	2.5 days	✓ 2.46 days

Significance of measure

Elective

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

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

Acute

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

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

This result is taken from Ministry of Health reports, year ending March 2017.

Waikato DHB performance

Elective

The Waikato DHB has met the target for 2016/17. There were a number of initiatives undertaken during 2016/17 they included:

- Agreed SAFER programme

The 2017/18 year will focus on:

- Rollout in Quarter 1 of the SAFER project with all inpatients to have an identified expected date of discharge
- Engage a consultancy with expertise on production planning process to improve surgical patient journey including theatre scheduling and production plan end to end process improvement; project to commence in Quarter 1.

Acute

The Waikato DHB has met the target for 2016/17. There were a number of initiatives undertaken during 2016/17 they included:

- Prepare for opening an additional 27-bedded ward to assist with the current bed constraints. Business case approved to open the Older Person and Rehabilitation (OPR) ward OPR5 in September 2017 and aligned with Waikato Hospital bed plan requirements
- Rollout in Quarter 1 of the SAFER project with all inpatients to have a senior consultant view of acre plan and rounded twice a day to assess ability to be safely discharged to home, and review of long stay patients

The 2017/18 year will focus on:

- ACS patient pathway for direct entry to cardiac service for treatment and for regional patient return to DHB of domicile
- The implementation of the Telstra heath patient flow management whiteboard
- Engage a consultancy with expertise on production planning process to improve surgical patient journey including theatre scheduling and production plan end to end process improvement; project to commence in Quarter1 Project scope will include arranged patients with longer stay due to slow access the theatre based procedure/ treatment

Output measure

People receive timely and appropriate specialist care

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

Measures	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within **3 weeks**	75%	79%	80%	✗ 77%
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within **8 weeks**	91%	92%	95%	✗ 91%

Significance of measure

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

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

Waikato DHB performance

The targets were not achieved for the 2016/17 year. Alcohol and Other Drug (AOD) services are consistently achieving or exceeding targets. The Mental Health Services have not met the national target however, work is ongoing to improve results. The Child and Youth Mental Health Model of Care commencing late 2017 will address access issues as part of its development.

Discussions with Healthshare are taking place to understand issues around data integrity, which may be contributing to a failure to meet this target. Once any potential errors are identified, the appropriate solutions will then be implemented.

People receive timely and appropriate specialist care

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

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of child and youth with a transition (discharge) plan	98%	97%	95%	✓ 96%

Significance of measure

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

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

Waikato DHB performance

Our result has exceeded the target for the 2016/17 year. Our quarterly results against this target have been consistently above 95 percent showing consistent delivery against the target.

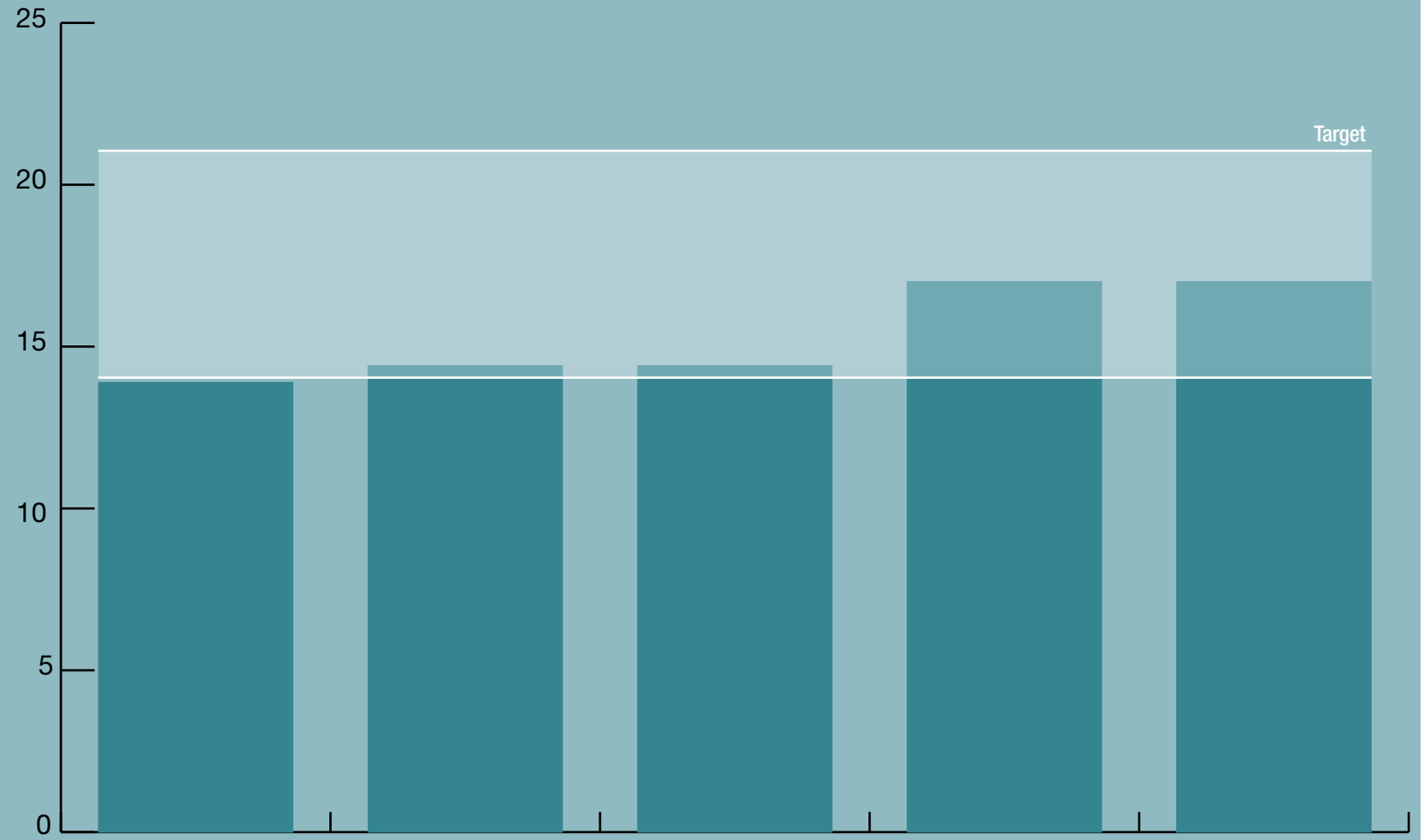
Our results indicate that the processes and expectations in place are clear and the plans are communicated to primary care upon discharge of the child or young person.

Output measure

People receive timely and appropriate specialist care

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

Average length of acute inpatient stay



People receive timely and appropriate specialist care

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

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Average length of acute inpatient stay	14.41 days	17 days	14-21 days	✓ 17 days

Significance of measure

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

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

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

Waikato DHB performance

The Waikato DHB has met the target for 2016/17.

The increase in length of stay is indicative of the growing complex nature of the presentations we are seeing to inpatient services. In addition, the inpatient services move to not discharge service users to homelessness has resulted in the need for some service users to remain in hospital for longer whilst appropriate accommodation arrangements are made for them. There remain a cohort of people whose needs are not currently well met in the community and mental health services, is, in some cases, the only option to support them.

The 2017/18 year we will:

- Redevelop the Adult Acute Model of Care
- Improve discharge planning/transition

Output measure

People receive timely and appropriate specialist care

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

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Rates of post-discharge community care	87%	85%	90-100%	✓ 91%

Significance of measure

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

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

Waikato DHB performance

The Waikato DHB has met the target for 2016/17.

Through 2016/2017 we have continued to focus on ensuring service users remain engaged in their recovery plan following discharge from hospital.

Efforts to improve performance in this area have included a thorough review of data and reporting to ensure information is accurate in terms of the number of service users followed up in a timely way. Where non-compliance has been identified, every individual service user has been followed up to ensure the service has worked to achieve contact within 7 days of discharge.

Whilst we are pleased with the increasing level of performance, in 2017/2018 we will continue to retain a strong focus in this area and to closely monitor all service users discharged from hospital to ensure appropriate follow up and engagement.

People receive timely and appropriate specialist care

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

Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Improving the health status of people with severe mental illness through improved access – **0-19 years old**	2.97%	New measure	4%	✗ 3.99%
Improving the health status of people with severe mental illness through improved access – **20-64 years old**	4.33%	New measure	4.66%	✓ 4.70%
Improving the health status of people with severe mental illness through improved access – **65 years old**	2.27%	New measure	2.69%	✗ 2.01%

Significance of measure

Specialist mental health and addictions services are funded for those people who are most severely affected by mental illness or addictions.

In addition to the access expectations set out in Rising to the Challenge, it is expected that DHBs provide access to specialist services for a minimum of 3 percent of their population. A focus on early intervention strategies will mean specialist services may be delivered to people who are at risk of developing more severe mental illness or addictions.

Waikato DHB performance

The Waikato DHB has met the target for 20-64 year olds however we have not met the target for 0-19 and 65+ year olds for 2016/17.

There were a number of initiatives undertaken during 2016/17 they included:

- Continuation of Youth INtact
- Model of care development
- Packages of care for individuals with high and complex needs

The 2017/18 year will focus on:

- Implantation of the Model of Care work
- Integration of primary and secondary services
- Great linkage with community services

Output measure

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of aged residential care facilities utilising advance directives	100%	New measure	100%	✓ 100%

Significance of measure

An advance directive is a statement signed by a person setting out in advance the treatment they do or don't want if they become unwell in the future and are considered unable to give consent.

Ensuring people in aged residential care facilities have an advance directive offers health providers an understanding of individual's wishes for their care and treatment.

The Health and Disability Sector Standards (HDSS) require that an Advance Directive is on file for every long-term resident in aged residential care facilities and is used when indicated.

Waikato DHB performance

The Waikato DHB has met the target for 2016/17. 100 percent of long-term residents audited as part of residential care audits carried out in Waikato DHB in 2016-17 had an Advanced Directive in place and these were used as appropriate.

The Advance Directive icon has been added to the DHB Clinical Work Station signalling an Advance Directive is loaded into the system and general practitioners can email Advance Directives to the DHB for loading into the system. In 2017-18 we will ask all general practitioners providing services to residential aged care facilities to email through each resident's Advance Directive for loading into the system.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

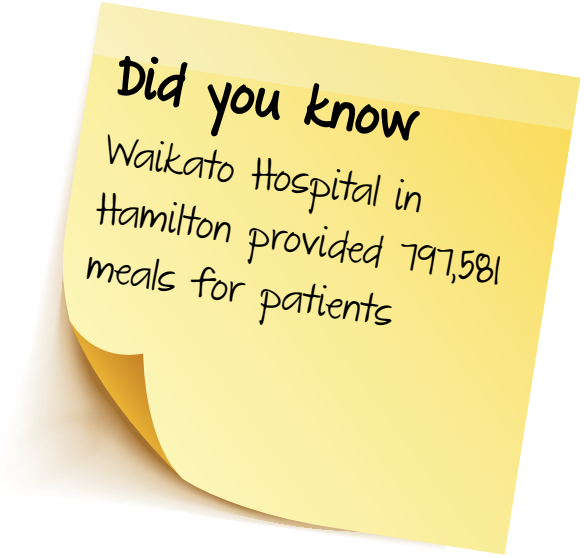
Output measure

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Number of new patients seen by the Waikato Hospital palliative care service	652	New measure	>650	✓ 572

Significance of measure

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

The team has been working very closely with Hospice Waikato in a "one service two provider model" and also works closely with general practitioners.



Waikato DHB performance

The Waikato DHB together with Hospice Waikato has met the target for 2016/17.

There were a number of initiatives undertaken during 2016/17 they included:

- Development of the Waikato Palliative Care Strategic Plan
- Development of the Waikato Specialist Palliative Care Workforce Stocktake and Gap Analysis

The 2017/18 year will focus on:

- Work on refining the priorities within the Strategic Action Plan
- Developing a business case for additional Senior Medical Officers (SMOs)
- Investigating the case for paediatric palliative care
- Developing joint clinics with other specialties and Hospice, e.g. Radiation Oncology or Renal Clinics (subject to sufficient SMO resource)

At work in the Cardiac Catheterisation Laboratory.

People receive timely and appropriate specialist care

Support services

Output measure

Measure	Baseline 2016	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	94%	94%	95%	✗ 89%

Significance of measure

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

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

Waikato DHB performance

The Waikato DHB has not met the target for 2016/17.

There were a number of initiatives undertaken during 2016/17 they included:

- Planning and scheduling patients procedures in advance as much as possible
- Working on improving the patient flow of the cath-lab so to increase patient throughput and minimise inefficiencies for example minimising down time between patients
- Operating a 'short-call up system'. This system involves identifying patients who are willing to be called at short-notice for their angiogram should a space become available at the last-minute
- Outsourcing up to 40 patients per month in 2016/17

The 2017/18 year will focus on:

- ACS patient pathway for direct entry to cardiac service for treatment and for regional patient return to DHB of domicile
- Continue with 2016/17 initiatives and activity to consolidate improved patient flow and throughput

Output measure

People receive timely and appropriate specialist care

Support services

Measures	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of accepted referrals for CT scans, and accepted referrals for MRI scans will receive their scan within six weeks (42 days) – CT scans	90%	85%	95%	✗ 92%
Percentage of accepted referrals for CT scans, and accepted referrals for MRI scans will receive their scan within six weeks (42 days) – MRI scans	48%	82%	85%	✓ 88%

Significance of measure

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

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

Waikato DHB performance

CT scans

The Waikato DHB has not met the CT scans target for 2016/17. The CT target for 2016/2017 was 95 percent and a performance of 92 percent was achieved. This performance was above the national average and in the mid-range for the tertiary DHBs.

Scanning is occurring within a timely period, but reporting the scans is currently the constraint due to Radiologist staff vacancies. Reporting is being outsourced and active recruitment is underway. It is anticipated that the service will not be back to full strength until later in 2018.

MRI scans

Performance against the MRI target has exceeded the target of 85 percent for 2016/2017. This performance compares well with the national average of 59 percent and is significantly above the performance obtained by any other tertiary DHB.

This target was raised in the 2017/18 year. The DHB has formally notified the Ministry that it does not expect to have the capacity in place to meet the increased target for 2017/18. This advice is consistent with that of the wider sector as whole.

People receive timely and appropriate specialist care

Support services

Output measure

Measures	Baseline 2015/16	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of people accepted for an **urgent** diagnostic colonoscopy will receive their procedure within two weeks **(14 days)**	78%	78%	85%	✓ 87%
Percentage of people accepted for an **urgent** diagnostic colonoscopy will receive their procedure within **30 days**	94%	94%	100%	Data not available

Significance of measure

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

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

Waikato DHB performance

Waikato DHB has met the targets for urgent 14 days and surveillance 84 days; however, the target for non-urgent 42 days was not met, although the 2016/17 result is an improvement on the 2015/16 result.

There were a number of initiatives undertaken during 2016/17 which included:

- Use of the National Referral Criteria for direct access Outpatient Colonoscopy
- Worked regionally to improve access and timelines to colonoscopy procedures
- Standardised triage processes for surgical and medical colonoscopy referrals

The 2017/18 year will focus on:

- Developing an analysis of demand vs current capacity at Waikato DHB and procurement of funds to deliver increased service
- Introduction of a nurse endoscopist and gastroenterology fellow to enable us to augment the clinician time available onsite to deliver the increasing number of scopes required due to the direct access criteria
- Recruitment of a clinical nurse specialist to ensure quality of service is met through global rating score compliance which will also enable us to be compliant for the introduction of Bowel screening in 2018/19

Data for urgent 30 days, non-urgent 90 days, and surveillance 120 days was not captured for the 2016/17 year. This will be looked at for the 2017/18 year.

Output measure

People receive timely and appropriate specialist care

Support services

Measures	Baseline 2015/16	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of people accepted for a **non-urgent** diagnostic colonoscopy will receive their procedure within **42 days**	49%	49%	70%	✗ 53%
Percentage of people accepted for a **non-urgent** diagnostic colonoscopy will receive their procedure within **90 days**	**Baseline not available**	New measure	100%	**Data not available**

Significance of measure

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

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

Waikato DHB performance

Waikato DHB has met the targets for urgent 14 days and surveillance 84 days; however, the target for non-urgent 42 days was not met, although the 2016/17 result is an improvement on the 2015/16 result.

There were a number of initiatives undertaken during 2016/17 which included:

- Use of the National Referral Criteria for direct access Outpatient Colonoscopy
- Worked regionally to improve access and timelines to colonoscopy procedures
- Standardised triage processes for surgical and medical colonoscopy referrals

The 2017/18 year will focus on:

- Developing an analysis of demand vs current capacity at Waikato DHB and procurement of funds to deliver increased service
- Introduction of a nurse endoscopist and gastroenterology fellow to enable us to augment the clinician time available onsite to deliver the increasing number of scopes required due to the direct access criteria
- Recruitment of a clinical nurse specialist to ensure quality of service is met through GRS compliance which will also enable us to be compliant for the introduction of Bowel screening in 2018/19

Data for urgent 30 days, non-urgent 90 days, and surveillance 120 days was not captured for the 2016/17 year. This will be looked at for the 2017/18 year.

People receive timely and appropriate specialist care

Support services

Output measure

Measures	Baseline 2016/17	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of people waiting for a surveillance colonoscopy will wait no longer than **84 days** beyond the planned date	70%	New measure	70%	✓ 70%
Percentage of people waiting for a surveillance colonoscopy will wait no longer than **120 days** beyond the planned date	**Baseline not available**	New measure	100%	Data not available

Significance of measure

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

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

Waikato DHB performance

Waikato DHB has met the targets for urgent 14 days and surveillance 84 days; however, the target for non-urgent 42 days was not met, although the 2016/17 result is an improvement on the 2015/16 result.

There were a number of initiatives undertaken during 2016/17 which included:

- Use of the National Referral Criteria for direct access Outpatient Colonoscopy
- Worked regionally to improve access and timelines to colonoscopy procedures
- Standardised triage processes for surgical and medical colonoscopy referrals

The 2017/18 year will focus on:

- Developing an analysis of demand vs current capacity at Waikato DHB and procurement of funds to deliver increased service
- Introduction of a nurse endoscopist and gastroenterology fellow to enable us to augment the clinician time available onsite to deliver the increasing number of scopes required due to the direct access criteria
- Recruitment of a clinical nurse specialist to ensure quality of service is met through GRS compliance which will also enable us to be compliant for the introduction of Bowel screening in 2018/19

Data for urgent 30 days, non-urgent 90 days, and surveillance 120 days was not captured for the 2016/17 year. This will be looked at for the 2017/18 year.

Output measure

People receive timely and appropriate specialist care

Support services

Measure	Baseline 2014/15	Previous year 2015/16	Target 2016/17	Result 2016/17
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	99.6%	✓ 100%

Significance of measure

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

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

Waikato DHB performance

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

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

Pathlab's clinical director and business manager are active participants on the Waikato Community Laboratory Clinical Governance group.

Microbiology sample.

Part 3 Financial statements

Crunching the numbers.

Statement of comprehensive revenue and expense

For the year ended 30 June 2017

	Note	Group 2017 Budget	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Revenue		**$000**	**$000**	**$000**	**$000**	**$000**
Patient care revenue	1	1,338,320	1,339,628	1,285,114	1,339,628	1,285,114
Other revenue	2	17,318	17,756	16,847	17,226	16,450
Finance revenue	3	1,505	1,839	1,882	1,675	1,709
Total income		1,357,143	1,359,223	1,303,843	1,358,529	1,303,273
Expenses						
Personnel costs	4	535,340	537,041	515,996	537,041	515,996
Depreciation	5	34,790	34,954	33,019	34,954	33,019
Amortisation	6	8,632	5,260	5,541	5,260	5,541
Outsourced services		59,949	78,419	61,715	78,419	61,715
Clinical supplies		136,527	135,538	128,997	135,538	128,997
Infrastructure and non-clinical expenses		73,512	75,491	63,103	75,491	63,103
Other district health boards		54,714	56,643	58,284	56,643	58,284
Non-health board providers		415,209	407,107	398,791	407,107	398,791
Other operating expenses	7	7,329	6,995	7,458	6,980	7,443
Finance costs	8	8,043	4,974	8,814	4,974	8,814
Capital charge	9	18,468	15,188	18,124	15,188	18,124
Total expenses		1,352,513	1,357,610	1,299,842	1,357,595	1,299,827
Share of associate surplus/(deficit)	10	-	(59)	28	(59)	28
Share of joint venture surplus/(deficit)	11	-	56	(40)	56	(40)
Surplus/(deficit)		4,630	1,610	3,989	931	3,434
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	176,237	-	176,237	-
Other comprehensive revenue and expense for the year		-	176,237	-	176,237	-
Total comprehensive revenue and expense for the year		4,630	177,847	3,989	177,168	3,434

Explanations of major variances to budget are provided in note 36.

The accompanying notes form part of the financial statements.

Statement of changes in equity

For the year ended 30 June 2017

	Note	Group 2017 Budget	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
		$000	$000	$000	$000	$000
Balance at 1 July		235,834	236,111	234,861	235,761	234,522
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		4,630	1,610	3,989	931	3,434
Other comprehensive revenue/(expense)		-	176,237	-	176,237	-
Total comprehensive revenue and expense for the year		4,630	177,847	3,989	177,168	3,434
Owner transactions						
Conversion of Crown loans to Crown equity		-	211,659	-	211,659	-
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	23	-	(747)	(545)	-	(1)
Balance at 30 June	12	238,270	622,676	236,111	622,394	235,761

Explanations of major variances to budget are provided in note 36.

The accompanying notes form part of the financial statements.

Statement of financial position

As at 30 June 2017

	Note	Group 2017 Budget $000	Group 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Assets						
Current assets						
Cash and cash equivalents	13	5,762	9,577	7,046	2,718	856
Receivables	14	31,921	51,789	31,709	51,749	31,679
Prepayments	15	6,468	16,144	6,404	16,144	6,404
Inventories	16	10,418	11,006	10,344	11,006	10,344
Non-current assets held for sale	17	40	-	40	-	40
Total current assets		54,609	88,516	55,543	81,617	49,323
Non-current assets						
Property, plant and equipment	5	562,108	708,995	544,622	708,995	544,622
Intangible assets	6	30,582	27,320	23,489	27,320	23,489
Investment in associate	10	59	-	59	-	59
Investment in joint venture	11	247	303	247	303	247
Total non-current assets		592,996	736,618	568,417	736,618	568,417
Total assets		647,605	825,134	623,960	818,235	617,740

	Note	Group 2017 Budget $000	Group 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Liabilities						
Current liabilities						
Derivative financial instruments	18	-	-	270	-	270
Borrowings	19	18,007	324	204	324	204
Employee entitlements	20	100,237	103,990	97,380	103,990	97,380
Trade and other payables under exchange transactions	21	51,728	64,157	47,906	64,143	47,892
Trade and other payables under non-exchange transactions	21	6,385	12,088	8,465	12,088	8,465
Provisions	22	518	845	756	845	756
Total current liabilities		176,875	181,404	154,981	181,390	154,967
Non-current liabilities						
Borrowings	19	211,926	678	212,131	678	212,131
Employee entitlements	20	14,740	13,505	14,637	13,505	14,637
Provisions	22	244	268	244	268	244
Restricted trust funds	23	5,550	6,603	5,856	-	-
Total non-current liabilities		232,460	21,054	232,868	14,451	227,012
Total liabilities		409,335	202,458	387,849	195,841	381,979
Net assets		238,270	622,676	236,111	622,394	235,761
Equity						
Crown equity (Contributed capital)	12	75,078	286,737	77,273	286,737	77,273
Revaluation reserve	12	84,951	261,188	84,951	261,188	84,951
Retained earnings (Accumulated surplus)	12	78,037	74,469	73,537	74,469	73,537
Trust funds	12	204	282	350	-	-
Total equity		238,270	622,676	236,111	622,394	235,761

Explanations of major variances to budget are provided in note 36.
The accompanying notes form part of the financial statements.

For and on behalf of the board

Bob Simcock, Chair
Waikato DHB, 25 October 2017

Sally Webb, Deputy Chair
Waikato DHB, 25 October 2017

Statement of cash flows

For the year ended 30 June 2017

	Note	Group 2017 Budget	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Cash flows from operating activities		$000	$000	$000	$000	$000
Operating receipts		1,355,525	1,348,237	1,298,079	1,347,708	1,297,682
Interest received		1,260	1,969	2,012	1,813	1,709
Payments to suppliers		(744,307)	(762,200)	(724,548)	(762,198)	(724,548)
Payments to employees		(533,530)	(531,229)	(515,678)	(531,215)	(515,665)
Interest paid		(8,645)	(6,221)	(9,095)	(6,221)	(9,095)
Payments for capital charge		(18,468)	(15,188)	(18,124)	(15,188)	(18,124)
Goods and services tax (net)		45	1,207	(321)	1,207	(321)
Net cash flows from operating activities	24	51,880	36,575	32,325	35,906	31,638
Cash flows from investing activities						
Purchase of property, plant and equipment		(42,189)	(23,116)	(14,305)	(23,116)	(14,305)
Purchase of intangible assets		(25,812)	(9,091)	(5,143)	(9,091)	(5,143)
Receipts from sale of property, plant and equipment		-	31	108	31	108
Net cash flows from investing activities		(68,001)	(32,176)	(19,340)	(32,176)	(19,340)

	Note	Group 2017 Budget	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Cash flows from financing activities		$000	$000	$000	$000	$000
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		17,804	600	-	600	-
Repayment of borrowings		(198)	(274)	(9,228)	(274)	(9,228)
Net cash flows from financing activities		15,412	(1,868)	(11,422)	(1,868)	(11,422)
Net increase/ (decrease) in cash and equivalents		(709)	2,531	1,563	1,862	876
Cash and cash equivalents at beginning of year		6,471	7,046	5,483	856	(20)
Cash and cash equivalents at end of year	13	5,762	9,577	7,046	2,718	856

Explanations of major variances to budget are provided in note 36.

The accompanying notes form part of the financial statements.

Notes to the financial statements

Statement of accounting policies

Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2017, and were authorised for issue by the board on 25 October 2017.

Basis of preparation

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

Statement of compliance

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

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

Presentation currency and rounding

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

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the Waikato DHB and group are:

Interests in other entities
In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6-8). The new standards are effective for annual periods beginning on or after 1 January 2019 with early application permitted.

These changes have no implication on the Waikato DHB and group.

Financial Instruments
In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

The Waikato DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Impairment of revalued assets
In April 2017, the XRB issued Impairement of Revalued Assets which now scopes in revalued property, plant and equipment into the impairement accounting standards. Previously only property, plant and equipment assets measured at cost were scoped into the impairement accounting standards. The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted.

The Waikato DHB plans to apply this standard in preparing its 30 June 2020 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

Subsidiaries

Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated

financial statements in relation to the economic entity for the financial year. Consolidated financial statements have been prepared to include Waikato Health Trust due to the control that Waikato DHB has over the appointment and removal of the Trustees of Waikato Health Trust. Transactions between Waikato DHB and the Waikato Health Trust have been eliminated for consolidation purposes.

Associates

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

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

Joint ventures

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

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

Budget figures

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

Revenue

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

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

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

Ministry of Health (MoH) population-based revenue

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

Ministry of Health (MoH) contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contracts. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of the revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contract revenue

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

Revenue from other district health boards

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Grants received

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

Donations and bequests
Donations and bequests to Waikato DHB are recognised as non-exchange revenue when control over the asset is obtained. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive revenue and expense. Volunteer services received are not recognised as revenue or expenses.

Capital charge

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

Borrowing costs

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

Leases

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

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Waikato DHB as lessor
A lease where Waikato DHB, as lessor, has in fact all the benefits and risks of ownership is designated as an operating lease; otherwise, such agreements are recognised as finance leases. Property, plant and equipment made available to third parties by means of an operating lease is recognised in accordance with the accounting standards for property, plant and equipment.

Lease revenue from operating leases shall be recognised as revenue on a straight-line basis over the lease term, unless another systematic basis is more representative of the time pattern in which benefits derived from the leased asset is diminished.

Initial direct costs incurred by Waikato DHB in negotiating and arranging an operating lease shall be added to the carrying amount of the leased asset, and recognised as an expense over the lease term on the same basis as the lease revenue.

Foreign currency transactions

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

Cash and cash equivalents

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

Receivables

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

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

Derivative financial instruments

Derivative financial instruments are used to manage exposure to foreign exchange risk arising from the group's operational activities. The group does not hold or issue financial instruments for trading purposes. The group has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost and adjusted where applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The amount of any write-down for the loss of service potential is recognised as an expense in the period of the write-down.

Non-current assets held for sale

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

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

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

Property, plant and equipment

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

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

Land and buildings

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

Revaluations

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

Land and buildings revaluation movements are classified on a class-of-asset basis.

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

Additions

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

Subsequent costs

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

Disposal

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

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as:

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

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

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

Intangible assets

Software acquisition and development

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

relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred.

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

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

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

Impairment of property, plant, equipment and intangible assets

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

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

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

If an asset's carrying amount exceeds its recoverable service amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in the movement of revaluation reserve in the statement of comprehensive revenue and expense 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 revenue and expense. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to movement in the revaluation reserve in the statement of comprehensive revenue and expense 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 surplus or deficit, a reversal of the impairment loss is recognised as revenue in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised as an expense in the statement of comprehensive revenue and expense.

Payables

Short term payables are recorded at their face value.

Borrowings

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

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

Employee entitlements

Short-term employee entitlements
Employee benefits that are due to be settled within twelve months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken, continuing medical education leave and sick leave.

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

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

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

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

Presentation of employee entitlements
Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within twelve months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

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

Defined benefit schemes
Employer contributions to the Defined Benefit Plan Contributors Scheme are a multi-employer defined benefit scheme managed by the Board of Trustees of the National Provident Fund. Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus or deficit of the scheme will affect future contributions by individual employers as there is no prescribed basis for the allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

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

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

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

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

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

Equity

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

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

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

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

Income tax

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

Goods and services tax (GST)

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST received from, or paid to, the Inland Revenue Department, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

Estimating useful lives and residual values of property, plant, and equipment
At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires Waikato DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset.

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

Retirement gratuities and long service leave
Note 20 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Critical judgements in applying accounting policies

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

Notes to the financial statements

1: Patient care revenue	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Non-exchange transactions	$000	$000	$000	$000
Health and disability services (Crown appropriation revenue)[1]	1,110,592	1,060,995	1,110,592	1,060,995
Other MoH and government revenue	27,773	27,175	27,773	27,175
Patient co-payments	1,575	1,139	1,575	1,139
Exchange transactions				
Health and disability services (MoH)	28,551	27,892	28,551	27,892
ACC contract revenue	14,084	16,535	14,084	16,535
Revenue from other district health boards	129,030	125,433	129,030	125,433
Clinical training agency revenue	11,357	11,083	11,357	11,083
Other patient care related revenue	16,666	14,862	16,666	14,862
Total patient care revenue	1,339,628	1,285,114	1,339,628	1,285,114

1. Performance against this appropriation is reported in the Statement of Performance on pages 37 to 128.

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

   The budgeted appropriation amount from the Ministry of Health for the current year is $1,088,800,000 (2016–$1,042,741,000).

2: Other revenue	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Non-exchange transactions				
Donations and bequests received	1,112	1,149	151	165
Grants received	-	-	431	587
Exchange transactions				
Rental revenue	1,193	1,148	1,193	1,148
Net gain on sale of property, plant and equipment	29	57	29	57
Other revenue	15,422	14,493	15,422	14,493
Total other revenue	17,756	16,847	17,226	16,450

Other revenue includes revenue from parking, cafeterias, drug trials and tutoring.

3: Finance revenue (exchange transactions)	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Interest revenue	1,839	1,882	1,675	1,709
Total finance revenue	1,839	1,882	1,675	1,709

4: Personnel costs	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Salaries and wages	515,888	499,071	515,888	499,071
Increase/(decrease) in liability for employee entitlements	5,478	2,188	5,478	2,188
Defined contribution plan employer contributions	15,675	14,737	15,675	14,737
Total personnel cost	537,041	515,996	537,041	515,996

5: Property, plant and equipment	Group Actual				
Movements for each class of property, plant and equipment are as follows:	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2015	29,525	491,162	204,853	3,694	729,234
Additions	-	-	-	14,305	14,305
Transfers	-	2,477	8,221	(10,698)	0
Disposals	-	-	(5,083)	-	(5,083)
Balance at 30 June 2016	29,525	493,639	207,991	7,301	738,456
Balance at 1 July 2016	29,525	493,639	207,991	7,301	738,456
Additions	-	-	-	23,116	23,116
Transfers	40	6,750	15,439	(22,189)	40
Disposals	-	-	(3,294)	-	(3,294)
Revaluation	14,911	95,582	-	-	110,493
Balance at 30 June 2017	44,476	595,971	220,136	8,228	868,811

5: Property, plant and equipment (continued)	Group Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2015	-	28,404	137,271	-	165,675
Depreciation charge for the year	-	18,379	14,640	-	33,019
Disposals	-	-	(4,860)	-	(4,860)
Balance at 30 June 2016	-	46,783	147,051	-	193,834
Balance at 1 July 2016	-	46,783	147,051	-	193,834
Depreciation charge for the year	-	18,961	15,993	-	34,954
Disposals	-	-	(3,228)	-	(3,228)
Revaluation adjustment	-	(65,744)	-	-	(65,744)
Balance at 30 June 2017	-	-	159,816	-	159,816
Carrying amounts					
At 1 July 2015	29,525	462,758	67,582	3,694	563,559
At 30 June 2016	29,525	446,856	60,940	7,301	544,622
At 1 July 2016	29,525	446,856	60,940	7,301	544,622
At 30 June 2017	44,476	595,971	60,320	8,228	708,995

5: Property, plant and equipment (continued)	Parent Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 2015	29,525	491,162	204,853	3,694	729,234
Additions	-	-	-	14,305	14,305
Transfers	-	2,477	8,221	(10,698)	-
Disposals	-	-	(5,083)	-	(5,083)
Balance at 30 June 2016	29,525	493,639	207,991	7,301	738,456
Balance at 1 July 2016	29,525	493,639	207,991	7,301	738,456
Additions	-	-	-	23,116	23,116
Transfers	40	6,750	15,439	(22,189)	40
Disposals	-	-	(3,294)	-	(3,294)
Revaluation adjustment	14,911	95,582	-	-	110,493
Balance at 30 June 2017	44,476	595,971	220,136	8,228	868,811

5: Property, plant and equipment (continued)	Parent Actual				
	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
Balance at 1 July 2015	-	28,404	137,271	-	165,675
Depreciation charge for the year	-	18,379	14,640	-	33,019
Disposals	-	-	(4,860)	-	(4,860)
Balance at 30 June 2016	-	46,783	147,051	-	193,834
Balance at 1 July 2016	-	46,783	147,051	-	193,834
Depreciation charge for the year	-	18,961	15,993	-	34,954
Disposals	-	-	(3,228)	-	(3,228)
Revaluation adjustment	-	(65,744)	-	-	(65,744)
Balance at 30 June 2017	-	-	159,816	-	159,816
Carrying amounts					
At 1 July 2015	29,525	462,758	67,582	3,694	563,559
At 30 June 2016	29,525	446,856	60,940	7,301	544,622
At 1 July 2016	29,525	446,856	60,940	7,301	544,622
At 30 June 2017	44,476	595,971	60,320	8,228	708,995

Valuation
The most recent valuation of land and buildings was carried out by P.D. Todd, an independent registered valuer with Darroch and a member of the New Zealand Institute of Valuers. The valuation was carried out at 30 June 2017.

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 intensively.

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

5: Property, plant and equipment (continued)

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

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Waikato DHB's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

Restrictions
Waikato DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Finance leases
The net carrying amount of plant, equipment and vehicles held under finance lease is $0.5 million (2016:0.3 million). Note 19 provides further information about finance leases.

Property, plant and equipment under construction
Buildings work in progress at 30 June 2017 is $4.5million (2016: $4.7million) and capital commitments is $5.5 million (2016: $6.1 million). Plant, equipment and vehicles work in progress at 30 June 2017 is $3.7million (2016: $2.6million) and capital commitments is $3.6 million (2016: $4.6 million).

6: Intangible assets

Group 2017 Actual	Internally generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2015	530	47,769	10,383	58,682
Additions	-	-	5,143	5,143
Disposals		(209)	-	(209)
Transfers	346	5,422	(5,768)	-
Balance at 30 June 2016	876	52,982	9,758	63,616
Balance at 1 July 2016	876	52,982	9,758	63,616
Additions	-	-	9,091	9,091
Transfers	92	1,584	(1,676)	-
Balance at 30 June 2017	968	54,566	17,173	72,707
Accumulated amortisation and impairment losses				
Balance at 1 July 2015	205	34,591	-	34,796
Amortisation charge for the year	40	5,501	-	5,541
Disposals	-	(209)	-	(209)
Reclassifications	-	(1)	-	(1)
Balance at 30 June 2016	245	39,882	-	40,127
Balance at 1 July 2016	245	39,882	-	40,127
Amortisation charge for the year	9	5,251	-	5,260
Balance at 30 June 2017	254	45,133	-	45,387
Carrying amounts				
At 1 July 2015	325	13,178	10,383	23,886
At 30 June 2016	631	13,100	9,758	23,489
At 1 July 2016	631	13,100	9,758	23,489
At 30 June 2017	714	9,433	17,173	27,320

6: Intangible assets

	Parent 2017 Actual			
	Internally generated	Other	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2015	530	47,769	10,383	58,682
Additions	-	-	5,143	5,143
Transfers	346	5,422	(5,768)	-
Disposals	-	(209)	-	(209)
Balance at 30 June 2016	876	52,982	9,758	63,616
Balance at 1 July 2016	876	52,982	9,758	63,616
Additions	-	-	9,091	9,091
Transfers	92	1,584	(1,676)	-
Balance at 30 June 2017	968	54,566	17,173	72,707
Accumulated amortisation and impairment losses				
Balance at 1 July 2015	205	34,591	-	34,796
Amortisation charge for the year	40	5,501	-	5,541
Disposals	-	(209)	-	(209)
Reclassifications	-	(1)	-	(1)
Balance at 30 June 2016	245	39,882	-	40,127
Balance at 1 July 2016	245	39,882	-	40,127
Amortisation charge for the year	9	5,251	-	5,260
Balance at 30 June 2017	254	45,133	-	45,387
Carrying amounts				
At 1 July 2015	325	13,178	10,383	23,886
At 30 June 2016	631	13,100	9,758	23,489
At 1 July 2016	631	13,100	9,758	23,489
At 30 June 2017	714	9,433	17,173	27,320

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 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	**$000**	**$000**	**$000**
Net impairment of trade receivables	319	512	319	512
Audit fees for the audit of the financial statements	226	220	213	207
Audit related fees for assurance and internal audits	239	10	239	10
Board members' remuneration and expenses	337	356	337	356
Koha and donations	20	29	20	29
Operating lease expenses	6,058	5,889	6,056	5,887
Net change in fair value of forward foreign exchange contracts	(268)	270	(268)	270
Loss on disposal of property, plant and equipment	64	172	64	172
Total other operating expenses	6,995	7,458	6,980	7,443

Waikato DHB pays audit fees for the audit of financial statement to Audit New Zealand. The total amount for the period ended 30 June 2017 was $212,707 (2016: $207,315).

8: Finance costs

	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	**$000**	**$000**	**$000**
Interest and financing expenses	4,974	8,814	4,974	8,814
Total finance cost	4,974	8,814	4,974	8,814

9: Capital charge

	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	**$000**	**$000**	**$000**
Capital charge	15,188	18,124	15,188	18,124
Total capital charge	15,188	18,124	15,188	18,124

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 2017 was initially 8% decreasing to 6% in the course of the year (2016: 8%).

10: Investment in associate

a: General information

Name of entity	Principal activities	Interest held at 30 June 2016	Balance date
Urology Services Limited	Provision of urology services	50%	30 June

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

2017 Actual	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
Urology Services Limited	27	26	1	1,605	(117)
	27	26	1	1,605	(117)
2016 Actual					
Urology Services Limited	1,646	1,528	118	6,549	56
	1,646	1,528	118	6,549	56

c: Share of profit of associate (50%)	Group 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Share of profit before tax	(59)	28	(59)	28
Less: Tax expense	-	-	-	-
Share of profit after tax	(59)	28	(59)	28
d: Investment in associate (50%)				
Carrying amount at beginning of year	59	31	59	31
Share of associate surplus/(deficit)	(59)	28	(59)	28
Carrying amount at end of year	-	59	-	59

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

11: Investments in joint venture

a: General information

Name of entity	Principal activities	Interest held at 30 June 2017	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b: Carrying amount of investment	Group 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Opening balance	247	287	247	287
Share of joint venture surplus/(deficit)	56	(40)	56	(40)
Closing balance	303	247	303	247
c: Summary of Waikato DHB's interests in HealthShare Limited (20%)				
Current assets	642	702	642	702
Non-current assets	2,351	2,298	2,351	2,298
Current liabilities	(1,164)	(1,438)	(1,164)	(1,438)
Non-current liabilities	(1,526)	(1,315)	(1,526)	(1,315)
Net assets	303	247	303	247
Revenue	2,736	2,418	2,736	2,418
Expenses	(2,680)	(2,458)	(2,680)	(2,458)
Share of surplus/(deficit) of joint venture	56	(40)	56	(40)

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 2015	340	79,467	83,411	71,644	234,862
Total comprehensive revenue/(expense)	555	-	-	3,434	3,989
Reclassification of revaluation reserve	-	-	1,540	(1,540)	-
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted fund	(545)	-	-	-	(545)
Other movement	-	-	-	(1)	(1)
Balance at 30 June 2016	350	77,273	84,951	73,537	236,111
Balance at 1 July 2016	350	77,273	84,951	73,537	236,111
Total comprehensive revenue/(expense)	679	-	176,237	931	177,847
Conversion of Crown loans to Crown equity	-	211,659	-	-	211,659
Transfer to restricted fund	(747)	-	-	-	(747)
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Other movement	-	(1)	-	1	-
Balance at 30 June 2017	282	286,737	261,188	74,469	622,676

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 2015	79,467	83,411	71,644	234,522
Total comprehensive revenue/(expense)	-	-	3,434	3,434
Reclassification of Revaluation Reserve	-	1,540	(1,540)	-
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	-	-	(1)	(1)
Balance at 30 June 2016	77,273	84,951	73,537	235,761
Balance at 1 July 2016	77,273	84,951	73,537	235,761
Total comprehensive revenue/(expense)	-	176,237	931	177,168
Conversion of Crown loans to Crown equity	211,659	-		211,659
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	(1)	-	1	-
Balance at 30 June 2017	286,737	261,188	74,469	622,394

Trust funds

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

Transactions between Waikato DHB and Waikato Health Trust are disclosed in note 30.

13: Cash and cash equivalents	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Cash at bank and on hand	215	45	215	45
Advance to New Zealand Health Partnerships Limited	2,503	811	2,503	811
Trust funds	6,859	6,190	-	-
Total cash and cash equivalents	9,577	7,046	2,718	856

14: Receivables	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Ministry of Health trade receivables	6,588	1,684	6,588	1,684
Other trade receivables	4,812	5,479	4,772	5,449
Total trade receivables	11,400	7,163	11,360	7,133
Ministry of Health accrued revenue	27,149	17,745	27,149	17,745
Other accrued revenue	13,240	6,801	13,240	6,801
Total receivables	51,789	31,709	51,749	31,679
Total receivables comprises:				
Receivables from non-exchange transactions	11,632	8,310	11,632	8,310
Receivables from exchange transactions	40,157	23,399	40,117	23,369

Receivables and accrued revenue are shown net of impairment losses (provision for doubtful debts) amounting to $1.05 million (2016:$1.03 million). The carrying value of debtors and other receivables approximates their fair value.

The ageing profile of receivables and their impairment is:

14: Receivables (continued)	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Receivables - gross	$000	$000	$000	$000
Not past due	43,878	27,175	43,838	27,145
Past due 0-30 days	1,398	2,767	1,398	2,767
Past due 31-120 days	6,184	871	6,184	871
Past due 121-360 days	385	1,034	385	1,034
Past due more than 1 year	994	889	994	889
	52,839	32,736	52,799	32,706
Receivables - impairment	$000	$000	$000	$000
Not past due	-	-	-	-
Past due 0-30 days	139	78	139	78
Past due 31-120 days	133	143	133	143
Past due 121-360 days	275	520	275	520
Past due more than 1 year	503	286	503	286
	1,050	1,027	1,050	1,027
Net Receivables	$000	$000	$000	$000
Not past due	43,878	27,175	43,838	27,145
Past due 0-30 days	1,259	2,689	1,259	2,689
Past due 31-120 days	6,051	728	6,051	728
Past due 121-360 days	110	514	110	514
Past due more than 1 year	491	603	491	603
	51,789	31,709	51,749	31,679

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

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

14: Receivables (continued)	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Movements in provision for impairment of trade receivables are as follows:	$000	$000	$000	$000
At 1 July	1,027	542	1,027	542
Additional provisions made during the year	11	511	11	511
Receivables written off during the year	(4)	(77)	(4)	(77)
Receivables recovered during the year	16	51	16	51
At 30 June	1,050	1,027	1,050	1,027

15: Prepayments	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Prepayments	16,144	6,404	16,144	6,404
Total prepayments	16,144	6,404	16,144	6,404

16: Inventories	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Pharmaceuticals	1,077	1,083	1,077	1,083
Surgical and medical supplies	9,188	8,409	9,188	8,409
Other supplies	741	852	741	852
Total inventories	11,006	10,344	11,006	10,344

The amount of inventories recognised as revenue due to change in stock value during the year was -$210,524 (2016: $1,104,000), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $32,000 for 2017 (2016 $102,000). There have been no reversals of write-downs. The provision for obsolete inventories adjustment recognised in the statement of comprehensive revenue and expense for the year ended 30 June 2017 was $Nil (2016 $Nil). No inventories are pledged as security for liabilities.

17: Non-current assets held for sale

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

Non-current assets held for sale	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Land	-	40	-	40
Total non-current assets held for sale	-	40	-	40

18: Derivative Financial Instruments

The notional principal amount of outstanding forward foreign exchange contracts in NZ$ was $ Nil (2016: $5.98 million). The foreign currency principal amounts were $ Nil (2016: USD4.2 million).

The fair values of forward foreign exchange contracts have been determined using a discounted cash flows valuation technique based on quoted market price. The inputs into the valuation model are from independently sourced market parameters such as currency rates.

19: Borrowings	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Current portion	$000	$000	$000	$000
Loan from Energy Efficiency and Conservation Authority	104	104	104	104
Finance leases	220	100	220	100
	324	204	324	204
Non-current portion				
Crown loans	-	211,658	-	211,658
Loan from Energy Efficiency and Conservation Authority	169	274	169	274
Finance leases	509	199	509	199
	678	212,131	678	212,131
Loan facility limits				
Crown loans	-	211,658	-	211,658

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Capital equity injections. The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date. As a consequence of the changes there has been a decrease in DHB revenue 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

19:Borrowings (continued)

Analysis of finance leases	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Minimum lease payments payable	$000	$000	$000	$000
No later than one year	220	100	220	100
Later than one year and not later than five years	509	199	509	199
Later than five years	-	-	-	-
Total minimum lease payments	729	299	729	299
Future finance charges	(73)	(45)	(73)	(45)
Present value of minimum lease payments	656	254	656	254
Present value of minimum lease payments payable:				
No later than one year	214	99	214	99
Later than one year and not later than five years	442	155	442	155
Later than five years	-	-	-	-
Total present value of minimum lease payments	656	254	656	254

19:Borrowings (continued)

Finance leases

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

The fair value of finance leases is $656,000 (2016: $254,000). Fair value has been determined by using a discount rate of 2.6% (2016:4.59%).

Description of finance leases

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

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

20: Employee entitlements	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Current portion	$000	$000	$000	$000
Liability for long service leave	2,608	2,786	2,608	2,786
Liability for retirement gratuities	3,083	2,940	3,083	2,940
Liability for annual leave	65,967	61,631	65,967	61,631
Liability for sick leave	1,325	1,325	1,325	1,325
Liability for continuing medical education leave and expenses	9,826	11,394	9,826	11,394
PAYE payable	5,052	4,837	5,052	4,837
Salary and wages accrual	16,129	12,467	16,129	12,467
	103,990	97,380	103,990	97,380
Non-current portion				
Liability for long service leave	1,723	1,509	1,723	1,509
Liability for sabbatical leave	3,919	3,682	3,919	3,682
Liability for retirement gratuities	7,863	9,446	7,863	9,446
	13,505	14,637	13,505	14,637

20: Employee entitlements (continued)

Key assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advise from an independent actuary. Two discount rates for retirement and long service leave are used, 2.7% and 2.0% respectively (2016:2.2% and 2.2% respectively) and a salary inflation factor of 3.0% (2016:3.0%).

If the discount rate were to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.6 million higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.6 million higher/lower.

21: Trade and other payables

	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	$000	$000	$000
Payables under exchange transactions				
Creditors	60,285	47,739	60,271	47,725
Revenue received in advance	3,872	167	3,872	167
Total payables under exchange transactions	64,157	47,906	64,143	47,892
Payables under non-exchange transactions				
ACC levy payable	899	637	899	637
GST payable	7,547	6,340	7,547	6,340
Accrual - non exchange expenses	3,642	1,488	3,642	1,488
Total payables under non-exchange transactions	12,088	8,465	12,088	8,465
Total payables	76,245	56,371	76,231	56,357

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.

22: Provisions

	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	598	512	598	512
Motor vehicle repairs on disposal	247	244	247	244
	845	756	845	756
Non-current liabilities				
Motor vehicle repairs on disposal	268	244	268	244
	268	244	268	244

Movements for each class of provision	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2015	514	708	1,222
Additional provisions made	411	(54)	357
Amounts used	(413)	(166)	(579)
Balance at 30 June 2016	512	488	1,000
Balance at 1 July 2016	512	488	1,000
Additional provisions made/ released	499	(145)	354
Amounts used	(413)	172	(241)
Balance at 30 June 2017	598	515	1,113

22: Provisions (continued)

ACC Partnership Programme

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

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

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

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

An external independent actuarial valuer, Aon Hewitt, has calculated the ACC Partnership Programme liability as at 30 June 2017. The valuer has attested that they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the valuer's report.

A prudent margin of 15% (2016:11%) 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 1.7% per annum (2016:1.7%); and
- a discount factor of 2.8% for 30 June 2017 (2016:2.5%).

Motor vehicle repairs on disposal

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

23: Restricted trust funds

	Group 2017 Actual	Group 2016 Actual
	$000	$000
Movements are as follows:	**Waikato Health Trust**	**Waikato Health Trust**
Balance at 1 July	5,856	5,311
Transfer from accumulated funds	747	545
Balance at 30 June	6,603	5,856

The restricted trust funds represent the reserved funds held by the Waikato Health Trust. Reserved and partially reserved funds are donated or bequeathed for specific purposes. The Trustees are required to manage these funds in accordance with the trust deed or the wishes of the donor. Partially reserved funds are externally bequeathed and bound by specific governing statements. Fully reserved funds are funds externally bequeathed that are held in perpetuity. The fund is not reduced and interest earned is transferred to a general fund where distributions can be made.

Transactions between Waikato DHB and Waikato Health Trust are disclosed in note 30.

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

	Note	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
		$000	$000	$000	$000
Net surplus/(deficit)		1,610	3,989	931	3,434
Add/(less) non-cash items:					
Depreciation	5	34,954	33,019	34,954	33,019
Amortisation	6	5,260	5,541	5,260	5,541
Bad and doubtful debts	14	11	511	11	511
Share of associate (surplus)/deficit	10	59	(28)	59	(28)
Share of joint venture (surplus)/deficit	11	(56)	40	(56)	40
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	2, 7	35	115	35	115
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	16	(662)	(407)	(662)	(407)
(Increase)/decrease in gross receivables	14	(20,091)	(2,658)	(20,081)	(2,788)
(Increase)/decrease in prepayments	15	(9,740)	3,694	(9,740)	3,694
Increase/(decrease) in employee entitlements	20	5,478	2,188	5,478	2,188
Increase/(decrease) in trade and other payables	21	19,874	(13,727)	19,874	(13,729)
Increase/(decrease) in other provisions	22	113	(222)	113	(222)
Increase/(decrease) in derivative financial instruments	18	(270)	270	(270)	270
Net cash flows from operating activities		36,575	32,325	35,906	31,638

The termination and conversion to equity of all existing Crown loans in February 2017 amounting to $211.7 million (2016: $Nil) was completed by a non-cash transaction, other than interest due at conversion date.

25: Capital commitments and operating leases	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Capital commitments	**$000**	**$000**	**$000**	**$000**
Buildings	5,477	6,134	5,477	6,134
Plant, equipment and vehicles	3,628	4,641	3,628	4,641
Intangible assets	816	950	816	950
Total capital commitments	9,921	11,725	9,921	11,725

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

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

	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
	$000	**$000**	**$000**	**$000**
Not later than one year	6,596	4,436	6,596	4,436
Later than one year and not later than five years	23,689	4,309	23,689	4,309
Later than five years	7,967	67	7,967	67
	38,252	8,812	38,252	8,812

Waikato DHB leases a number of buildings, vehicles and office equipment under operating leases. The leases typically run for a period of 3-35 years for buildings, 1-3 years for office equipment and 6 years for vehicles. In the case of leased buildings, lease payments are adjusted every 1-11 years to reflect market rentals. None of the leases includes contingent rentals.

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

26: Contingencies	Group 2017 Actual	Group 2016 Actual	Parent 2017 Actual	Parent 2016 Actual
Contingent liabilities	**$000**	**$000**	**$000**	**$000**
Personal grievances	200	495	200	495
	200	495	200	495

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 2017 (2016:$Nil).

27: Client funds

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

	2017 Actual	2016 Actual
	$000	**$000**
Balance at 1 July	20	19
Receipts	82	89
Payments	(77)	(88)
Balance at 30 June	25	20

28: Financial instruments

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

Credit risk

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

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

Concentrations of credit risk from trade receivables are limited due to ACC and Ministry of Health being the largest single debtors (7% and 53% respectively, at 30 June 2017). They are assessed to be a low risk and high-quality entity due to their nature as the government funded purchaser of health and disability support services.

Liquidity risk

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

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

Accounting policies for financial instruments have been applied to the line items below:

	Group		Parent	
Financial Instrument categories	**2017 Actual $000**	**2016 Actual $000**	**2017 Actual $000**	**2016 Actual $000**
Cash and cash equivalents	9,577	7,046	2,718	856
Receivables	51,789	31,709	51,749	31,679
Total loans and receivables	61,366	38,755	54,467	32,535
Fair value through surplus or deficit				
Derivative financial instrument liability	-	270	-	270
Total derivative financial instrument liability	-	270	-	270
Other financial liabilities				
Trade and other payables	76,245	56,371	76,231	56,357
Borrowings - loans	1,002	212,335	1,002	212,335
Total other financial liabilities	77,247	268,706	77,233	268,692

Credit quality of financial assets

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

	Group		Parent	
Counterparties with credit ratings	**2017 Actual $000**	**2016 Actual $000**	**2017 Actual $000**	**2016 Actual $000**
Cash and cash equivalents				
AA	48	45	48	45
AA-	7,026	6,190	167	-
Total cash and cash equivalents	7,074	6,235	215	45
Counterparties without credit ratings				
New Zealand Health Partnership Limited	2,503	811	2,503	811
Receivables				
Counterparty with no defaults in the past	51,499	31,465	51,459	31,435
Counterparty with defaults in the past	290	244	290	244
Total receivables	51,789	31,709	51,749	31,679

	Group 2017 Actual						
	Balance sheet $000	**Contractual cash flow $000**	**6 months or less $000**	**6-12 months $000**	**1-2 years $000**	**2-5 years $000**	**More than 5 years $000**
Loans from Energy Efficiency and Conservation Authority	273	273	52	52	93	76	-
Trade and other payables	76,245	76,245	76,245	-	-	-	-
	76,518	76,518	76,297	52	93	76	-

	Parent 2017 Actual						
	Balance sheet $000	**Contractual cash flow $000**	**6 months or less $000**	**6-12 months $000**	**1-2 years $000**	**2-5 years $000**	**More than 5 years $000**
Loans from Energy Efficiency and Conservation Authority	273	273	52	52	93	76	-
Trade and other payables	76,231	76,231	76,231	-	-	-	-
	76,504	76,504	76,283	52	93	76	-

28: Financial instruments (continued)

Market risk

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

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market interest rates. Waikato DHB's exposure to fair value interest rate risk is limited to its cash balance held under a contract with New Zealand Health Partnership Limited (NZHPL) through a national DHB shared banking arrangement. NZHPL 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.

Group 2016 Actual

	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,658	211,658	-	-	-	211,658	-
Loans from Energy Efficiency and Conservation Authority	378	378	52	52	104	170	-
Trade and other payables	56,371	56,371	56,371	-	-	-	-
	268,407	268,407	56,423	52	104	211,828	-

Parent 2016 Actual

	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000	$000
Crown loans	211,658	211,658	-	-	-	211,658	-
Loans from Energy Efficiency and Conservation Authority	378	378	52	52	104	170	-
Trade and other payables	56,357	56,357	56,357	-	-	-	-
	268,393	268,393	56,409	52	104	211,828	-

Fair value interest rate sensitivity analysis

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

At 30 June 2017, it is estimated that a general increase of one percentage point in interest rates would decrease the group surplus by approximately $95,000 (2016:$70,000).

Currency risk

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

Waikato DHB's currency risk is mainly limited to purchases of large clinical equipment from overseas and licence payments. 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.

The group has no unhedged foreign-denominated payables at balance date (2016: $ 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.

29: Capital management

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

30: Related parties

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

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

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 $1.14 billion (2016:$1.12 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2017 was $33.7 million (2016:$19.4 million). Waikato DHB incurred a capital charge of $15.2 million (2016:$18.1 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 2017 of $14.1 million (2016:$16.5 million) to provide health services.

Revenue earned from other DHBs for the care of patients outside of the Waikato DHB district for the year ended 30 June 2017 was $129 million (2016:$125.8 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2017 was $56.6 million (2016:$58 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 2017 totalled $15.7 million (2016$14.6 million). These purchases included the purchase of electricity from Genesis Power NZ, 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.

30: Related parties (continued)

As at 30 June 2017, HealthShare Limited had total assets of $14.940 million (2016:$15.001 million) and total liabilities of $13.453 million (2016:$13.735 million).

During the year Waikato DHB received $1,254,000 (2016: $845,000) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $5,640,000 (2016:$5,501,000) for services provided.

As at 30 June 2017 Waikato DHB owed Healthshare Limited $705,000 (2016: $ Nil) and Healthshare Limited owed Waikato DHB $710,000 (2016: $1,540,000).

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.

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

No dividends have been received from Urology Services Limited. During the period Waikato DHB received inpatient urological services from Urology Services Limited of $1.6 million (2016: $5.8 million). Waikato DHB received facility and management service fees of $0.9 million (2016: $3.2 million) from Urology Services Limited. During the period Waikato DHB's share of revenue amounted to $0.8 million (2016:$3.27 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 2016 are Pippa Mahood, Lydia Aydon and Maureen Chrystall. The purpose of the Trust is to fund health or disability services, related services or projects, health research or education and other appropriate health related purposes within the communities served by Waikato DHB.

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $0.431 million (2016:$0.599 million). There was $Nil owing to Waikato District Health Board at 30 June 2017 (2016:$Nil).

NZ Health Partnerships Limited
NZ Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2016:6,948,005) shares being 10.17% (2016:10.17%). Waikato District Health Board does not have a controlling interest in New Zealand Health Partnership Limited.

31: Key management personnel remuneration

Compensations
There were no loans to board members during the year ended 30 June 2017 (2016:$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 2017 (2016:$Nil).

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

	2017 Actual	2016 Actual
	$000	$000
Board members		
Salaries and other short-term benefits	327	348
Contributions to superannuation schemes	-	-
Full-time equivalent members	11	11
Executive management team		
Salaries and other short-term benefits	4,615	4,152
Contributions to superannuation schemes	159	143
Full-time equivalent members	18	18

Due to the difficulty in determining the full-time equivalent for Board members, the full-time equivalent figure is taken as the number of Board members. Total remuneration and compensation to close members of the family of key management personnel occurred within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the Waikato DHB would have adopted if dealing with that individual at arm's length in the same circumstances. An executive management restructure was undertaken that added four new key management personnel. These were recruited to around February 2016, and the full year effect of these appointments appears in this financial year, compared to only a part year cost being reported in the prior financial year.

31 :Key management personnel remuneration (continued)

Board members	No. of meetings eligible to attend 2017	No. of meetings actually attended 2017*	Remuneration 2017 Actual	Remuneration 2016 Actual
			$	$
Bob Simcock (Chairman)	25	20	54,750	56,250
Sally Christie (Deputy Chair)	19	16	30,156	36,750
Sally Webb (Deputy Chair) (new)	15	12	17,938	-
Crystal Beavis	22	21	27,813	29,563
Phillippa Mahood	17	16	26,750	27,250
Andrew Buckley	10	9	11,625	30,000
Martin Gallagher	19	19	27,250	28,000
Sharon Mariu	19	18	27,438	27,563
Clyde Wade	19	19	27,125	27,750
Ewan Wilson	4	4	6,875	27,750
Gay Shirley	9	9	11,750	29,000
Tania Hodges	17	12	26,250	27,750
Mary-Anne Gill (new)	10	10	15,625	-
Dave Macpherson (new)	12	11	16,125	-
			327,470	347,626

* No. of Meetings Actually Attended does not include committee meetings Board members voluntarily attended.

31 :Key management personnel remuneration (continued)

Non-board members who attended committee meetings	No. of meetings eligible to attend 2017	No. of meetings actually attended 2017	Remuneration 2017 Actual	Remuneration 2016 Actual
			$	$
Mark Arundel	1	1	250	-
Yvonne Boyes	1	1	250	500
Mary Burdon	4	1	250	1,500
Janise Eketone	5	2	500	250
Alisa Gathergood	4	1	250	1,250
Robyn Klos	1	-	-	1,500
Ross Lawrenson	-	-	-	2,000
Paul Malpass	4	3	750	1,500
Kahu McClintock	1	1	250	-
John McIntosh	5	4	1,000	1,750
Fungai Mhlanga	5	4	1,000	2,250
Ken Price	4	1	250	250
Anna Rolleston	1	1	250	-
Ron Scott	4	1	250	1,500
David Slone	5	2	500	2,500
David Stewart	-	-	-	500
Te Pora Thompson-Evans	2	2	500	-
Glen Tupuhi	1	1	250	-
Judy Turner	4	1	250	750
Rob Vigor-Brown	1	1	250	750
Ned Wikaira	-	-	-	1,000
			7,000	19,750

32: Employee remuneration

Employee remuneration over $100,000 ($10,000 bands)	2017 Actual	2016 Actual
100,001 - 110,000	139	126
110,001 - 120,000	96	97
120,001 - 130,000	82	65
130,001 - 140,000	48	52
140,001 - 150,000	32	30
150,001 - 160,000	35	25
160,001 - 170,000	26	22
170,001 - 180,000	16	24
180,001 - 190,000	17	20
190,001 - 200,000	13	20
200,001 - 210,000	27	22
210,001 - 220,000	24	19
220,001 - 230,000	21	22
230,001 - 240,000	22	22
240,001 - 250,000	17	21
250,001 - 260,000	24	16
260,001 - 270,000	15	21
270,001 - 280,000	23	19
280,001 - 290,000	19	16
290,001 - 300,000	17	11
300,001 - 310,000	16	13
310,001 - 320,000	17	20
320,001 - 330,000	13	16
330,001 - 340,000	10	3
340,001 - 350,000	9	10
350,001 - 360,000	2	6
360,001 - 370,000	6	4
370,001- 380,000	1	2

32: Employee remuneration (continued)

Employee remuneration over $100,000 ($10,000 bands)	2017 Actual	2016 Actual
380,001 - 390,000	3	1
390,001 - 400,000	1	3
400,001 - 410,000	1	2
410,001 - 420,000	3	-
420,001 - 430,000	2	1
430,001 - 440,000	-	1
440,001 - 450,000	1	-
470,001 - 480,000	-	1
530,001 - 540,000	-	1
560,001 - 570,000	2	1
630,001 - 640,000	1	-
640,001 - 650,000	1	-
650,001 - 660,000	-	1
	802	756

Of the 802 (2016:756) employees shown above, 84% or 674 (2016:651) are or were clinical employees.

In 2017, payments on termnation of employment such as annual leave due, excluding severance pay, have beeen included in the calculations, and 2016 has been restated accordingly. The remuneration of the Chief Executive for the year ended 30 June 2017 was in the $560,001 to $570,000 band (2016:$560,001 - $570,000). Unlike the other employees shown above, the remuneration of the Chief Executive is calculated on a total remuneration basis and includes non-monetary benefits. Remuneration does not include operational costs relating to the role.

Termination payments

During the year the Board made payments to 25 employees (2016:25) in respect of the termination of employment with Waikato DHB.

	2017 Actual	2016 Actual
	$000	$000
Amount paid	700	617

33: Waikids early childhood centre – Waikato Hospital

Summary of transactions relating to Waikids	Group 2017 Actual $000	Group 2016 Actual $000	Parent 2017 Actual $000	Parent 2016 Actual $000
Subsidy Funding - Ministry of Education	259	48	259	48
Equity funding - Ministry of Education	41	8	41	8
Other income	1	3	1	3
Personnel costs	(117)	(63)	(117)	(63)
Minor equipment purchases	(16)	(6)	(16)	(6)
Administration costs	(2)	(2)	(2)	(2)
Surplus/(Deficit) for the year	166	(12)	166	(12)
Bank and cash	167	64	167	64
Receivables	2	-	2	-
Accounts payable	-	(61)	-	(61)
Net current assets	169	3	169	3
Accumulated surplus	169	3	169	3

Waikids early childhood centre is a hospital based play specialist service operated by the Waikato District Health Board within the Waikato Hospital, funded primarily by the Ministry of Education.

Waikato DHB supports the centre through provision of building, facilities and general administration. Expenses do not include these costs.

34: Subsequent event

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

35: Comparative information

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

36: Explanation of financial variances from budget

Waikato DHB recorded a net comprehensive surplus of $177.8 million against its budgeted surplus of $4.6 million. Explanations of major variances are:

Variances in comprehensive revenue and expenses
Waikato DHB recorded a $173.2 million favourable variance to budget. This includes a revaluation of land and buildings amounting to $176.2 million. The variance to budget (excluding revaluation reserve movement) is $3.0 million unfavourable. This includes:

- revenue was $2.1 million favourable mainly due to additional funding for extra health services delivered together with reimbursement of specific costs incurred (offset in expenses)
- interest, depreciation, amortisation and capital charge cost is $9.6 million favourable due mainly to a decrease in charges from MoH relating to capital charge and interest due (offset in revenue) and lower depreciation due to the timing of IS capitalisations
- personnel costs are $1.7 million unfavourable mainly due to annual leave not taken
- outsourced services and personnel are $18.5 million unfavourable due to higher outsourcing of clinical services to meet elective targets (partially offset in favourable variances in clinical supplies), and cost of contractors to cover specific external projects (offset in revenue)
- clinical supplies are $1.0 million favourable mainly due to lower than planned spend on treatment disposables, pharmaceuticals and implant and prosthesis, partially offset in unfavourable outsourced services
- other operating expenses are $4.5 million favourable due to variances against a wide range of costs

Variances in statement of changes in equity
The surplus was $173.2 million favourable to budget due to the statement of comprehensive revenue and expense explanations provided above.

Variances in financial position
Current assets are $33.9 million higher than budget. This includes:

- Cash and cash equivalents higher than budget $3.8 million due to timing of payments
- Prepayments higher than budget $9.7 million due to contracts entered into requiring payment upfront
- Receivables higher than budget $19.9 million due to timing of funds received against budget assumptions

Current liabilities are $4.5 million higher than budget due to a range of accruals for multiple creditors tracking higher than budget.

Non-current assets are $143.6 million higher than budget due to revaluation of land and buildings $176.2 million, offset by slower than planned capital expenditure.

Non-current liabilities are $211.4 million lower than budget mainly due to a national debt to equity swap for all district health boards.

Variances in cash flows

- Net cash flows from operating activities are $15.3 million lower than budget partly due to higher outsourcing of clinical services to meet elective targets.
- Net cash flows from investing activities are $35.8 million lower than budgeted due to slower than planned capital spend.
- Net cash flows from financing activities are $17.3 million lower than budgeted due to budgeted long term loan not drawn down.

Part 4 Audit report

Checking the balances.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Waikato District Health Board's group financial statements and performance information for the year ended 30 June 2017

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

We have audited:

- the financial statements of the Group on pages 130 to 161, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 22 to 27 and 38 to 126.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Group on pages 130 to 161:

- present fairly, in all material respects:
  - its financial position as at 30 June 2017; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the Group (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The Group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the Group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Group on pages 22 to 27 and 38 to 126:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 25 October 2017. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis for our opinion

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

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

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

Responsibilities of the Board for the financial statements and the performance information

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

The Board is responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Group or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieved fair presentation.

- We obtain sufficient appropriate evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 21 and 28 to 36, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than the audit, we have no relationship with, or interests in, the Group.

B H Halford
Audit New Zealand
On behalf of the Auditor-General
Tauranga, New Zealand