Waikato District Health Board 2017-18 Annual Report

For the year ended 30 June 2018

PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 150(3) OF THE CROWN ENTITIES ACT 2004

Waikato District Health Board

Statement of responsibility for the year ended 30 June 2018

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 2017-18 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 DHBs 2017-18 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/about-us/key-publications/

The Board and management of Waikato District Health Board accept responsibility for the preparation of the financial statements and Statement of Service Performance for the year ended 30 June 2018 and the judgements used in them.

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

In the opinion of the Board and management of Waikato District Health Board, the financial statements and the Statement of Service Performance for the year ended 30 June 2018 fairly reflect the financial position and operations of Waikato District Health Board.

Signed on behalf of the Board

Sally Webb
Board Chair
Waikato District Health Board

24 October 2018

Sharon Mariu
Chair of Audit and Corporate Risk Management Committee
Waikato District Health Board
24 October 2018

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.

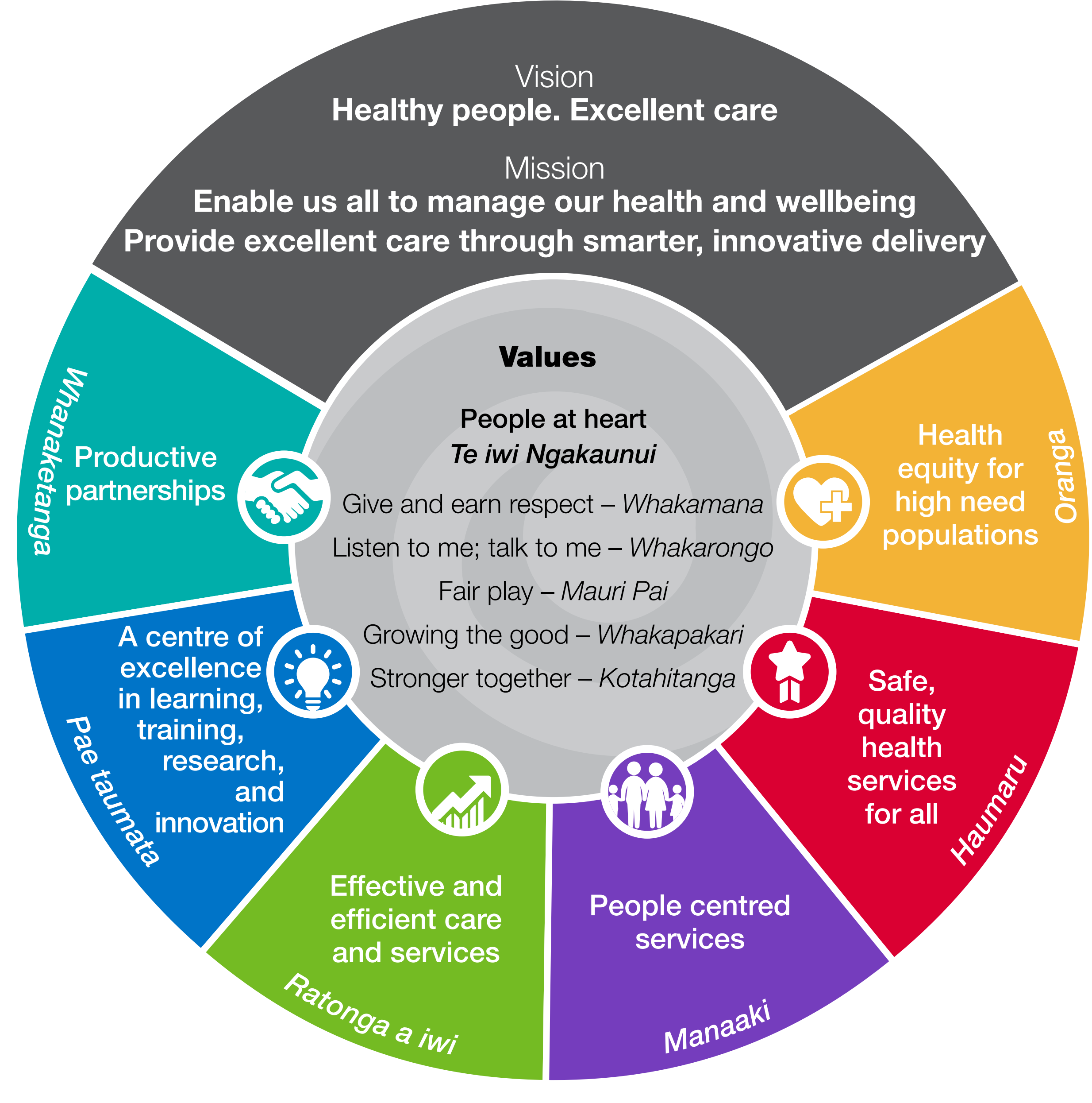
Confirms that what follows is the Waikato DHB annual report for public scrutiny, thus confirming an old saying, which translates, in this case, as:

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

'It shall be done!'

'Gather it together; weave everything together!'

'It is accomplished!'


Vision
Healthy people. Excellent care
Mission
Enable us all to manage our health and wellbeing
Provide excellent care through smarter, innovative delivery
Values
People at heart
Te iwi Ngakaunui
Give and earn respect – Whakamana
Listen to me; talk to me – Whakarongo
Fair play – Mauri Pai
Growing the good – Whakapakari
Stronger together – Kotahitanga
Whanaketanga
Productive partnerships
Health equity for high need populations
Oranga
A centre of excellence in learning, training, research, and innovation
Pae taumata
Safe, quality health services for all
Haumaru
Effective and efficient care and services
Ratonga a iwi
People centred services
Manaaki

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Foreword from the Interim Chief Executive and the Board Chair

Sally Webb
Board Chair

Derek Wright
Interim Chief Executive

This last year has been a challenging one for Waikato DHB with a huge increase in demand for many of our services, the ending of our SmartHealth online health service and the departure of our CE and Board Chair. Despite these setbacks, we have continued to focus on serving our diverse population across our region, and staying true to our vision of Healthy People, Excellent care.

The increasing demand on our services has been an issue for us, as it has for many DHBs around the country. We treated more people than ever before at our hospitals in Hamilton, Thames, Te Kuiti, Tokoroa and Taumarunui, and the acute demand has stretched our Emergency Departments, especially at Waikato Hospital.

To help address this, in September we opened a new 27-bed ward catering for geriatric, medical and orthopaedic rehabilitation patients at Waikato Hospital. We also recruited more doctors and nurses into our busy ED and started work on a patient flow programme. This will help us improve the movement of patients through the hospital and get patients admitted to wards quickly for treatment.

Our rural health services have played an important role in helping address the health needs of our remote population. The revamp of our maternity services in South Waikato, Ruapehu and King Country has been progressing well.

The changes included a primary maternity hub service model to help women navigate access to services like smoking cessation, lactation, parenting education and specialist services like diabetes. We also closed Te Kuiti Birthing Unit and moved to a Lead Maternity Carer (LMC) model and enhanced facilities in Tokoroa and Taumarunui.

In April, we pulled the plug on our SmartHealth online health service at the end of its two year trial. The service, delivered on mobile phones and smart devices, was aimed at providing healthcare to those in our community who have poor access and suffer worse health as a result.

While many of our patients who used SmartHealth were very positive about the experience, we didn't sign up enough people for it to be value for money. But we are still committed to reaching out to our remote rural communities and to help reduce the inequities, particularly in our large Māori community.

In September we signed a new Memorandum of Understanding (MoU) between Waikato DHB and Iwi Māori Council that will lead the way for radical change in the delivery of health and disability services in the Waikato for Māori.

It was a historic moment for us as a DHB and also represents a symbol of strong relationships with our iwi as we move forward to improve the status of Māori health. The MoU is based on the principles of partnership, participation and protection.

It is no surprise that the number one priority in our DHB strategy is radical improvement in Māori health outcomes by eliminating health inequities for Māori. And this year we began work on a 10 year Health System Plan (HSP) that will help us implement this strategy.

The HSP will be a whole of system view, bringing together a number of strategies and plans from across the organisation. It will outline a roadmap for future healthcare for our Waikato communities. It will cover some of the challenges we face going forward, and provide details on how we intend to overcome these. The Plan will have clearly defined actions with timelines to be delivered in the first three years and will set out initiatives for the medium to longer term.

But we can't create a plan like this without input from our community and just as importantly other healthcare providers in the Waikato. This year we have been working hard on improving relationships with our providers and the other DHBs in the Midland region and have been pleased to see an increase in collaboration across the sector.

If we are to make real change to health outcomes we need to listen to those affected and understand from them about what would work to make that difference.

This is one of the reasons that this year we set up a new Consumer Council for the DHB to enable the Waikato people to have more of a say into how their health service is run. The Consumer Council is working in partnership with the DHB to provide a consumer perspective and is helping make sure our services meet the needs of Waikato communities.

One of the areas where we have been doing a lot of community engagement in the last year is mental health. Waikato Mental Health and Addictions service launched a programme of work called 'Creating our futures' as part of a larger Waikato DHB mental health continuous quality improvement programme. This work will help us meet contemporary best practice standards and deliver safe, quality mental health services for the Waikato community.

In a series of public meetings called "Let's Talk – mental health and addictions" we asked the Waikato community to share experiences, views and ideas that will help guide the new direction of mental health and addiction services in the Waikato. We want the community to have involvement in the whole process so we can get it right.

We are pleased to put some of the distractions of the last year behind us and look forward to an exciting future as we move towards true partnership with the community to deliver the healthcare they need and deserve.

Sally Webb

Board Chair,
Waikato DHB

Date: 24 October 2018

Derek Wright

Interim Chief Executive,
Waikato DHB

Date: 24 October 2018

Waikato DHB board interests
2017-18

Sally Webb
Board Chair
Appointed: December 2016

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

Waikato DHB was formed in 2001 and is one of 20 DHBs 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. Seven of which 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.

Bob Simcock resigned as Chair of the Board in November 2017 with Sally Webb now the Chair of the Board. The Interim Chief Executive is Derek Wright, who began October 2017. Our Board and executive offices are located in Hamilton at the Waiora Waikato Hospital campus.

Agendas and minutes of all Board meetings are on the Waikato DHB website: www.waikatodhb.health.nz

Crystal Beavis
Re-elected: October 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 Christie
Re-elected: October 2016

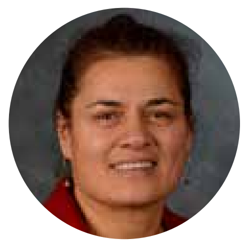
- Partner, employee of Workwise
- Member of Thames Coromandel District Council

Martin Gallagher
Re-elected: October 2016

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

Mary Anne Gill
Elected: October 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



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
- Member, Whānau Ora Review Panel
- 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: October 2016

- Councillor, Hamilton City Council
- Deputy Chair, Waikato Regional Passenger Transport Committee
- Member, Waikato Regional Transport Committee
- Member, Future Proof Joint Council Committee
- Partner is occasional contractor for the DHBs 'Creating our Futures' project

Pippa Mahood

Re-elected: October 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 Business Services 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

Bob Simcock

Re-appointed: December 2016 – Resigned as Waikato DHB Chair in November 2017

- 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.

Dr Clyde Wade

Re-elected: October 2016

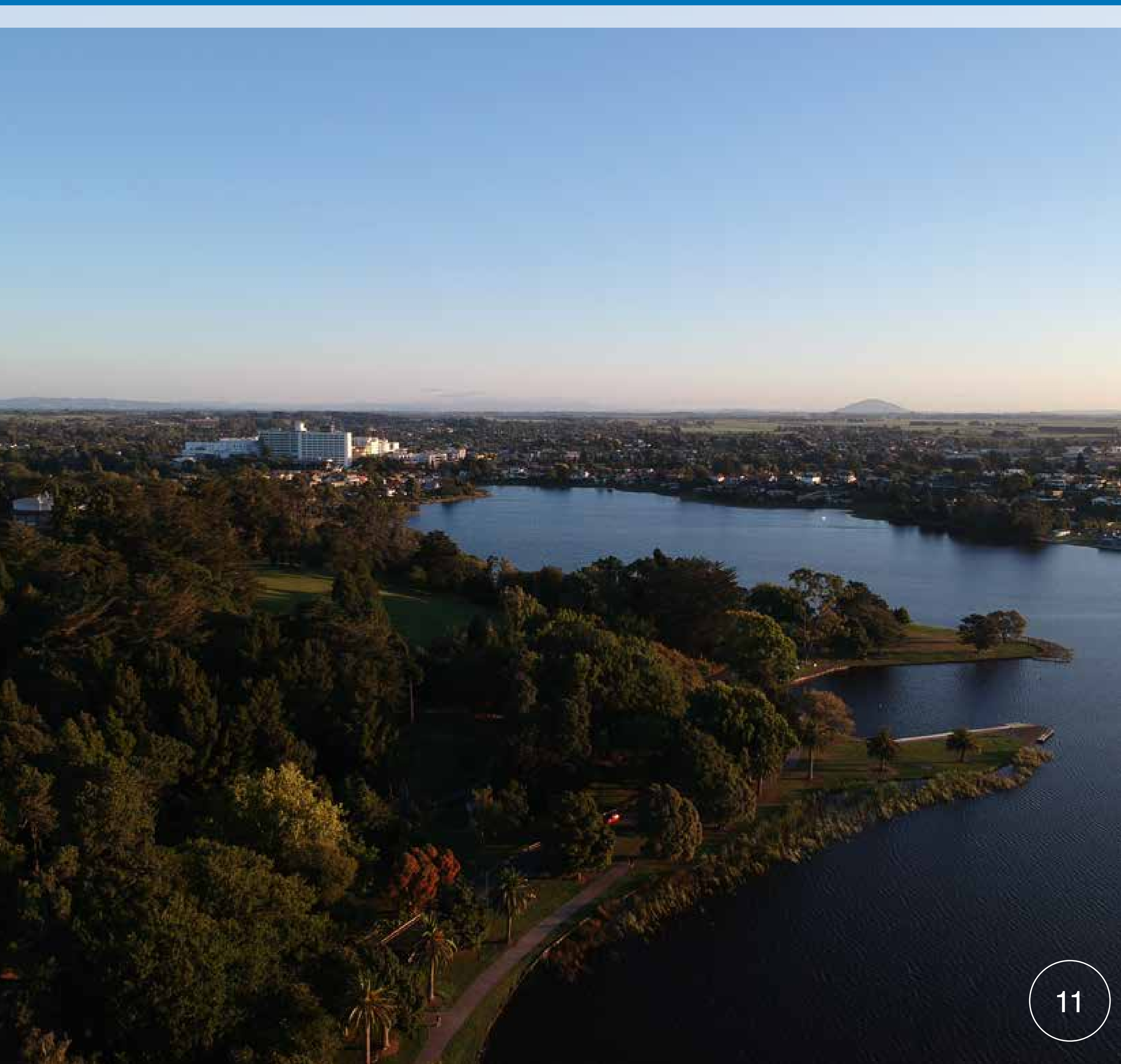
- Shareholder, Midland Cardiovascular Services
- Trustee, Waikato Health Memorabilia Trust
- Trustee, Waikato Heart Trust
- Trustee, Waikato Cardiology Charitable Trust
- Patron, Zipper Club of New Zealand
- Emeritus Consultant Cardiologist, Waikato DHB
- Cardiology Advisor, Health & Disability Commission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

We would like to thank you and your amazing team of midwives and medical staff for everything they did for us. We were made to feel comfortable, well informed by our midwives and they all made it a priority to ensure both mother and baby were healthy and not stressed. We feel privileged to have been treated and cared for by your team.

Celeste – new mum

Waikato Hospital with Lake Rotoroa captured by John Tagalog

Part one: Overview



Overview introduction

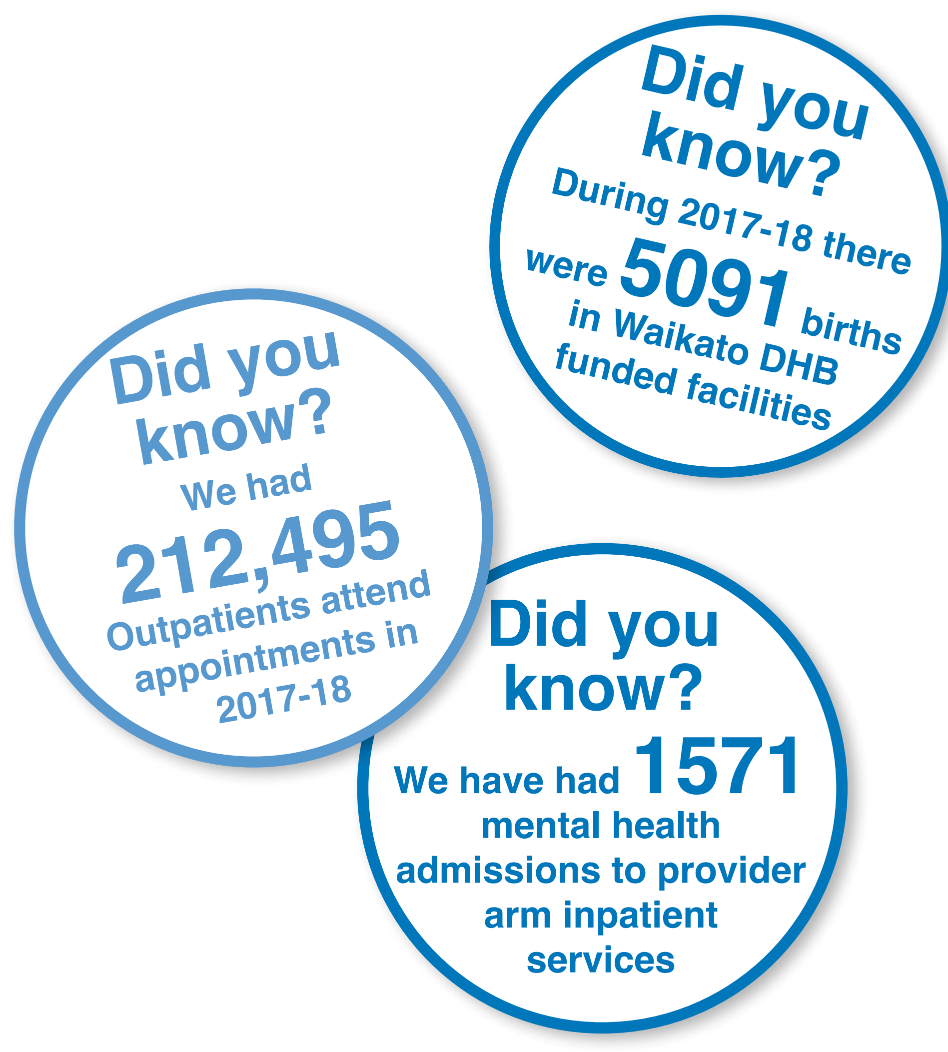
This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2018. In the Statement of Service Performance (part three), we present our actual performance results against the non-financial measures and targets contained in our Statement of Intent 2017-18.

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 2017-18 year, we received approximately $1.3 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The funding amount we received is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status.

During 2017-18 approximately 60 percent of the funding received by Waikato DHB was used to directly provide hospital and health services. The remaining 40 percent was used to fund contracted services provided by non-government organisations (NGOs), primary health care organisations (PHOs), Māori providers, Pacific providers, aged residential care, other DHBs, 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 local, regional and national 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).



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

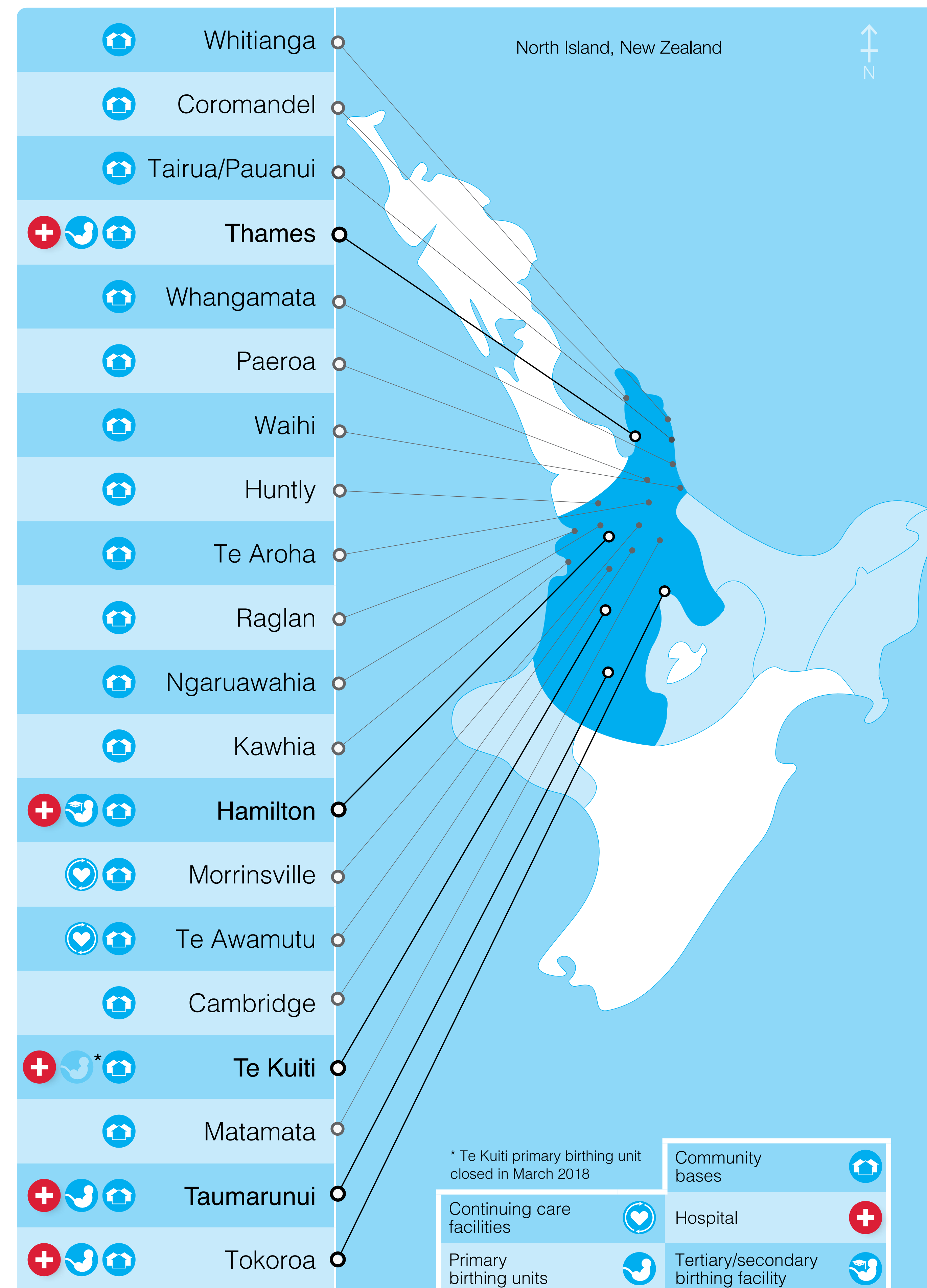
Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• An improvement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

Stewardship

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

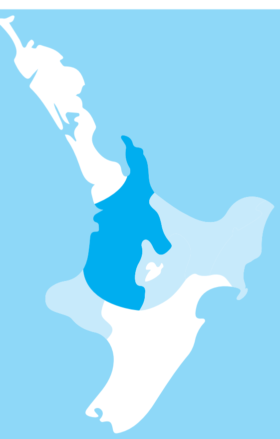
* These are only an example of the outputs, full details in Part three of this report.

Waikato DHB profile



Location and population at a glance

5th
Waikato DHB has the fifth largest population out of the 20 DHBs in NZ



10
Territorial local authorities within our boundary

417,130
Our population in 2017-18, 9% of NZs total population

51% Female
49% Male

16% Of our population are 65 or over

28% Of our population are under 20 years

Our ethnicity population make up

Māori **23%**
Asian **10%**
Pacific **3%**
Other **64%**

23% Estimated Māori population compared to national average of 15%

- Waikato DHB covers almost nine percent of New Zealand's population, from Northern Coromandel to close to Mt Ruapehu in the South. There are 10 territorial local authorities within our boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames Coromandel, Waikato, Waipa, and Waitomo. We have a larger proportion of people living in areas of high deprivation than in areas of low deprivation. Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in high deprivation areas.
- Our population is getting proportionately older (the 65-plus age group is projected to increase by 40 percent between 2017-18 and 2028). This, and the increase in chronic and complex health conditions, informs many of the strategies we are putting in place to meet future health needs.
- The Māori population is significantly impacted by many chronic conditions such as diabetes and smoking related diseases and are disproportionately presented in adverse health statistics. These facts, combined with the acknowledgement of the status of iwi in the Waikato, provides 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 three percent of our population and are a group that requires targeted health initiatives.

Our workforce at a glance

As at 31 May 2018, the DHB had 7138 employees with 5960.6 full time equivalents. The numbers include all active employees with the exclusion of parked employees (i.e. those on parental leave, yet to start, and those on career break leave) and contingent workers. Employees are central to the DHBs ability to plan, fund, and deliver health services to Waikato communities.

Employee diversity

New Zealand European is 50 percent of the workforce and Māori is nine percent.

Ethnic group	Headcount	Percent
NZ European	3571	50%
Asian	1515	21%
Other European	1107	16%
Māori	622	9%
Not Stated	128	2%
Pacific Peoples	109	2%
Middle Eastern	37	1%
African	36	1%
Latin American	11	0%
Other ethnicity	2	0%
Total	7138	100%

Age range

The average age of all Waikato DHB employees is 44.3. The age range distribution is shown below:

Age range	Total	Percent
<25	448	6%
26-34	1700	24%
35-44	1359	19%
45-54	1635	23%
55-64	1633	23%
≥65	363	5%
Grand Total	7138	100%

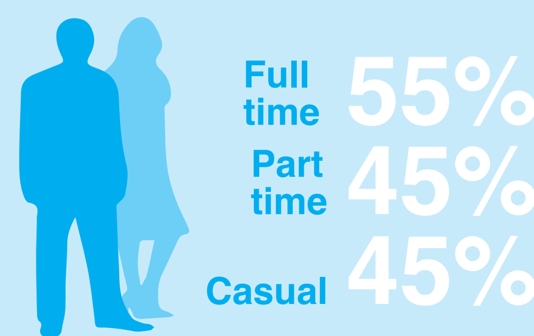
Employment status

The majority of staff are full-time (49.8 percent), 46.9 percent are part-time, and 3.2 percent of the staff are casual employees.

Status	Headcount
Full-Time	3557
Part-Time	3350
Casual	231
Grand Total	7138

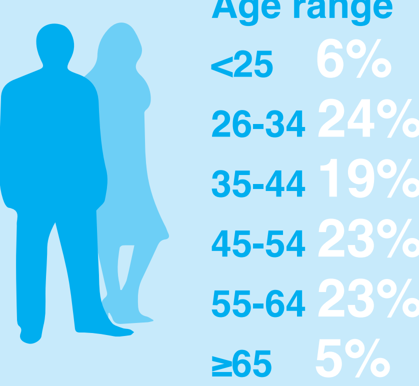
Staff type

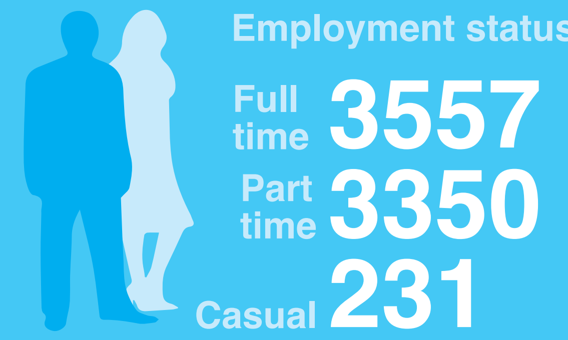
Type	Headcount	Percent
Allied	1272	17.8%
Medical	855	12.0%
Management/Admin	1281	17.9%
Nursing	3338	46.8%
Support	392	5.5%
Total	7138	100.0%



Employee diversity

NZ European	50%
International	39%
Māori	9%
Pacific Peoples	2%
Not identified	2%





Organisational and workforce development

Leadership, accountability and culture

- Leadership Success Profile

  Waikato DHB is implementing the Talent Management and Leadership Framework developed by the State Services Commission, which includes adopting a Leadership Success Profile (LSP).

  The LSP is made up of five core dimensions:

  1. leadership character
  2. making it happen – with and through others
  3. identifying and developing our talent
  4. navigating for the future; and
  5. stewardship – of people, functions, organisations, and systems.

  Our use of the LSP dimensions and capabilities provides further opportunity for growing leadership capability and maximising our talent. It also builds on our:

  a) legacy with leadership development and programmes; and

  b) existing approach of leadership capabilities aligning with professional/position and organisational capabilities.

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 of behaviours is offered (managers are encouraged to attend).

Recruitment, selection, and induction

- Pre-employment health screening

  Waikato 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.

- Appropriately accommodate employees with known disabilities

  Waikato DHB continues to meet its obligations under the Human Rights Act to provide a supportive environment and reasonable accommodations for its disabled staff, patients and visitors.

- 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 Checking continues to be implemented as part of the recruitment and selection process. Targeted questions are being asked of candidates at interviews, and about candidates as part of reference checks. Police vetting and identification checks are completed prior to commencement. Since the Vulnerable Children's legislation came into place Waikato DHB has completed 5000 safety checks.

  The last group of existing children's workers will be being safety checked before July 2018. Waikato DHB designing a process for repeat safety checks and will begin implementing this in July 2019.

Employee development, promotion, and exit

- Gateway programme

  Each year the DHB facilitates a number of clinical and non-clinical placements for Year 12 and 13 students through the Gateway programme. The Gateway programme consists of a one day placement per week for approximately 10 weeks so that students can experience the work environment, with the goal of attracting them to a career in health with the Waikato DHB.

  In 2018 we are providing placements in nursing, attendants, sterile services unit, anaesthetic technicians, dental, and Māori health for approximately 60 students.

- Hamilton Careers Expo

Waikato DHB had a stand at the Hamilton Careers Expo on 10-11 June 2018. 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.

- Exiting information

Waikato DHBs 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 102 registrars completed the exiting form. This may have been due to rotation.

Total number of staff who left the DHB for 2017-18. N= 1064 approx.

The top five reasons why people left over 2017-18 are similar to the reasons stated for 2016-17.

The top 10 reasons people left the Waikato DHB for 2017-18 are:

Reason	Total	Percentage of total
Relocation	230	11.2%
End Employment Agreement	167	8.1%
Better Career Prospects	143	6.9%
More Time With Family	133	6.5%
Better Challenges	117	5.7%
New Job Higher Salary	112	5.4%
Retirement	85	4.1%
Health Reasons	64	3.1%
Better Work Life Balance	62	3.0%
Advancement opportunities	60	2.9%
Total	1173	

- Dedicated education units

Dedicated Education Units continue to provide the student model with our education partners at Wintec and Te Whare Awanuiarangi. Currently this continues within Older Persons and Rehab Services, Orthopaedics, Internal Medicine, and two aged care facilities (Tamahere and Cascades). Enhancements of the model have been implemented in both Midwifery and Mental Health with unique attributes for the individual contexts. Within Mental Health additional priority has been applied to the development of a Māori workforce. 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.

- Flexibility and work design

As per Part 6AA of the Employment Relations Amendment Act 2007, any employee has the right to request flexible working arrangements and expect their request to be considered.

Recognition, conditions, and remuneration

- Staff Service Recognition Programme 2018

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 2018, there is approximately 600 staff celebrating 10 years or more of continuous service. This number includes staff working in rural locations.

The Chief Executive, members of the 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 DHBs.

  The DHB has regular meeting with unions to exchange views and information. The DHB supports the bipartite action group.

Safe and healthy environment

The DHB continues to support its employees to participate in DHB health and safety systems. There are currently 395 employees from across the DHB who have completed the organisation's own comprehensive Health and Safety Representative training. The DHB continues to provide employees with a safe working environment by identifying and controlling hazards, providing education, and training, and undertaking incident follow ups. Staff wellness is supported through WorkWell, the vaccination programme, and smoking cessation programmes.

- Staff Safety Culture Working Group.

  Progress with four key safety culture initiatives has resulted in the following achievements:

  - Values communication and marketing, and socialisation of the values through Living the values sessions
  - Staff safety educational deliverables have included three new online courses
  - The Workplace Support Person initiative was launched offering staff the option of discussing with a trained colleague a low level discourteous concern; and if their concern is bullying; and
  - WorkWell, an evidenced based approach that supports the well-being of staff, resulted in Community and Clinical Support achieving bronze standard accreditation.

ACC partnership

The annual ACC workplace safety management audit covers policy and practices across the organisation. Waikato DHB currently holds Tertiary status and continues to participate in annual audits.

- Director responsibilities for Health and Safety

  The Waikato DHB continues to support and advocate for Board and other persons who fit within the statutory criteria of being an officer of the DHB to complete the Institute of Directors governance training in the terms of their obligations under the Health & Safety at Work Act 2015.

  The Board receives regular reports on key elements of the governance framework, these reports focus on the four principles of due diligence in health and safety governance:

  - policy and planning
  - monitor
  - delivery; and
  - review.

  Waikato DHB continues its long-term trend of having workplace injuries and claims at a lower level than its peers when benchmarked against other hospitals and employers within the same levy group for workplace injuries.

Organisational and workforce development
continued

Employee remuneration

The below table represents the number of Waikato DHB employees who, during the 2017-18 financial year, were paid in excess of $100,000 per annum in their capacity as employees.

Employee Remuneration	2018 Actual	2017 Actual
Employee remuneration over $100,000 ($10,000 bands)		
100,001 - 110,000	180	139
110,001 - 120,000	121	96
120,001 - 130,000	90	82
130,001 - 140,000	55	48
140,001 - 150,000	45	32
150,001 - 160,000	25	35
160,001 - 170,000	24	26
170,001 - 180,000	22	16
180,001 - 190,000	25	17
190,001 - 200,000	22	13
200,001 - 210,000	20	27
210,001 - 220,000	18	24
220,001 - 230,000	31	21
230,001 - 240,000	20	22
240,001 - 250,000	24	17
250,001 - 260,000	19	24
260,001 - 270,000	22	15
270,001 - 280,000	18	23
280,001 - 290,000	24	19
290,001 - 300,000	21	17
300,001 - 310,000	15	16
310,001 - 320,000	12	17
320,001 - 330,000	13	13
330,001 - 340,000	13	10
340,001 - 350,000	7	9
350,001 - 360,000	13	2
360,001 - 370,000	4	6
370,001 - 380,000	3	1
380,001 - 380,000	5	3
390,001 - 400,000	4	1
400,001 - 410,000	1	1
410,001 - 420,000	-	3
420,001 - 430,000	2	2
440,001 - 450,000	2	1
500,001 - 510,000	1	-
560,001 - 570,000	-	2
600,001 - 610,000	1	-
630,001 - 640,000	-	1
640,001 - 650,000	-	1
670,001 - 680,000	1	-
	923	802

Of the 923 (2017:802) employees shown above, 84 percent or 775 (2017:674) are or were clinical employees.

Termination payments

The table below shows the number of terminations for the past 12 months (1 June 2017 to 31 May 2018, source: PeopleSoft):

Reasons	Total
End temporary employment	309
Personal reasons	222
Relocation	196
Career progression	154
Family reasons	103
Retirement	79
Travel	50
Health reasons	39
Dissatisfied with work conditions	37
Changed status to casual	37
Offer declined	27
Career change	18
Further study	14
Mutual consent	13
Reason unknown	3
Elimination of position	3
Resigned from parental leave	3
Death	2
Dissatisfied with company policies	1
Dissatisfied with manager/supervisor	1
Misconduct	1
Dissatisfied with type of work	1
Dissatisfied with hours	1
Externally paid	1
Total	1315

Futher information on Board member, key management and key personnel remuneration on pages 124-125 (Finance section)

Governance and accountabilities

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

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

Ministerial directions

Directions issued by a Minister during the 2017-18 year, or that remain current are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May 2016 under section 107 of the Crown Entities Act
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000
- Directions to support a whole of Government approach, issued in April 2014 under section 107 of the Crown Entities Act. The three directions cover procurement, ICT and property; and
- The direction on use of authentication services, issued in July 2008, continues to apply to all Crown agents from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Functions of a DHB

As a DHB we:

- plan the strategic direction for health and disability services in partnership with key stakeholders
- plan regional and national work in collaboration with the National Health Board and other DHBs
- fund the provision of the majority of the public health and disability services in our district through the agreements we have with providers
- provide hospital and specialist services primarily for our population but also for people referred from other DHBs; and
- promote, protect, and improve our population's health and wellbeing through health promotion, health protection, 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, and reduce duplication, variation and waste across the health system to achieve the best outcomes for our community.

Providing health and disability services

We are responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services. Our hospitals provide a range of inpatient and outpatient services and are located across the district:

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

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 DHBs health service delivery. The hospitals work 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; and
- outpatient clinics for a wide range of services including orthopaedics, medicine, surgery, paediatrics and women's health.

Strategy and Funding health and disability services

Strategy and Funding within the 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; and
- strategic planning for the long-term.

Strategy and Funding contracts services from a wide range of NGO providers, as well as other DHBs 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 DHBs priorities. Additional focus in these areas has been required over the past few years and will continue to be a focus, given the fiscal constraints and the need for DHBs 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.

Local performance story

The following diagram is part of our wider performance story (see pages 14 and 15). During 2017-18 we made significant progress, but there is still more to be done.

Our vision	Healthy People. Excellent Care		
Our mission	Enable us all to manage our health and wellbeing Provide excellent care through smarter, innovative delivery		
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.

Our strategic imperatives and priorities

The strategic imperatives are our long-term goals, which will be reviewed after five years along with the vision and mission. Under each strategic imperative are four priorities, which connect the strategy with the day-to-day activities of the Waikato DHB. These priorities are areas of work that will be the focus for Waikato DHB. These are not our only priorities, as we have policy priorities that we deliver on as required by the Ministry of Health and Central Government.

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 DHBs 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.

Accountability for results

The Annual Report will provide an update on work that is occurring in the pursuit of achieving our vision. On the next page (24-25) you will see a snap shot of activities linked to each of the strategic imperatives that Waikato DHB has been progressing over 2017-18 year. This is not a complete list of activities but more of a 'highlight reel' to show we have actions in place to achieve what we say we are going to do.

Waikato DHB strategic priorities

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

What we have achieved

A snapshot of some current work across the DHB helping us achieve our strategic priorities.

- Kia Ora Hauora programme supports Māori to pursue a career in the health and disability sector. Kia Ora Hauora is in its eighth year and has focused on Māori students in secondary schools and wharekura students, tertiary sector students, Māori in-work, and Māori in communities
- The DHB is writing a Māori Health Strategy, in partnership with the Health System Plan
- We are developing a Disability Responsiveness Plan to provide guidance, direction and structure to all stakeholders involved. The plan will provide clear direction for health sector leaders and managers working alongside disability communities to address inequities and ensure better health outcomes

- We are implementing the National Early Warning Score chart to improve and standardise recognition and response of patient deterioration
- The Choosing Wisely Project aims to improve the way patients and clinicians engage in conversations about tests, treatments and procedures. Ensuring those that are carried out are necessary, appropriate and beneficial
- The advanced care planning project will ensure that people are informed about future health care and treatment choices and that care providers are better informed about patients' care preferences including end of life care

- Our Harti Hauora programme is a targeted wrap-around service for priority groups accessing Waikato DHB services. The programme links patients and whānau with the appropriate primary and community services
- Hapu Wananga programme provides pregnancy and birth courses throughout the Waikato district, targeting pregnant wahine Māori and their whānau. Running alongside Hapu Wananga is smoking cessation services, safe sleeping advice and materials

- Improving organisational efficiencies and meeting patient health needs by providing a coordinated system for the follow up and support for patients who do not attend an outpatient appointment
- Establishment of an outpatient appointment reminder system that includes sending a text message to remind people of their appointment
- Health Pathways transformation: The pathways of care team, under the Governance of the Regional Pathways of Care Group, are in the process of translating the 126 localised pathways onto our Midland Region version of the Community Health Pathways tool that will be launched on 1 July 2018

- Qlik sense development will allow users across the organisation to interact with their data through the rich visualisation capabilities
- The Research, Innovation and Improvement Hub is in the early stages of discovery and development of what it would look like for Waikato DHB
- A Radiology transformation programme is underway to ensure the department has the capacity to deliver on expected demand. Changes include reducing outsourcing and overtime, increasing the establishment of Radiologists and MRTs, increasing MRT leadership capacity. A comprehensive programme of work including over 60 activities

- Te Ara Totika is a face-to-face workshop for DHB staff, facilitated by the University of Waikato. It provides an understanding on the Māori world view, Te Tiriti o Waitangi and the importance of applying tikanga best practice in healthcare
- The System Level Measure programme of work involves six clinically led working groups and focus on children, youth and vulnerable populations. The working groups have representatives from the DHB, PHOs, NGO stakeholders, and the provider arm

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 and shows the regional strategic direction.

Midland vision	All New Zealanders live well, stay well, get well					
Our strategic imperatives	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 2017-2020 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 collaboratively. 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. Health equity for Māori;
2. integrate across continuums of care (to provide more timely effective care);
3. improve quality across all regional services;
4. build the workforce;
5. improve clinical information systems; and
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 the 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 importance of clinical networks leading 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

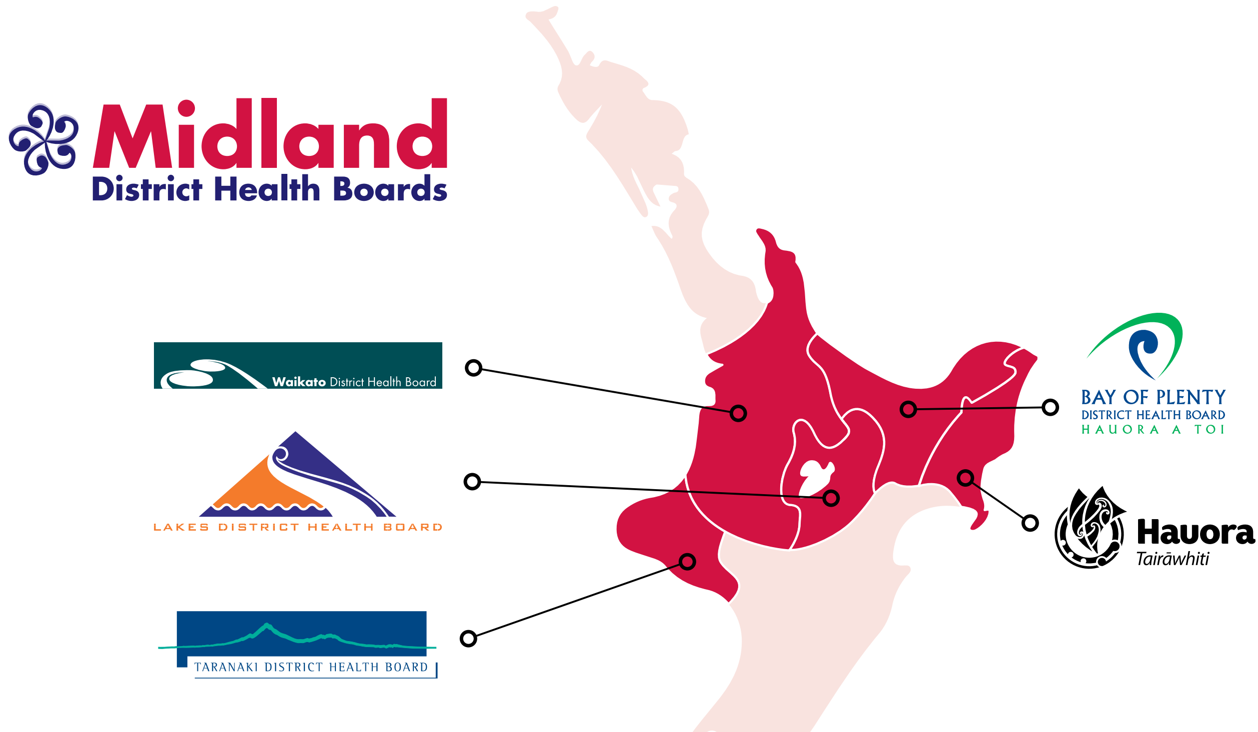
The Midland region covers an area of 56,728km², or 21 percent of New Zealand's land mass

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

Five DHBs: Bay of Plenty, Lakes, Tairāwhiti, Taranaki, and Waikato

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

924,165 people (2017-18 population projections), including 237,020 Māori (26 percent) and 43 local iwi groups.



Midland region Iwi

DHB	Iwi
Bay of Plenty DHB 19 iwi	Waitaha, Tapuika, Tuwharetoa-ki Kawerau, Tuhoe, Ngaiterangi, Te Whānau -a- Apanui, Te Whānau -a- Te Ēhutu, Ngaitai, Whakatōhea, Ngāti Pukenga, Ngāti Mākino, Ngāti Manawa, Ngati Whakaue ki Maketu, Ngāti Rangitihi, Ngāti Whare, Ngāti Awa, Ngāi Tai, Ngāti Ranginui, Ngāti Whakahemo
Lakes DHB three iwi	Te Arawa, Ngāti Tuwharetoa, Ngāti Manawa
Tairawhiti DHB five iwi	Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu
Taranaki DHB eight iwi	Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngaruahinerangi, Ngāti Ruanui, Ngā Rauru
Waikato DHB eight iwi	Waikato, Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Ngāti Haua, Tuwharetoa, Whanganui, Maata Waka

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

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 significant positive impact on the lives of New Zealanders. The health and disability system is dynamic and integrated, with many activities contributing to 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. A key example are the Health Targets which provide a clear and specific focus for action to ensure that New Zealand's health care is of the highest quality and within the best possible time.

Health target results

DHBs report their progress in the Health Targets to the Ministry of Health four times a year; the Ministry then reports their findings to the Minister. We do not always meet the Health Targets however we do ensure that we report on our results using a variety of mechanisms, including the Annual Report and posters displayed throughout Waikato DHB hospitals and other facilities. Reporting our result is done so the public has opportunities to see how we are performing. This encourages us to work as hard as possible to excel at achieving the targets and holds us accountable to the public.

Shorter stays in Emergency Departments

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		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	89%	89%	82%	92%	88%	89%	90%	88%	86%	91%	86%	84%
All DHBs	92%	93%	91%	94%	94%	93%	94%	94%	91%	94%	93%	91%

Improved access to elective surgery

Target: The volume of elective surgery will be increased by an average of 4000 discharges per year

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	119%	108%	111%	120%	106%	104%	120%	110%	105%	119%	114%	105%
All DHBs	104%	105%	104%	105%	103%	102%	106%	104%	102%	108%	106%	103%

Faster cancer treatment

Target: 90 percent of patients 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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	57%	81%	98%	68%	86%	98%	77%	86%	97%	73%	86%	95%
All DHBs	69%	78%	92%	75%	82%	93%	75%	82%	91%	74%	81%	91%

Increased immunisation

Target: 95 percent of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	90%	92%	88%	92%	92%	90%	91%	90%	89%	89%	89%	88%
All DHBs	93%	93%	92%	94%	93%	92%	93%	92%	92%	93%	92%	91%

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		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	84%	87%	88%	88%	87%	88%	88%	86%	88%	89%	88%	87%
All DHBs	83%	87%	89%	85%	86%	88%	86%	86%	89%	88%	89%	90%

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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018	2015-2016	2016-2017	2017-2018
Waikato DHB	N/A	47%	76%	N/A	79%	100%	N/A	84%	100%	N/A	81%	100%
All DHBs	N/A	49%	92%	N/A	72%	98%	N/A	86%	98%	N/A	91%	98%

Some highlights from the year

Community Oral Health service Saturday clinic and dental care with nitrous oxide sedation

Staff in the Community Oral Health service have established Saturday clinics. Appointments are available from 9am to 1pm. The weekend clinic options for busy parents is proving very popular with our patients and their parents.

Community Oral Health has introduced a nitrous oxide clinic in one of its community dental clinics. This service is provided by the community dentists. It is proving extremely beneficial in the provision of treatment for anxious children. Enabling children access to this new service to complete their dental care means they do not need hospital-based care with general anaesthetic.

Waikato DHB launches new Consumer Council

The Council will work in partnership with Waikato DHB and enable the Waikato people to have more of a say on how their health service is run.

The Council represent the consumer voice to the Waikato DHB Board and senior management, a move towards true partnership with communities.

Waikato Hospital opens the new Ward OPR5

A new 27 bed ward catering for geriatric, medical and orthopaedic rehab clients opened in September 2017, the final step in the completion of the Older Persons and Rehabilitation Building.

Ward OPR5 will help to futureproof our services, enabling us to offer what the community needs as our population ages and demand for services increases.

Thames Hospital gets a new high tech Computer Tomography (CT) scanner

Thames Hospital has received a CT scanner with the latest technology, including higher resolution images with lower radiation doses; one of the very first and few systems of its kind in New Zealand.

Services are now closer to home and people will no longer have to travel to Waikato Hospital for complex scans. We will be able to scan patients much quicker than before which improves flow and demand from the different services using the CT scanner at Thames Hospital.

The new CT scanner at Thames Hospital is the first part of a multi-million dollar project to upgrade four CT scanners this year. Two of these other CTs are operated by the DHBs Radiology service from their base at Waikato Hospital. The final one, which will be upgraded early in 2018, is used exclusively by the Oncology service at Waikato Hospital to plan treatment for cancer patients.

Waikato DHB and Waikato iwi sign MoU for Māori health

A Memorandum of Understanding (MoU) between Waikato DHB and Iwi Māori Council will lead the way for radical change in the delivery of health and disability services in the Waikato for Māori. The MoU recognises the DHBs strong relationship with iwi and raises the focus from operational to strategic matters.

The MoU is based on the principles of:

Partnership: working together with iwi, hapū, whānau and Māori communities to radically improve Māori health outcomes and reduce Māori health inequities, and to develop appropriate health and disability services.

Participation: that requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning and development roles, and the delivery of health and disability services.

Protection: which requires the Government to safeguard Māori cultural concepts, values and practices, and to ensure that Māori have at least the same level of health as non-Māori.

Iwi involved with the signing for Waikato were Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, Te Rūnanga O Kirikiriroa (Urban Māori Authority) and Kaunihera Kaumātua.

Waikato DHB first in Australasia to trial new app for alcohol or drug recovery

Waikato DHB launched a 12 month trial of Recovery in Hand, powered by ACHESS, New Zealand's first smartphone application that provides extra support to people recovering from alcohol or other drug issues. This new tool will help complement and support the counselling services we provide.

ACHESS has been successful in halving the rate of relapse among alcoholics in the United States. Waikato DHB is the first in Australasia to look at how we can support people in recovery with the use of technology. Recovery in Hand is about doing things differently and enabling client care when they need it, recognising addictions are a 24 hour a day challenge.

Key features include:

- A hot button (Beacon) for access to emergency support;
- GPS detection for when a patient has entered a potential high risk location (optional feature patients can choose to enable);
- a variety of supportive resources including video, and audio;
- goal setting, journalling, and the ability to upload pictures, texts, and video that will motivate people to stay clean;
- medication and appointment reminders; and
- recovery tracking and progress.

Robot doctors being trialled in Waikato and Thames hospitals

Fondly referred to as Dougie and Daphne, Thames and Waikato hospitals have welcomed New Zealand's first-of-a-kind clinical robots. Dougie and Daphne allow Waikato Hospital specialists the ability to log-on to a hospital computer or a mobile app and have their face instantly visible on the robot screen and navigate to where needed with their fingertips. Being mobile, Dougie and Daphne can navigate around clinical areas, saving valuable time getting specialist help to wherever the patient presents.

Dougie and Daphne can act as eyes and ears on the ground. The aim is to make assessments faster, and support patients, families, and clinical teams.

Waikato DHB centre of excellence for new post-heart surgery resuscitation training

Waikato DHB is leading New Zealand training in Cardiac Surgery Advanced Life Support training – or CALS for short – an internationally endorsed training course involving simulations that allows surgical teams to practice and efficiently respond to cardiac arrest following heart surgery. The team are working closely with other teams in Melbourne, Sydney, Adelaide, Perth, Europe, and the USA to develop and deliver this essential healthcare.

The course focuses on optimizing team work and uses a sophisticated manikin designed to imitate the upper half of a patient's body post-heart surgery including the internal structures covered by the sternum and held together with sternal wires.

Waikato Hospital's Cardiothoracic department in one of the busiest in Australasia and performs over 600 open heart surgeries each year.

For more information visit:
www.csu-als.com/cals-anz

Aloha Hapū Wānanga

Waikato DHBs Hapū Wānanga, a birthing programme for expectant mums, is spreading across the Pacific with interest to improve indigenous health in Hawaii.

Hapū Wānanga is run by Te Puna Oranga project manager Kelly Spriggs and Rawinia Hohua who are taking mammas by storm by empowering them with the best information, choices and skills for maternity that fit with their whānau's traditions.

The success of Hapū Wānanga is real, now reaching hundreds of women. What started out as a service for young pregnant women and their whānau is now attracting all walks of life and cultures, and other DHBs are looking at adopting the model.

51 Gallagher Drive opens

This new warehouse and distribution facility allows us to get resources and supplies to where they need to be quickly, enabling clinicians to do their job. Taking up 4,800m2 of space, the size and layout has been designed to meet the requirements of the range and volume of products the DHB requires now and into the future. The warehouse area contains specialty racking, a clean room, conveyor systems and cool/dry storage areas. Radio frequency identification, Voice Pick and Carton Live Technology has been implemented to order and deliver products ensuring increased efficiency.

Community and Southern Rural Health has also moved to 51 Gallagher Drive. Along with modern, fit for purpose office space the new Waikato DHB facility incorporates state of the art consult rooms used by both district nurses and allied health staff. Patient comments about the new facilities have all been positive including: "Purpose-built, light airy rooms with good heating and ventilation; Excellent parking and waiting area", "Appreciate not having to walk through staff work-space to treatment rooms" and "Wow, this is nice."

Health workers in the Waikato DHB region are now just one click away

Health workers in the Waikato DHB region will now have one click access to patient health information

Health workers in the Waikato DHB region are now just one click away from patient health information held in the general practice or hospital systems. Hospital doctors and nurses, GPs and practice nurses, community pharmacists, midwives and certain St John's staff are all included in the latest electronic sharing initiative from Waikato DHB. This provides access to important health information such as medications, diagnoses, immunisation status, test results, and in some cases consultation notes. This is a major step forward in patient safety.

Sexual Health Clinic refurbishment

The long awaited refurbishment of Waikato DHB Sexual Health Clinic has been completed this year. The service now has fit for purpose areas throughout the clinic. Staff and patients are delighted with the changes. Improvements include a triage room, refurbished reception, staff kitchen, office areas, sluice room and additional storage.

Just knowing I have saved a life and created a life – my recipient ‘T’ has gone on to have children which gives me a warm feeling. My kidney is good, still going strong and I’ve helped give ‘T’ freedom and a full life with his family.

Nicci – live kidney donor

Part two: Quality and patient safety

Quality and patient safety annual quality account

Our focus for 2017-2018

Quality and patient safety annual quality account

Patient outcomes:

- Reduce the number of people dying from preventable conditions

Patient safety:

- Keep patients safe in our care
- Improve end of life care

Patient experience:

- Listening to our patients and community
- Improve care around deteriorating patients

Listen, learn, Improve:

- Monitoring outcomes
- Learning from adverse events

Consumer engagement:

- Working with consumers across the organisation - primary and secondary

Continuous quality improvement:

- Identifying priorities
- Quality improvement projects

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, US).

Quality and safety markers

Quality and safety markers measurements that look at specific areas of harm that can occur to patients when they are in hospital. The measurements help to show where changes or improvements can be made and how effective those changes have been.

● We've achieved the target	● On target to achieve	● We've not met the target

Falls risk assessment and care planning.

- 90 percent of older patients are given a falls risk assessment and individualised care plan where indicated.

● **We achieved the provision of falls risk assessment and individualised care plans for 98 percent of older patients.**

Safe surgery – theatre check lists.

Measures the levels of teamwork and communication around the use of the three paperless surgical checklist parts: sign in, time out, and sign out.

- 100 percent of audits where all three parts of the checklist were reviewed; and
- 95 percent of audits with engagement scores of five or higher.

● **We achieved 48 percent, 76 percent, and 97 percent for the check list.**

● **We achieved engagement scores of 91 percent, 92 percent, and 81 percent.**

Cardiac surgery – protecting patients having cardiac surgery

- 100 percent of patients will receive prophylactic antibiotics 0-60 minutes before surgery begins;
- 95 percent of patients receive 2mg or more of cefazolin; and
- 100 percent of patients have an appropriate skin preparation.

● **We achieved 96 percent for antibiotic timing and 100 percent for dose and skin preparation.**

Hand hygiene

- 80 percent compliance with good hand hygiene practice; and
- monitoring five contact points with a patient of their immediate environment.

● **We achieved 85 percent hand hygiene compliance.**

Safe surgery – protecting patients having hip and knee joint replacements from infection.

- 100 percent of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision; and
- 95 percent of hip and knee replacement patients receiving 1.5g or more of cefazolin or 1.5g or more cefuroxime.

● **We achieved 99 percent for timing and 94 percent for dosage.**

Current priorities – What we have done

Patient safety

Priority one: Reduce harm from medications

The Medication Safety programme has a number of work streams in progress, including:

- reviewing and revising medicine related guidelines, procedures, protocols and standing orders, including oncology and haematology administration guidelines and prescribing templates;
- review and update of the DHB Medicine Management Policy;
- development and recruitment of a renal outpatient pharmacist role;
- audits of compliance to HML criteria for high cost or high risk medicines;
- implementation of the use of a tool for prioritisation of high risk patients (for a medication related event) and a team based clinical pharmacist approach; and
- ongoing development of e-medicines management – installation of MedDispense in two new clinical areas.

Patient outcomes

Priority three: Reduce the number of people dying from preventable conditions

- Pinnacle roll out "Onceandforall" smoking cessation referral programme with a specific focus on Māori and Pacific people;
- suicide Prevention and Postvention programme: Supported 10 'Safe Hands Safe Plans' workshops across the Waikato DHB area with over 270 staff participating;
- expanded work with bereaved families following suicide. Improving awareness and increasing uptake of DHB funded bereavement counselling;
- Waikato DHB Smokefree Maternity Leadership group supports women to have smoke-free pregnancy and motherhood, with increasing success year on year in the numbers of women who quit; and
- a co-designed community led obesity, diabetes and chronic disease prevention programme has seen seven whānau with nine adults and 15 children during the first eight weeks. This programme is already showing significant results in its weight loss programme with resulting positive impact on health and lifestyle for participants.

Patient experience

Priority five: Continue to improve care around the deteriorating patient

- Implemented the national vital sign and Early Warning Score (EWS) chart to 100 percent adult inpatient areas across the DHB, improving the ability to recognise and respond to patient deterioration;
- 1436 staff completed the online learning for EWS;
- Developed the Sepsis Six programme to improve recognition, response and management of patients with sepsis, which is a serious and life threatening condition. We have started using the Sepsis Six screening tool in our emergency departments, paediatrics and maternity departments;
- Sepsis education is in progress, more than 200 doctors and nurses have already participated; and
- Increasing the number of staff on the Patient At Risk team to respond to patient deterioration and support patients recently discharged from ICU.

Patient safety

Priority two: Improve end of life care for patients and their family/whānau

- 164 staff trained at level 1a in Advance Care Planning (ACP) and 42 at level two;
- 220 staff trained on level one through e-learning. 82 percent of those trained work in community based settings;
- 300 ACP plans have been completed across the Waikato DHB region;
- Set up system to share ACP's electronically across organisations;
- Working with front line clinical staff to improve the completion of resuscitation plans on patient admission;
- Started planning for Bereavement Care service with service specifications completed. Planning implementation stage;
- Pathway for discharging patients home for End of Life Care nearing completion; and
- Te Ara Whakapiri End of Life Care documents agreed across the DHB with implementation started.

Patient experience

Priority four: Listening to our patients and community

- Set up the new Consumer Council in January 2018. The council members work in partnership with the DHB to provide a consumer perspective, help shape our services and make sure what we do and how we do it meets the needs of our consumers; and
- Eleven experienced based co-design projects under way. Each with consumer representation. These include amongst others:
- Redesign of mental health outpatient waiting area;
- Improving services and access to Needs Assessment and Service Coordination (NASC) services for over 65 Māori; and
- Suicide prevention service – to prevent repeat suicide attempts, deliberate self-harm, and deaths from suicide.

Priorities for 2018-2019

- **End of Life:** Year two of a three year programme. Implementing a Bereavement Care service, Focus on frailty, and the last 1000 days of life. Continue to roll out Advance Care Planning across the DHB, primary sector, and community;
- **Deteriorating patient:** Year two of five year programme. Continue to implement Sepsis Six programme to include the whole of the DHB with the aim of spreading the program to primary sector. Plan for implementation of the electronic E-Vital patient observation system;
- **Listening to our patients and community:** Continue to support the work of the Consumer Council. Increase experience based co-design in our quality improvement work; and
- **Choosing wisely:** Year one of three year programme. Focussing on areas where evidence shows that a test, treatment, or procedure provides little or no benefit to a patient and could even cause harm.

> I started to take charge of my health and began controlling my diabetes with such good results.

I have diabetes and depression. Last year things became overwhelming. Then Work and Income put me in touch with REACH. I was sceptical, but desperate, so ready to clutch at straws.

When key worker and registered nurse Shirley talked to me about REACH it sounded unique. With my permission she came with me to my health appointments - the GP, the diabetic clinic and the eye clinic. She asked lots of questions and for the first time I started to really understand what the doctors were saying, and what I could do to improve my health.

Shirley was my mentor, she was genuinely interested in me and met with me twice a week. I'd never had this kind of support before. I started to take charge of my health and began controlling my diabetes with such good results. I had more breath, more energy, more taste - it was a real breakthrough.

My depression meant I wasn't paying attention to my relationships. I was missing out on my family and my daughter's milestones. When I started prioritising my health, these things fell into place too. I started taking my daughter to the park, running after her and playing with her. I saw her joy and it was enough to drive me on. Everyone noticed a difference in me. I stopped dwelling on things that brought me down, and learned how to deal with how I was feeling.

Ian, living well coach, met with me every week and encouraged me to get back into gym work. It was hard, but the more I did it, the more I wanted to do.

Michelle, living well coach, took me for long walks in the park, and now I take my family out with me on these walks.

Shirley, Ian and Michelle were genuine. It wasn't just a job for them, they were made for the job. They had real compassion. They still call me every now and then to see how I'm doing. It's good to know I can go back to them if I need to.

REACH worked with me on all aspects of my life, health, work and my relationships with family. I am satisfied with my life now and am enjoying it on a daily basis.

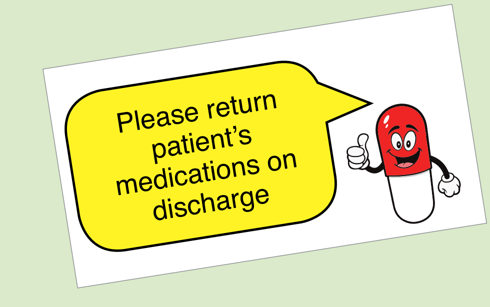
REACH (Realising Employment through Activated Co-ordinated Health Care) is a 12 week personalised programme for people who are registered as job seekers and manage a health issue or disability to enable them to attain employment. Find out more at www.reachout.nz.

***Manaaki* – People centred services**
Provide care and services that are respectful and responsive to individual and whānau needs and values

We carry out many large scale projects in the organisation but it is often the little changes that go unnoticed and make a difference to the patients and staff caring for them. The following are a few examples of these little changes.

Ward M2 – patient medications

Patients who bring their own medications into hospital often found that staff forgot to return them when they were discharged home. This is a waste of medications as they had to be disposed of, and a significant cost to the patient who had already paid for the prescription and would need to replace it. The nurses designed a sign in / sign out sheet and a sticker to go in the front of the patients bedside chart. This is seen as a daily reminder to nursing staff to return the medications on discharge. When the nurse starts the discharge paperwork they see the bright yellow sticker. It has already shown improvement and the ward continues to embed it in to practice.



High Dependency Unit communication book

Keeping staff up to date with information, whether this is to do with patient care, quality improvements, or general communication, is difficult. Shift work and large numbers of staff meant that communication can easily get lost. Keeping up to date is important for patient and staff safety. A simple solution was to create three different folders, readily recognised and organised into topics. Yellow for infection control, blue for quality and green for miscellaneous. Simple but effective.

Improving communication and patient safety in the Waikids wards

A paediatric ward received a complaint from a caregiver that highlighted a lack of documentation from nurses, along with appropriate escalation to the medical team, when parents or caregivers phone the ward with a concern.

One nurse decided to improve how phone calls were documented and what actions were taken. There was a good deal of collaboration with nurses and doctors on the unit to find out what they currently did, what they would want on a form and if such a form was already in use at Waikato or any other New Zealand hospitals. This led to the development of a phone enquiry form, which was then tested to see if it was easy and effective to use. Feedback was gathered and some minor changes made as a result. After three months, the form is still being used well. Copies are filed in the patient records. Ongoing audit measures of the effectiveness of the form ensure that concerns are passed on when they should be and the children are kept safe.

The nurses and health care assistants on Ward M14 are amazing and always treated me with dignity and respect. I know they're all busy but when I was there they always took time out of their day to chat with me, rub my hand and make sure I was ok. I really appreciated that because some days are really hard but I have to keep going because I love life and I have my kids to think about.

Joanne – Cardiac, thoracic and vascular surgery patient

Part three: Statement of performance

Statement of performance introduction

Long term impacts:	Long term impacts:	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

Our service performance

The Performance Expectations reported on in this section articulate Waikato DHBs commitment to make positive changes in the health status of our population. The performance measures chosen are not an exhaustive list of all of our activity, but they provide a good representation of the full range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional, and local outcomes. Where possible, we have included with each measure past performance as baseline data to support evaluation of our performance.

Our impacts

Impact measures are defined as "the contribution made to an outcome by a specified set of goods and services (outputs), or actions or both". While we expect our outputs will contribute to achieving the impact measures, it must be recognised that there are outputs from other organisations and groups that will also contribute to the results obtained for the impact measures.

Over the long-term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in the Waikato the decisions we make about which services will be delivered have a significant impact on our population. If services are coordinated and planned well, we will improve the efficiency and effectiveness of the whole Waikato health system. Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measureable difference in the health and wellbeing of the Waikato population. One of the functions of this document is to demonstrate how effective our decisions were and how we performed against the desired impacts outlined below. This demonstrates our commitment to an outcome-based approach to measuring performance.

We seek to make a positive impact on the health and wellbeing of the Waikato population and contribute to achieving the longer-term impacts we seek. The following impact measures will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

1. People are supported to take greater responsibility for their health;
2. People stay well in their homes and communities; and
3. People receive timely and appropriate specialist care.

Our outputs

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs. Identifying a set of appropriate measures for each output class can be difficult as we do not simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. In order to best demonstrate this, we have chosen to present our statement of performance expectations using a mix of measures of Timeliness, Quantity and Quality - all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the expected standard. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health impacts we are seeking over the intermediate and longer term. Additionally they cover areas where we are developing new services and expect to see a change in activity levels or settings over the 2017-2018 year - and therefore reflect a reasonable picture of activity across the whole of the Waikato health system.

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 2017-2018. 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 or 2017-2018 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 2018

	Parent	Parent	Parent
	2018 Actual	2018 Budget	2017 Actual
Revenue	$000's	$000's	$000's
Prevention	27,057	30,677	31,047
Early detection and management	301,341	285,262	265,255
Intensive assessment and treatment services	976,055	950,702	929,452
Rehabilitation and support	137,597	168,335	132,775
	1,442,050	1,434,976	1,358,529
Expenditure			
Prevention	23,327	28,436	23,034
Early detection and management	282,516	251,402	258,179
Intensive assessment and treatment services	1,037,416	1,002,130	947,063
Rehabilitation and support	137,000	163,508	129,319
	1,480,259	1,445,476	1,357,595
Share of associate surplus/(deficit)	-	-	(59)
Share of joint venture surplus/(deficit)	72	-	56
Surplus/(deficit)	(38,137)	(10,500)	931

People are supported to take greater responsibility for their health

Long term impact	Intermediate impacts	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of Year 10 students who have never smoked
		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
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds
		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)
	Improving health behaviours	95 percent of obese children identified in the Before 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)
		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

Why does this matter?

New Zealand is experiencing unprecedented levels of demand for health services and a growing prevalence of long-term conditions such as respiratory and cardiovascular disease, cancer and diabetes. These conditions are the leading drivers of poor health and premature death and place significant pressure on the health system in terms of demand for health services.

The likelihood of developing long-term conditions increases with age and these conditions are more prevalent amongst Māori and Pacific Island populations. With our higher than average Māori population (23 percent) and a predicted 40 percent increase in 65+ year olds in the Waikato DHB over the next 10 years, it is crucial that people are supported to take control of their health and help prevent illness to ensure the sustainability of our health services in the future.

Many health issues stem from health and lifestyle choices. With this in mind we must empower our people to make the right lifestyle choices. By shifting our focus from treatment to prevention, proactively promoting wellness and increasing health literacy we will enable our population to live well and stay well.

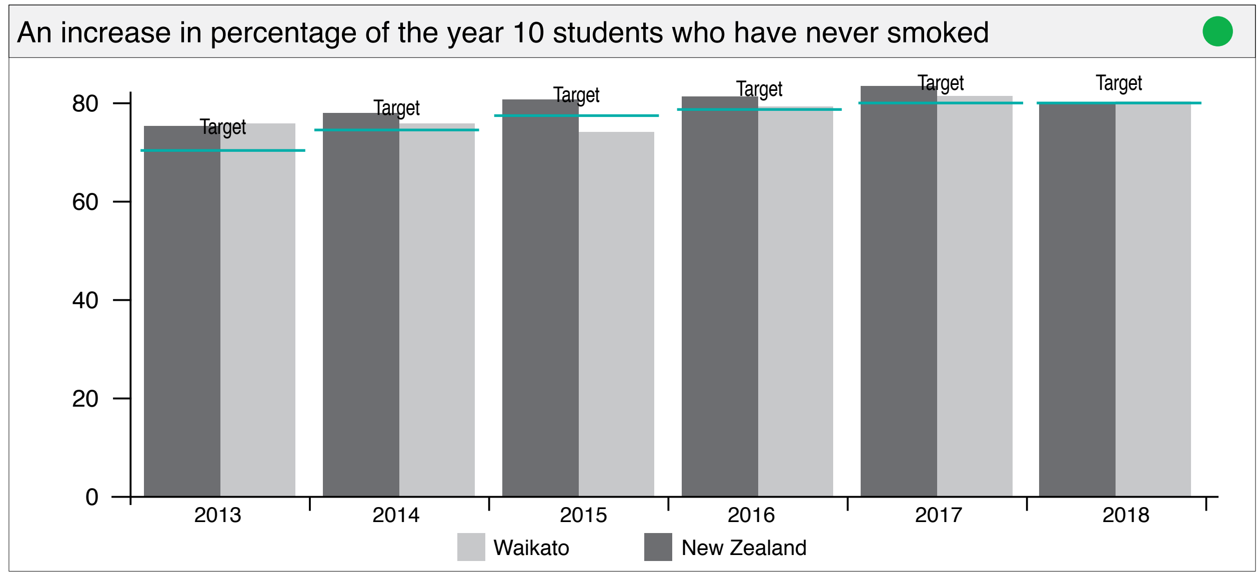
To support this Waikato DHB have chosen three key areas we believe will deliver the best long term impact for our population: smoking cessation; avoiding vaccine preventable diseases; and improving health behaviours.

● We've achieved the target	● We've not met the target

Fewer people smoke

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of Year 10 students who have never smoked	74%	77.4%	> 75.7%	80%	●

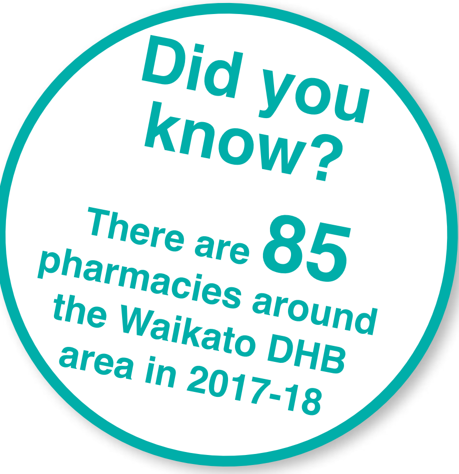
Our performance:



The result is for the 2017 calendar year to line up with the school calendar year. Waikato DHB has utilised ASH (Action for Smokefree 2025) Year 10 Snapshot surveys for some years to gain a perspective as to how well we compare to national averages for the percentage of students who have never smoked. Our result is slightly lower than the national average however we improve our result every year and feel confident that we can continue to do so.

Schools participation in the survey is voluntary. Due to this not all schools participated in the 2017 Snapshot (as in previous years), Despite this, the sample characteristics were very similar to the national Year 10 population for 2017. Responses to the survey are received from approximately 27,000 students nationally. ASH notes limitations for the survey include a potential for bias, with lower participation rates for wharekura (Māori medium schools).

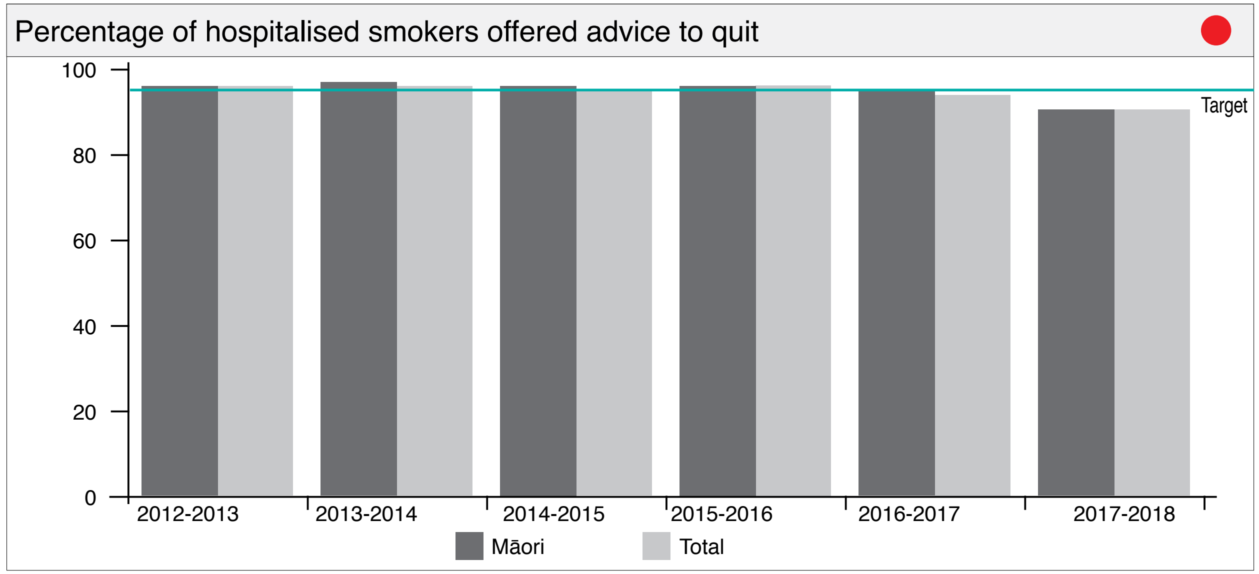
The increasing rates of year 10 students who have never smoked shows the effectiveness of the many interventions we have in place to move New Zealand towards the smoke free 2025 goal. The achievement, 80 percent of year 10 students having never smoked is significant as evidence shows if our tamariki/children are smoke-free at year 10 there is a much better chance they will remain so throughout their adult lives.



People are supported to take greater responsibility for their health

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
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	Māori 94% Pacific 100% Other 91% Total 94%	Māori 95% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 92% Pacific 92% Other 91% Total 92%	● ● ● ●

Our performance:



We have identified some data collection issues in relation to this measure over the 2017-2018 year. The result provided is an estimate, and we are currently working on a solution to this issue to ensure that we can report an accurate result for the 2018-2019 year. The intention to offer meaningful clinical interventions to every person who smokes is well embedded and for this reason most areas achieve target regularly. However, collectively Waikato DHB wards do not. One of the struggles we face in achieving this target is that when the number of discharged smokers from a ward is small, such as 10; one smoker being missed out of 10, results in a 90 percent intervention rate. These add up and affect our ability to reach the 95 percent target.

Key activities have been initiated to help improve our result, including:

- better withdrawal orientated treatments for inpatients
- nicotine replacement therapies are available to non-admitted people and staff
- cleaning up and reclaiming "Hot Spots" where people were smoking on the hospital campus
- employment of a dedicated smokefree security guard
- stop smoking practitioners coming onto wards to work with people who smoke and support clinical smokefree interventions
- "opt off" referral model has been incorporated onto wards. This normalises treatment for smoking while still making patient choice central with the option to "opt off" from referral to smoking cessation services
- "stop before your op" in pre-hospital, pre-admission planning. This includes identification of smoking status, allowing staff to have conversations about benefits of stopping smoking before surgery and allows patients the opportunity to get used to using Nicotine Replacement Therapy (NRT) prior to admission
- further "stop before your op" innovations will include work with primary care/GPs to develop a project to improve surgical outcomes and smoking prevalence
- better communication through our pre admission documents, the media, new campus signs, and face-to-face interactions on our zero tolerance policy and clear expectations of patients and their visitors that they remain Smokefree on campus; and
- the newly opened Hauora iHub providing visitors smokefree support, advice, and referral to stop smoking services.

Waikato DHB will continue to keep smokefree interventions a high priority. All new staff will be trained in best practice interventions and NRT options will remain readily available. We will continue to manage emerging issues in documentation, treatment, and referrals. Furthermore, we will look for new and innovative projects to ensure excellent clinical practice and better help for people who smoke.

Output measure	Baseline 2014-15		Previous year 2016-17	Target 2017-18		Result 2017-18		Rating
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	Māori	92%	88%	Māori	90%	Māori	85%	●
	Pacific	91%		Pacific	90%	Pacific	83%	●
	Other	89%		Other	90%	Other	88%	●
	Total	90%		Total	90%	Total	87%	●

Our performance:

Even though the target has not quite been achieved, we are pleased to report that a number of collaborative activities are in place which are working towards achieving this target in the future.

PHOs provide leadership and support for their general practices in data collection, clinical leadership/ clinical champions, dedicated management to support activities in practices, reminder, prompting audit tools, and systems and training.

Midland Health Network is Waikato DHBs smoking cessation provider that has arrangements within general practice and other independent providers for providing cessation services for clients.

Following ABC, (Ask, Brief Advice and Cessation) referrals are received from general practices, Health Waikato and other practitioners. Offering advice is shown to increase the chance of smokers making a quit attempt which in turn, results in an increase in successful quit attempts.

We remain committed to achieving this target, Māori are over represented in smoking statistics which is one of the major drivers of health inequity, targeting smoking is significant to achieving our strategic priority of eliminating health inequities for Māori. This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.

Output measure	Baseline 2014-15		Previous year 2016-17	Target 2017-18		Result 2017-18		Rating
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	Māori	95%	95%	Māori	90%	Māori	83%	●
	Pacific	N/A		Pacific	90%	Pacific	NA	NA
	Other	66%		Other	90%	Other	NA	NA
	Total	95%		Total	90%	Total	87%	●

Our performance:

The data is derived from the Ministry of Health and is only available for the whole population group and Māori women.

Children who have a parent who smokes are seven times more likely to become smokers. These children are also at greater risk of cot death (Sudden Unexplained Death in Infants), premature birth, low birth weight, and serious respiratory infections. Therefore, it is important mothers are given smoking cessation advice in hospital and through their LMCs. For all women in the Waikato 94 percent of women were offered advice and support to quit smoking at registration and just over a quarter (26 percent) accepted a referral to stop smoking services. For Māori Women 93 percent were offered advice and support and 20 percent accepted referral.

The data for DHB-employed midwives is a very small proportion of the information and is collected quarterly from DHB records and sent to the Ministry of Health. The remaining data is collected from the Ministry via the LMC payment data. It should be noted that at this stage this information is not accurate. The Ministry has reported a total 1498 registrations with a LMC or DHB employed midwife in Waikato for 2017-2018. Waikato facilities in 2017-2018 have recorded 5153 births. As a result there is a significant shortfall in the expected number of registrations with a midwife that the Ministry have recorded for this target in a one year period. Therefore, the data only gives us a view of how we are tracking in terms of supporting women to be smoke-free on a proportion of our population who register with a midwife in Waikato during the time period 2017-2018.

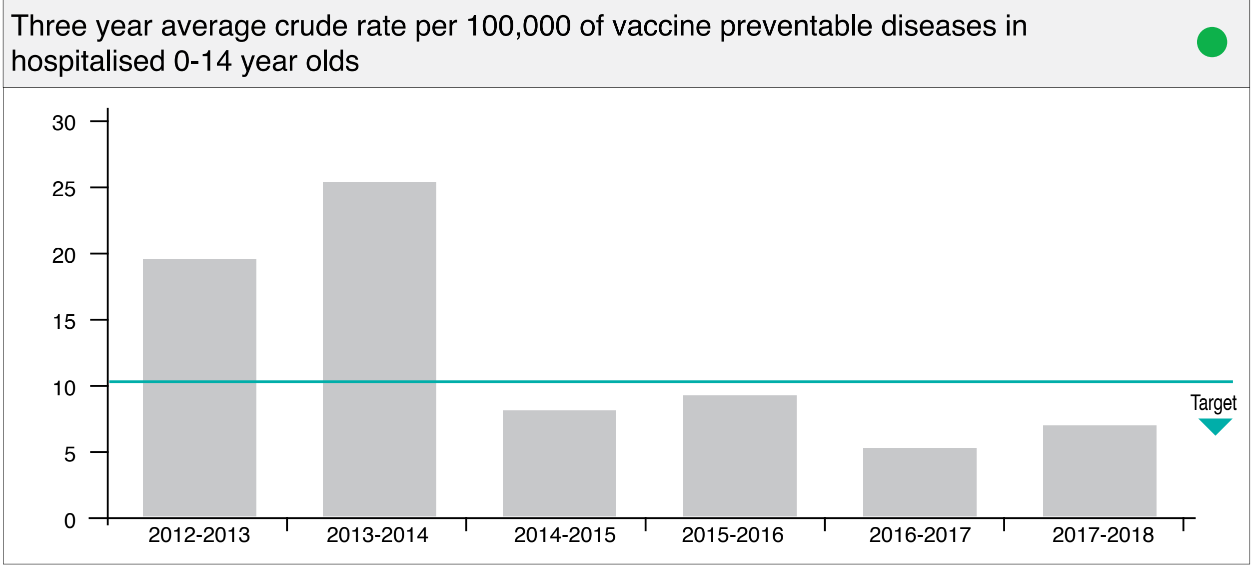
What has gone well this year has been encouraging midwives to refer women as early as possible to stop smoking services, the local stop smoking service incentive scheme for pregnant women, and promoting the local stop smoking service and staff to midwives. This is demonstrated in the data. In quarter one overall only 14.7 percent of women accepted referral and only seven percent of Māori women accepted referral. By quarter four 21.4 percent of all women accepted referral with 23.3 percent of Māori women accepted referral.

The focus going forward into 2018-2019 will be on young Māori women who smoke. Waikato DHB is also committed to increasing the number of babies living in a smoke-free household at six weeks post-natal. These interventions aim to break the generational smoking cycle and improve health outcomes for the whole whānau/family.

Reduction in vaccine preventable diseases

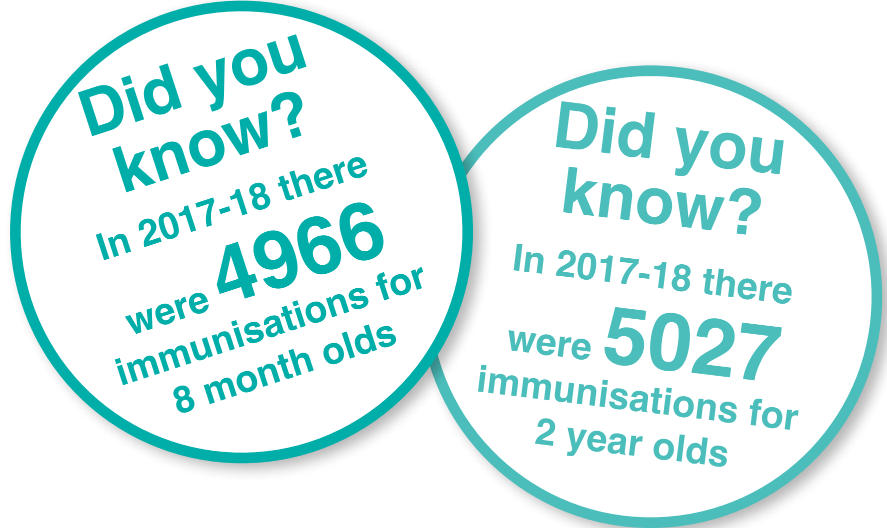
Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	Māori 19.4 Pacific 0 Other 4.5 Total 8.8	5.66	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori 6.4 Pacific 0.0 Other 7.9 Total 6.9	● ● ● ●

Our performance:



The number of Pacific people was so low it produced a result of 0 per 100,000 people. We are pleased to have met this target but acknowledge we still have a lot of work to do to increase immunisation rates and further reduce vaccine preventable hospitalisations. Immunisation can prevent a number of diseases and is a very cost effective health intervention, providing 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.

New Zealand's current immunisation 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 and we are currently working on many initiatives to increase the uptake of immunisations in our district. Some of these initiatives include the implementation of the Immunisation Action Plan in collaboration with PHOs and our Outreach Immunisation service. We are also aligning our B4 School dataset for immunisations to ensure the National Immunisation Register is not missing any immunisation events which will help to maximise opportunistic immunisations.



Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
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%	Māori 89%	Māori 95%	Māori 83%	●
	Pacific 95%	Pacific 95%	Pacific 95%	Pacific 94%	●
	Other 83%	Other 91%	Other 95%	Other 83%	●
	Total 91%	Total 89%	Total 95%	Total 87%	●

Our performance:

We are disappointed that despite an agreed immunisation action plan being signed off by key partners including PHOs and paediatrics we have still not achieved the 95 percent target. Vaccine-preventable diseases including diphtheria, tetanus, whooping cough, polio, hepatitis B, haemophilus influenzae type B, pneumococcal, measles, mumps, and rubella have a significant impact on health and can cause premature death.

Immunisation is a proven tool for controlling and eliminating these life-threatening infectious diseases. Immunisation not only provides individual protection against these diseases, but if sufficient people (90-95 percent of the population) are vaccinated we can achieve 'herd immunity.' If herd immunity is achieved then the spread of disease in the community can be slowed or even prevented completely. Accordingly, it is one of the best health prevention strategies for protecting our population. In the pursuit of achieving this target we have now implemented many new initiatives including increasing registered nurse resource with the National Immunisation Register to deliver opportunistic immunisations in emergency departments, outpatient, and rural hospitals. Opportunistic immunisations provide convenience for the parents and caregivers by eliminating the need for them to make another appointment and take more time off work or additional travel to services. We hope this will help lift rates of immunisations. We are also engaging with our 24/7 primary medical provider to determine the value and feasibility of establishing opportunistic immunisation clinics on site.

We will undertake a review of the child health coordination service in Waikato to ensure a future service is better able to track children and ensure there is follow up and referrals to appropriate services for those who have missed immunisations including whānau ora providers.

Furthermore, a review of outreach immunisation data and services will be undertaken to identify how to improve access and coverage by locality, and determine how best to meet needs by locality, increasing value for money.

To increase uptake of the six week vaccination event, agreements are now in place with PHOs to provide a free extended consultation for unenrolled mothers of new-borns as identified by LMCs, the National Immunisation Register or our hospital based Hauora ihub. This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of two year olds are fully immunised and coverage is maintained	Māori 91%	92%	Māori 95%	Māori 89%	●
	Pacific 95%		Pacific 95%	Pacific 93%	●
	Other 91%		Other 95%	Other 91%	●
	Total 90%		Total 95%	Total 90%	●

Our performance:

The new activities reported in the eight month immunisation performance are expected to have a positive impact on the percentage of two year olds who are immunised given uptake at the six month mark is an indicator of later uptake. It is important that we see improved results; less illness amongst children and in our community is not just about prevention, it also has other benefits. These include people being able to spend more time with their whānau/family, needing to take less time off work, and children spending more time playing or at school, activities that support children growing into happy and healthy adults.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of eligible children fully immunised at 5 years of age	Māori 73% Pacific 78% Other 76% Total 73%	88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 85% Pacific 86% Other 88% Total 87%	● ● ● ●

Our performance:

We will continue to work closely with our B4 School coordinator based at Midlands Health Network to support practice nurses, to immunise preferably on the same day as the check is completed. The reason we chose to have our B4 School check done in primary care was to ensure children were engaged with their usual general practice and receive child centred care from health professionals who know them.

We hope that continued work and the new initiatives will see Waikato DHB meet the target in 2018-2019. The initiatives discussed previously in the eight month immunisation performance will lead to better health services for children, increased immunisation rates, and consequently, better health and independence for children.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of eligible 12 year old girls have received HPV dose three	68%	67%	75%	66%	●

Our performance:

This immunisation is available to everyone aged nine to 26 years old. HPV immunisation aims to protect young people from HPV infection and the risk of developing cervical cancer and genital warts later in life. Currently, around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. Immunisation helps to protect against the spread of strains of human papillomavirus; known to cause cervical cancer and genital warts. The vaccine has been shown to be very effective in preventing infection from the types of HPV it targets. Studies show that more than 10 years after immunisation, protection from HPV infection remains high with no signs of weakening.

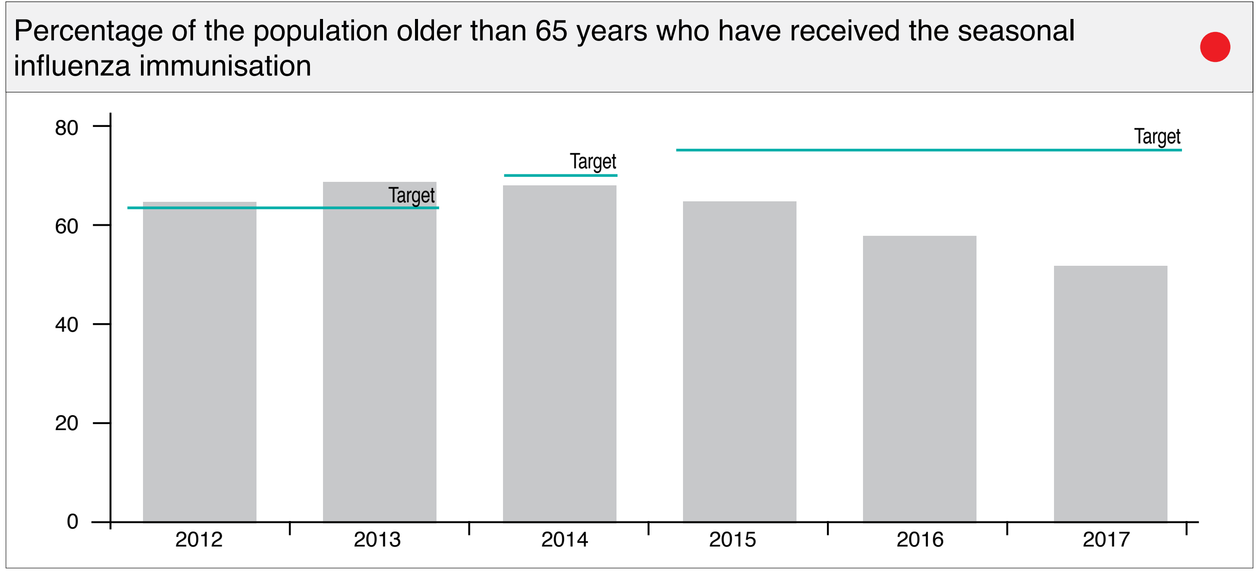
There have been challenges in achieving this target due to schools requesting changes of dates after being previously notified of immunisation dates earlier in the year. This causes significant logistical problems for the immunisation teams.

We faced issues in the wider Raglan area where a Board of Trustees and new principal agreed not to have vaccinations delivered at their school. Consequently, these students and families cannot receive education on the vaccination. The principal will hand out consent forms but the child will need to be vaccinated elsewhere. There are another three schools who have also opted to not participate in the HPV vaccination programme.

With four out of five people becoming infected with HPV at some stage in their lives, and peak incidence of HPV being between the ages of 16 and 20 we recognise the importance of achieving a better result in the future.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Seasonal influenza immunisation rates in the eligible population (65 years and over)	68%	58%	75%	52%	●

Our performance:



Influenza is a significant public health issue in New Zealand. Each year 10-20 percent of New Zealanders are infected, some of these become so ill they require hospital care, and a small number die. Influenza vaccination is funded for certain groups of people who are considered to be at greater risk of complications from influenza, one of these groups are those aged 65 and over.

Seasonal influenza immunisation rates in our population 65 and over remain lower than the baseline despite initiatives such as access to vaccinations at your pharmacy. We have also seen greater support from the Aged Residential Care sector, Older Persons Forum, and special immunisation events for kuia and kaumatua. Despite all these positive activities we have achieved a disappointing result and are investigating to identify why our immunisation results are declining.

There have been anecdotal reports from the Midlands Community Pharmacy Group that although patients wanted to have the their influenza and shingles vaccinations from their local pharmacy they did not want to pay for Zostavax and had to make another trip to their GP to get the vaccinations at no cost This may have had an impact on our rates.

People are supported to take greater responsibility for their health

Improving health behaviours

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
95 percent of obese children identified in the B4 School programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	Māori 7% Pacific 19% Other 8% Total 9%	Total 81%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 100% Pacific 100% Other 100% Total 100%	● ● ● ●

Our performance:

Children who are identified as obese are referred to a health practitioner usually by their general practice and after a health assessment are offered referral to Sport Waikato's Active Families service close to where they live. Obese children are at higher risk of adult obesity and are more likely to have diabetes and heart disease. With New Zealand's obesity rates now amongst the highest in the world it is important to support whānau/families to take responsibility for their health and wellbeing. We have invested in a number of early intervention health promoting and lifestyle programmes to reduce the long term impact that poor nutrition and exercise habits have on our communities.

Waikato has consistently achieved a 100 percent referral rate over the year and maintained a lower number of declines with a quarter four result of 12 percent, this is lower than the national decline rate of 22 percent. A qualitative review on declines will be completed by December 2018 as part of our Raising Healthy Kids funding.

Whaanau Kori, Tamariki Ora is the new programme being offered by Sport Waikato. The programme was launched in quarter four and referrals have been received from across the Waikato district.

The programme has been specifically developed as an intervention programme for four to six year old children and their whānau in the unhealthy weight range. Its content focuses on supporting whānau to make healthy lifestyle changes including food options, ideas to keep kids moving and active, reducing screen time and improving sleep. Evaluation is embedded in our new intervention programme and funding is allocated in 2018-2019 to start evaluating the programme. The evaluation will also capture consults reporting data being collected by primary care. This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
The number of people participating in Green Prescription programmes	5802	5868	6700	5784	● (red)

Our performance:

This service is provided by Sport Waikato to, where appropriate, support people to make healthy food choices and increase their physical activity rather than, or in addition to, taking medications to treat health issues.

Due to a reduction in staff numbers and in response to staff wellbeing concerns Sport Waikato were pleased to attain over 86 percent towards the target. 27 percent of all clients were Māori which compares favourably with Waikato DHBs current 23 percent of total Māori population.

Some highlights from the year include an increase in referrals from Waikato Hospital as well as from Ngaruawahia medical centres. Also, in the last quarter of the year, 10 businesses took up the 12 week challenge which allowed a better reach across a wide range of staff, and to work holistically with the business sector around healthy eating and physical activity initiatives.

Waikato DHB is working alongside Sport Waikato to look at some of the challenges faced with a view to reformulating how Green Prescriptions can best service our diverse Waikato population and target the right demographics. This work will help achieve better outcomes for identified high need areas that current Green Prescriptions cannot cater for including high need teenagers and family groups.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	100%	100%	93.8%	100%	● (green)
Output measure	**Baseline 2014-15**	**Previous year 2016-17**	**Target 2017-18**	**Result 2017-18**	**Rating**
Percentage of total primary schools participating in Project Energize	100%	100%	98.8%	100%	● (green)

Our 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. Engaging with all schools to increase children's physical activity and improve nutrition will improve health outcomes.

The programme has a team of Energizers from Sport Waikato who deliver practical 'hands on' support and assistance to schools and teachers with initiatives to increase physical activity and improve the uptake of healthy eating. The programme is tailored to each school to suit the needs of the children, teachers, parents and wider school community with the goal of achieving great changes in small steps. All Energisers have tertiary education skills in teaching or dietetics. Energizers working in Kura Kaupapa Māori can speak Te Reo Māori.

People stay well in their homes and communities

Long term impact	Intermediate impacts	Impact and outputs
People stay well in their homes and communities	An improvement in childhood oral health	Mean decayed missing and filled teeth score of Year 8 children 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
	Long-term conditions are detected early and managed well	Percent of the eligible population who have had their cardiovascular risk assessed in the last five years Percentage of 'eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past five years Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months Percentage of eligible women aged 50-69 who have a BreastScreen Aotearoa mammogram every two years
	Fewer people are admitted to hospital for avoidable conditions	Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45-64 year olds Percentage of eligible population who have had their B4 School checks completed Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to aged related residential care Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days Percentage of people enrolled with a PHO Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

Why does this matter?

Having an accessible primary and community health service lowers rates of premature mortality from long-term conditions and achieves better health outcomes, at a lower cost than relying on specialist level care. Providing services that support people to stay well in their home and community has many positive outcomes including good oral health, reduced hospital admissions for avoidable conditions, and long-term conditions being detected early and managed well. Meeting people's needs before they become acute reduces pressure on our hospitals and frees up specialist capacity and financial resources. It also means people are able to maintain independence, remain in their community and return to work or normal activities sooner.

Good health begins at home and in communities so it makes sense to support people's health through services located as close to home as possible. This poses some challenges for Waikato DHB where we have communities that range from affluent urban areas to isolated rural areas, some of which experience high deprivation. We are dedicated to delivering faster, more convenient health care closer to home. To achieve this we are using new technologies, mobile health screening services and developing workforce skills to provide a wider range of preventative and treatment services in the community.

● We've achieved the target	● We've not met the target

An improvement in childhood oral health

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Mean decayed missing and filled teeth score of Year 8 children	Māori 1.65	Total 0.92	Māori 0.92	Māori 0.69	
	Pacific 1.40	Pacific 0.92	Pacific 0.92	Pacific 0.71	
	Other 0.87	Other 0.92	Other 0.92	Other 0.34	
	Total 1.08	Total 0.92	Total 0.92	Total 0.58	

Our performance:

This measure is the mean number of decayed, missing and filled permanent teeth for 12-13 year olds. The result is sourced from the new Community Oral Health Service electronic information platform (Titanium). The cohort of Pacific children is statistically too small (211 children) for meaningful results.

Year eight children were the 2010 cohort of five year olds. Only 50 percent of this cohort group were caries-free at five years of age and the number of decayed missing and filled first teeth averaged 2.4. Past decay is a proven indicator of the likelihood of experiencing further episodes of decay and the subsequent seven years of access to regular services with a preventive focus has resulted in 78 percent who have never experienced decay in their permanent teeth at 12 years of age.

Children who identify as Māori are more likely to have decayed, missing and/or filled teeth (70 percent have never experienced decay in their permanent teeth for Māori versus 82 percent for 'other' ethnicities). The inequalities gap is reducing through preventively focused care including fluoride varnish.

The electronic patient record and management system, Titanium provides an easier way to manage recalls based on risk, sends automated text messages of appointment times, and will greatly assist with sustaining oral health improvements over time.

Parents are invited to assessment appointments with their children. This differs to previous generations of children who were taken from class with no parental involvement. The changes have been implemented because of recognition that parents' health literacy and the home environment is critical to good oral health.

An in-school brushing programme will be made available in schools who wish to implement it.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of children (0-4) enrolled in DHB funded dental services	Māori 72%	72%	Māori ≥95%	Māori 58%	
	Pacific 72%		Pacific ≥95%	Pacific 57%	
	Other 72%		Other ≥95%	Other 87%	
	Total 72%		Total ≥95%	Total 74%	

Our performance:

The Oral Health Service (the service) has been short staffed and struggled to recruit Oral Health Therapists to rural vacancies putting the service under pressure and significantly more time committed to travel to cover these areas. The Multi-Employer collective that restricts hours of work for dental therapists and affects salaries has resulted in Waikato DHB being a less favoured employer in a competitive market. The People and Performance team are helping the service management team to renegotiate with the relevant union and we hope to see a resolve by 2019. We will continue to provide opportunities for under-graduates to gain work experience at Waikato DHB in an effort to attract them back as graduates to help ensure there is adequate workforce for the future. We will target graduates to fill vacancies in late 2018.

The Service has a preventive focus which requires more than 2.00 appointments per annum for children who are identified as at-risk. This is proving effective in improving oral health but is also very time consuming. The service was scoped for 1.8 appointments per child. Some low-risk patient groups are being seen on a 15 month rotation thereby freeing time and resource for high risk patient groups.

We offer enrolled pre-schoolers an appointment from nine months of age. The number of appointments that are failed to attend remains high and at approximately 30 percent of appointments scheduled for pre-schoolers. To try and reduce this number an automated text messaging service is used for appointment reminders. Saturday and late night clinics have also been implemented in selected locations which are often more convenient for parents who are working.

People stay well in their homes and communities

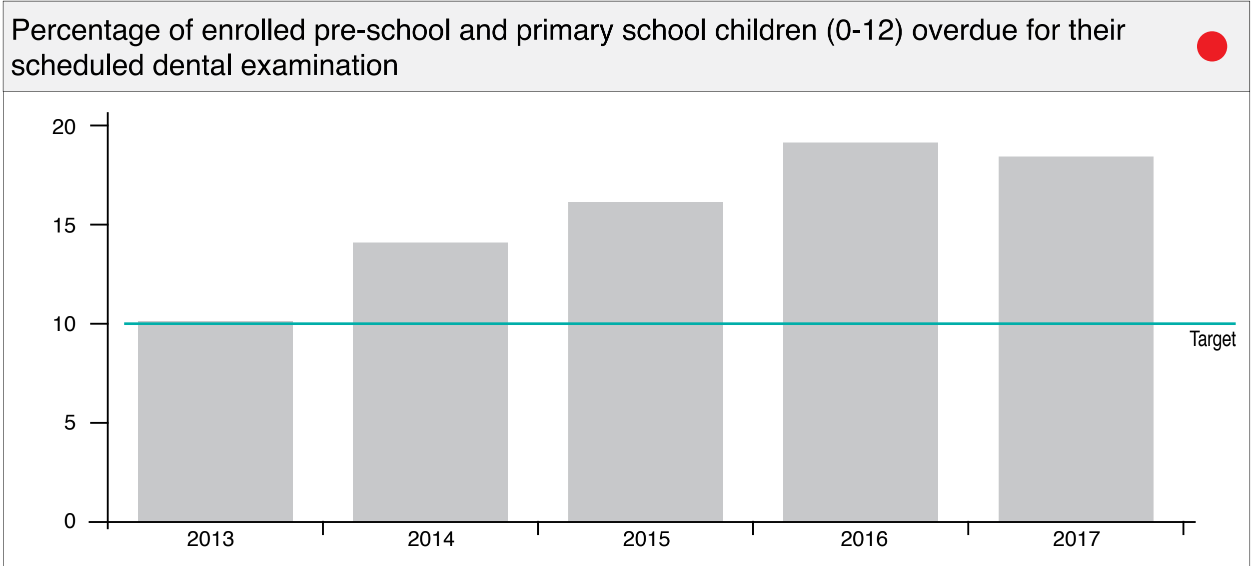
2017-2018 has seen the successful transition from a paper based system to the new electronic platform of clinical records, Titanium. This is an achievement but the transition process has slowed the service.

We remain committed to achieving targets and are actively enrolling pre-schoolers and commenced an enrolment project in February 2018.

Output measure		Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Total	14%	19%	≤10%	18%	●

Our performance:

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



It is important that oral health care commences very early in a child's life to prevent them experiencing decay. The Community Oral Health service has commenced setting first appointments for babies at nine months of age, rather than two and a half years as in the past. The first appointment includes offering the whānau/family advice on diet and brushing. Oral health is integral to health and wellbeing and it is anticipated this change will reduce the severity and prevalence of dental decay.

In addition to population growth and the increased number of appointments required from changing the age of the first appointment, the Community Oral Health service transitioned from paper-based clinical records to an electronic platform (Titanium) during 2017. This slowed the service for implementation and staff learning. The workforce is a challenge to recruit to, with the demand for oral health therapists exceeding supply of graduates. The Community Oral Health service has experienced shortages of staff in rural locations and staff have demonstrated their flexibility in travelling to rural locations to ensure patients have access to care. The service is working with the union to review terms and conditions to maintain its competitiveness in today's environment.

For 2018, the service is actively enrolling pre-schoolers, using the new system linkages now available with the electronic information system. Saturday and late night clinics in selected locations have been initiated to increase available appointment hours.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of adolescent utilisation of DHB funded dental services	Māori 45% Pacific 53% Other 80% Total 70%	70.8%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 50% Pacific 56% Other 85% Total 70%	● ● ● ●

Our performance:

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

We remain committed to increasing adolescent utilisation of DHB funded dental services, we know that maintaining good oral health during childhood and adolescents is an important indicator for good lifelong oral health. Establishing good oral health behaviours such as twice daily brushing and regular dental check-ups until a child turns 18 years old will help to put in place routines that should last a lifetime.

We have maintained our coverage, with mobile dental services in secondary schools having a positive impact on utilisation, especially for Māori uptake.

To further increase uptake we have been meeting with innovative mobile dental providers who demonstrate ability to understand how best to get youth into dental care including social networking.

Work is underway to support access for adolescents close to home by ensuring almost all our rural towns have local dentists willing to provide this service.

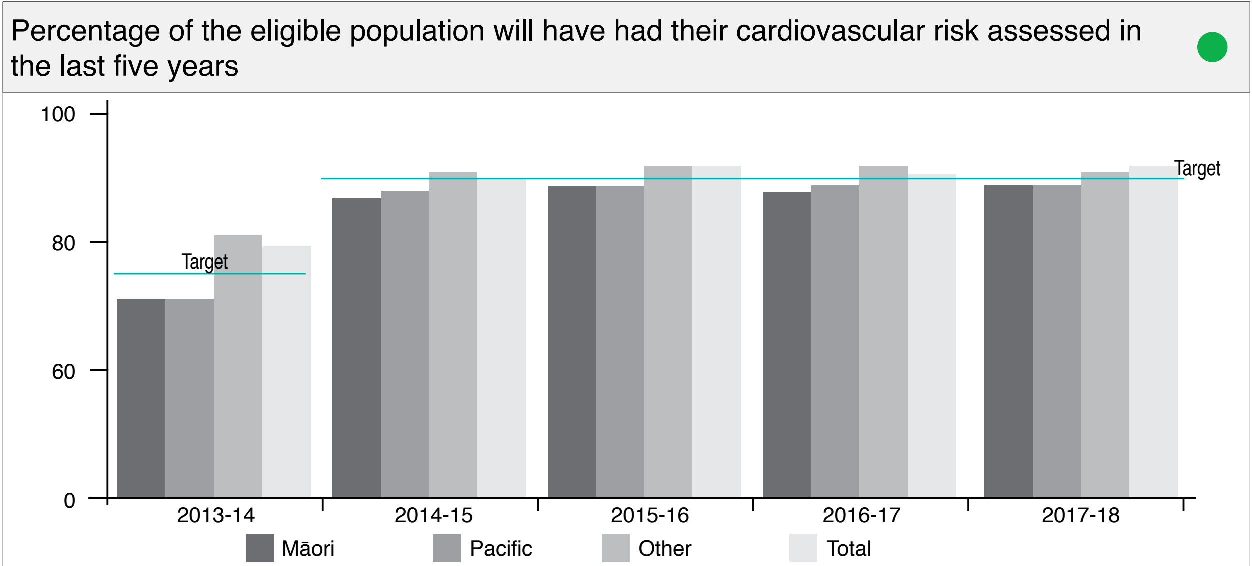
To ensure we are delivering the best service possible, we are collaborating with our regional colleagues at annual meetings where we share successes, challenges and learn from each other about how uptake can be improved.

People stay well in their homes and communities

Long-term conditions are detected early and managed well

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
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 88% Other 92% Total 91%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 88% Pacific 88% Other 92% Total 91%	Red Red Green Green

Our performance:



We are pleased to see we have met the target even with the shift in focus to the new measure of eligible Māori men aged 35-44 years. The PHOs have worked hard to achieve this result and have been working on many initiatives throughout the year. Some particular highlights have been:

- GPs are utilising Cardiovascular Disease (CVD) bio-markers to follow up patients
- The algorithm for CVD risk equation continues to be utilised by the practices
- PHO clinical advisory groups closely monitoring progress
- 'Text to remind' in all the practices to encourage patients to have their check
- Certified Case Manager (CCM) nurses and kaiāwhina following up patients who require assessment; and
- A joint DHB/PHO working group was set up to define and agree the service specification and funding.

These initiatives are proving to be successful and we will continue with them in 2018-19. Identifying our high risk populations and targeting specific interventions such as cardiovascular risk assessment, ensures our population have the best chance of early detection which often results in less invasive and more cost-effective treatment options and better long term outcomes than when conditions are diagnosed at a late stage.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past five years	74%	New measure	82%	88%	●

Our performance:

A cardiovascular disease risk assessment informs people about their risk of cardiovascular events, as well as strategies to improve their heart health. It also helps to identify people with diabetes to receive care and learn about helpful lifestyle changes. There remains a significant disparity between Māori and non-Māori access to primary care services and risk assessments making an equity focus for assessment coverage and risk management imperative.

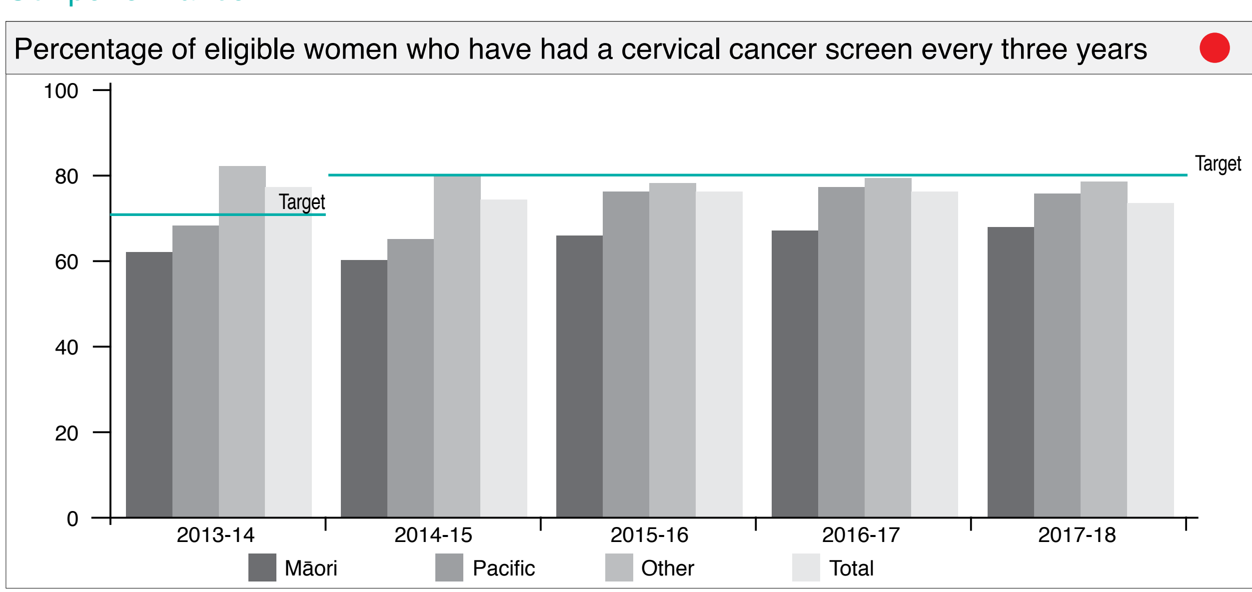
Over the 2017-18 year we achieved a lot of great initiatives to ensure we met the target, some particular highlights have been:

- a PHO Māori Health dashboard was set up to assist with identifying at-risk populations. The dashboard is being used as both a flag for patient follow-up and an early intervention tool. This will prove very useful in terms of the CVD target for Māori men
- the release of new CVD guidelines. Reconfiguration of the decision support tools and education resources
- Certified Case Manager (CCM) nurses and kaiāwhina following up patients who require assessment; and
- practice champions working hard to maintain the overall target

These interventions have been successful and we will continue with them in the 2018-19 year.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months	Māori 60%	Māori 67%	Māori 80%	Māori 68%	●
	Pacific 65%	Pacific 77%	Pacific 80%	Pacific 73%	●
	Other 80%	Other 79%	Other 80%	Other 78%	●
	Total 74%	Total 76%	Total 80%	Total 76%	●

Our performance:



While we have not met the target we have improved on last years result. The final quarter of the year has also seen an improvement in Māori coverage from 66 percent to 67 percent.

A challenge in meeting this target has been a vacancy in the Specialty Cervical Clinical Nurse role which has reduced the number of practice visits and education possible in 2017-18. However, we have now filled this position as at end of July 2018.

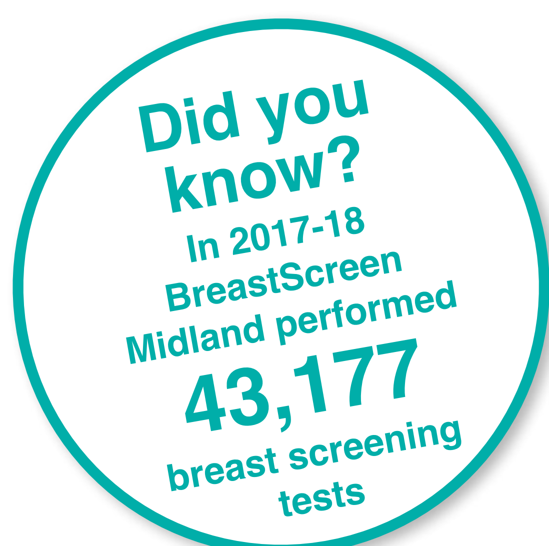
People stay well in their homes and communities

Despite having a resource gap we achieved many positive activities including:

- ongoing data matching between the National Cervical Screening Register and PHOs/medical centre data
- development of a joint breast and cervical screening clinic
- providing opportunistic smear taking in the new DHB Hauora iHub;
- monitoring effectiveness of the 'Significantly Overdue' contract the DHB has in place with PHOs
- organising and attending events for opportunistic smear taking for priority women such as Te Wānanga o Aotearoa
- supporting smear taking at events on Maraes and at Pokai's
- support to PHOs when attending events
- joint breast and cervical screening days on Saturdays for priority women
- collaborative participation in #Smearyourmea campaign
- working collaboratively to support staff with Support to Screening Services and Colposcopy
- presenting to a WINTEC education session for nurses doing their cervical smear training
- supporting screening services provided to priority women
- annual cervical cancer and smear taking update evening in May which had 165 primary care staff attend; and
- cervical screening newsletters for PHOs to distribute to their practices.

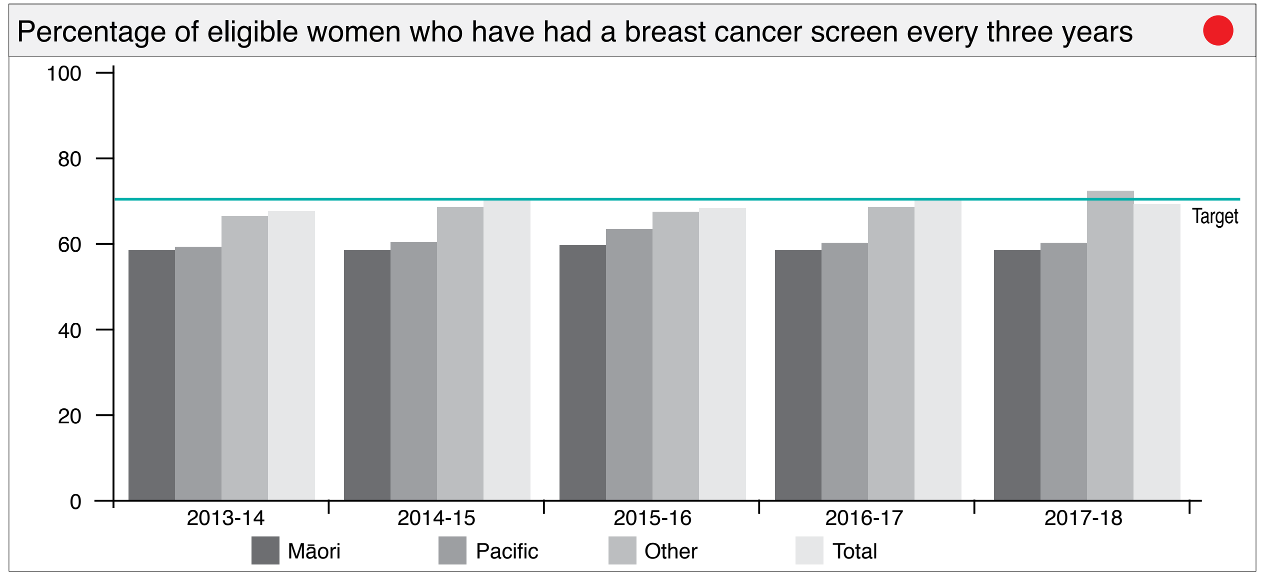
To continue our work towards achieving this target in the future we have planned activities for continuous improvement. These include:

- Development and implementation of a collaborative plan with PHOs and the DHB focusing on improving equity
- Increasing opportunistic screening 'closer to home' and within the Hauora iHub
- Education and training in targeted areas of highest need and lowest participation
- Focused initiatives on improving participation rates for priority women
- Improve the use of data-matching reports and timeliness to screening in primary care practices
- Leading the development of a North Island Hui and knowledge hub to improve shared learnings on improving equity within cervical screening; and
- Implementing national policy changes in age of eligibility onto the cervical screening programme.



Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
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 58% Pacific 60% Other 70% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 58% Pacific 59% Other 71% Total 69%	Red Red Green Red

Our performance:



Percentage of eligible women who have had a breast cancer screen every three years

While we have not achieved the target we have seen an increase in screening volumes with an additional 818 woman being screened compared to last year's result. Māori coverage has remained at 68 percent however this is still an additional 151 Māori wāhine being screened compared to last year. Waikato DHB has also seen an improvement for Pacific women from 57.4 percent in 2016-17 to 58.8 percent in 2017-18.

BreastScreen Midland (BSM) will continue to focus on the rescreen timeliness to get rescreens completed within the 24 month timeframe as well as improving the participation rates of our priority women. The 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 and despite screening more women each year, capacity constraints mean we cannot reach coverage targets. Eligible women on the programme should be screened within 24 months of their previous mammogram, however, the capacity constraints on the mobile schedule visits, and at fixed screening sites, means we are unable to achieve the target for our populations. To address the issue, a Business case for an additional Mammography machine has been developed.

Some highlights from 2017-18 include:

- Māori first timers – providing texts is continuing and an evaluation is in its early stages of development
- strengthening community engagement within identified communities with the lowest participation in the programme
- communication and engagement plan with a focus on targeted areas with low participation and coverage
- provided opportunistic breast screening for eligible women from the new DHB Hauora iHub;
- short notice bookings are accepted at all sites
- increased availability of Saturday appointments at fixed sites
- launch of new BreastScreen Midland Facebook page; and
- proactive participation in national initiatives relating to breast screening.

In 2018-2019 we will be looking to increase coverage through initiatives such as increase availability of out of hours appointments, increasing awareness and participation initiatives with a focus on improving equity, and implementing innovative ways to improve participation for priority women with events planned across the Midland region.

Fewer people are admitted to hospital for avoidable conditions

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for the following age group: 45 - 64 year olds	Māori 7758 Pacific 6557 Other 3239 Total 4066	4,386	Māori 7603 Pacific 6426 Other 3207 Total 4025	Māori 9434 Pacific 6844 Other 3471 Total 4544	● ● ● ●

Our performance:

There has been an increase in admissions within the 45-64 year age cohort, the increase is driven by admissions for angina/chest pain, Chronic Obstructive Pulmonary Disease (COPD), cellulitis and pneumonia. As part of the System Level Measure framework, Waikato DHB will be focusing on reducing amenable mortality rates and the number of acute bed days. This framework has a particular focus on Māori and Pacific and we expect the results of this work to have a positive impact on our ASH rates in the future.

Some key work that will be undertaken in the coming year includes:

- Increasing the proportion of Māori males (aged 35-44) having a CVD risk assessment.
- Carrying out chart audits of patients having a CVD event and not prescribed triple therapy
- Distribution of information and treatment packs containing education materials with basic creams/ antiseptics to Māori/Pacific whānau in order to manage Cellulitis ASH rates
- Increasing number of referrals of Māori/Pacific patients to the COPD Homebased support team. This new integrated care model will place respiratory nurse specialists in Waikato DHB, Hauraki PHO, and Pinnacle PHO who will work together with GPs/ambulance services to reduce COPD admissions targeting Māori/Pacific populations; and
- Increasing the number of Māori/Pacific Asthma patients undergoing GASP assessment and having a care plan in place to promote self-management and ultimately, reduce hospital admissions.

By June 2022 we aim to reduce amenable mortality for Māori and Pacific by 4 percent. By June 2019 we expect to have reduced acute bed days for Māori, Pacific and for 'Other' by 2 percent and 1 percent, respectively. 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, and are being used optimally.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of eligible population who have had their B4 School checks completed	Māori 77% Pacific 83% Other 98% Total 90%	90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	● ● ● ●

Our performance:

The 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 in school.

This target has been achieved by Midlands Health Network, working in partnership with Public Health Nurses (PHN) who deliver the check for those families/whānau who do not attend their usual general practice. Midland Health Network coordinates this service for Waikato DHB and works closely with their own general practices and other PHOs to ensure there remains a focus on getting checks completed for Tamariki Māori and those children living in areas of high deprivation (quintile 5). One of the positive initiatives that has helped achieve this target has been offering B4 School checks later in the day which is often more appropriate for parents who are working.

We know how crucial early identification of a child's needs is for them to have a good start to their primary education and we will continue to ensure we maintain good results in 2018-19.

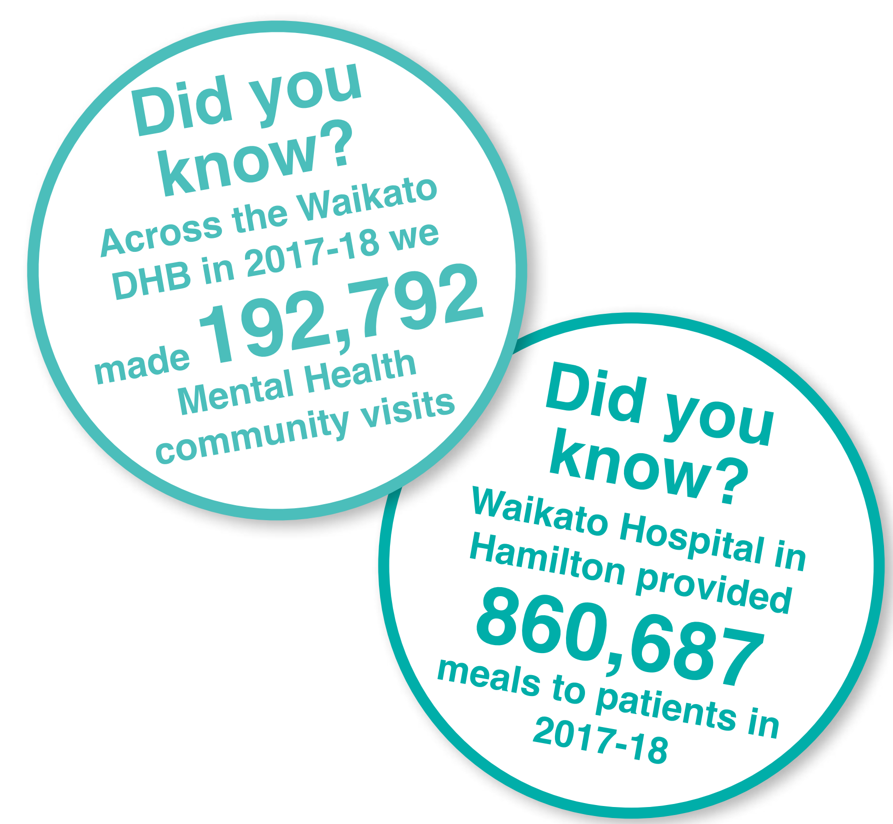
Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	3.9/100,000	2.5%	1.2/100,000	3.6 per 100,000	●

Our performance:

During the 2017-18 year, there were 15 notified cases of acute rheumatic fever in the Waikato district. This is a disappointing resurgence after a decrease in the initial years after the Better Public Services target was launched. All the cases in the 2017-18 year were Māori ethnicity, reflecting persisting inequities in health access, service, and outcomes.

A number of initiatives remain in place in an attempt to reduce these inequities, including:

- Quarterly meetings of the Waikato Rheumatic Fever Governance Group;
- Community contracts with Māori and Pacifika providers to increase awareness;
- Free sore throat swabbing services for eligible children in a number of pharmacies, schools, and primary care; and
- Whare ora programme to improve housing conditions for vulnerable whānau.



People stay well in their homes and communities

More people maintain their functional independence

Impact measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Average age of entry to aged related residential care:					
• Rest home	Resthome 85 years	Resthome 84	Resthome >84 years	Resthome 84	
• Dementia	Dementia 83 years	Dementia 82	Dementia >80 years	Dementia 82	
• Hospital	Hospital 86 years	Hospital 84	Hospital >85 years	Hospital 85	

Our performance:

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

Although extremely 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+). When 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 65 and over 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.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	100%	100%	100%	100%	

Our performance:

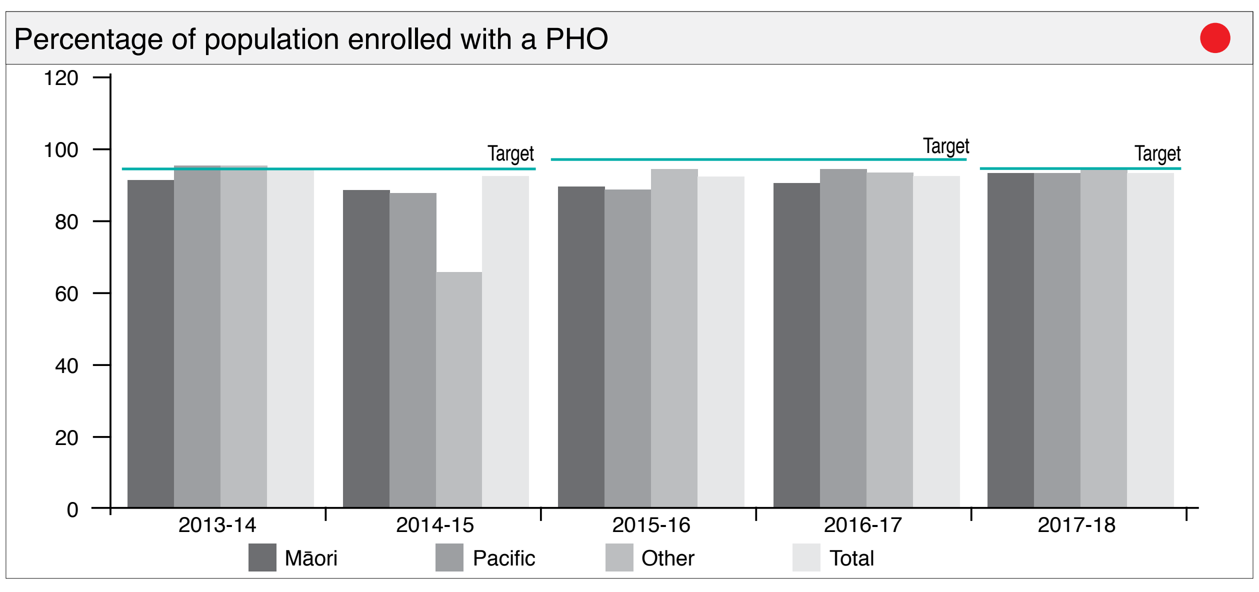
We maintained throughout the year the target of 100 percent of clients having a care plan. This target is based on the outcome of an International Residential Assessment Instrument (InterRAI) with the minimum data set- homecare assessment tool (MDS-HC). Any care plan that is put in place is tailored to the individual's needs and enables the older person to access the assistance they need while maintaining their independence.

Waikato DHB continues to use regional and district algorithms based on assessed data which inform the functional profiles of our older population. Using a common language of assessment across regions will help us to deliver a more unified and improved health and disability system.

Additional funding has been allocated to address the needs of clients who have been identified as 'at-risk' of avoidable admissions. The reassessment frequency has been increased to ensure changes or decline is identified and managed within the community. A service plan is also developed to meet the needs identified on the reassessment.

Output measure	Baseline		Previous year 2016-17		Target 2017-18		Result 2017-18		Rating
Percentage of people enrolled with a PHO	Māori	91%	Māori	93%	Māori	95%	Māori	94%	●
	Pacific	88%	Pacific	97%	Pacific	95%	Pacific	94%	●
	Other	66%	Other	96%	Other	95%	Other	95%	●
	Total	95%	Total	95%	Total	95%	Total	94%	●

Our performance:



We failed to meet the target for Māori and Pacific but there are a number of initiatives in place to ensure better enrolment rates for these population groups in the future. One of the activities to increase enrolment rates includes referral from Waikato Hospital Emergency Department and Hauora iHub for un-enrolled individuals and whānau to have a free consultation (avoiding casual fee) with a general practice of choice.

We will continue to encourage people to join a PHO because access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early. Māori tend to have lower enrolment rates and we will continue to target this group in the hope that we will achieve the target in 2018-19.

People stay well in their homes and communities

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days	62%	79%	100%	94%	●

Our performance:

While we have not met the target we have made significant gains. Whilst we prioritise these referrals and make every effort to assess clients within 20 working days, often family members or other circumstances can lead to a delay:

- Sometimes the client is away staying with a family member temporarily
- sometimes an existing acute service is in place such as START or acute home-based supports, meaning that we will assess and take over at a later date; or
- often a client will delay the assessment so that a family member can be present - this often happens with low-risk/non-urgent referrals.

Disability Support Link has a unique Māori NASC process. Clients who identify as Māori are able to access a Māori needs assessor, a Māori service coordinator and Māori service provision. This has improved access so that the proportion of Māori accessing services within the Disability Support Link population is higher than the proportion of Māori in the age bands of 65 and over within the Waikato.

Disability Support Link has continued to build on the service improvement it has put in place over the last three years. In 2015-16, the service completed 7542 interventions, in 2016-17 it completed 10,305 interventions and in 2017-18 it will have completed 13,620 interventions. This means more timely and frequent reviews and assessments, targeting high risk clients to prevent emergency department presentations and unplanned admissions.

One hundred percent of clients identified as high risk/urgent clients are seen and have services allocated within five days.

Disability Support Link has brought in acute home-based supports as part of the service, and also strengthened its links with START (supported discharge model). The aim is to create one referral to one service that manages the client and identifies what is the best support option for the client at that time. This will stop clients from being passed from one service to another and it will also simplify things for clients, families, and referrers. It will also allow for more timely acute interventions when required as part of a targeted admission avoidance model.

People receive timely and appropriate specialist care

Long term impact	Intermediate impacts	Impact and outputs
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours
		Percentage 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
	People have appropriate access to elective services	Standardised intervention rates (per 10,000)
		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
		Acute inpatient average length of stay
		Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates
		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
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives
		Number of new patients seen by the Waikato Hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
		Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)
		Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)
		Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)
		Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 2015-16) within 42 days
		Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date
		Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

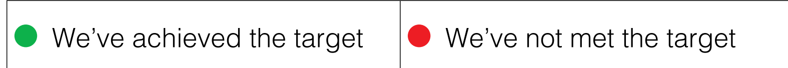
People receive timely and appropriate specialist care

Why does this matter?

Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience of care, and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system. Health care needs to be organised to meet the needs of patients in a timely manner. When people receive prompt and appropriate care it is indicative of a system that is working in a unified, coordinated, whole of system approach that improves hospital productivity and ensures health resources are used effectively and efficiently. Such a system would have timely access to acute care and elective services and effective services for those suffering from severe mental illness.

Where people have end-stage conditions it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.

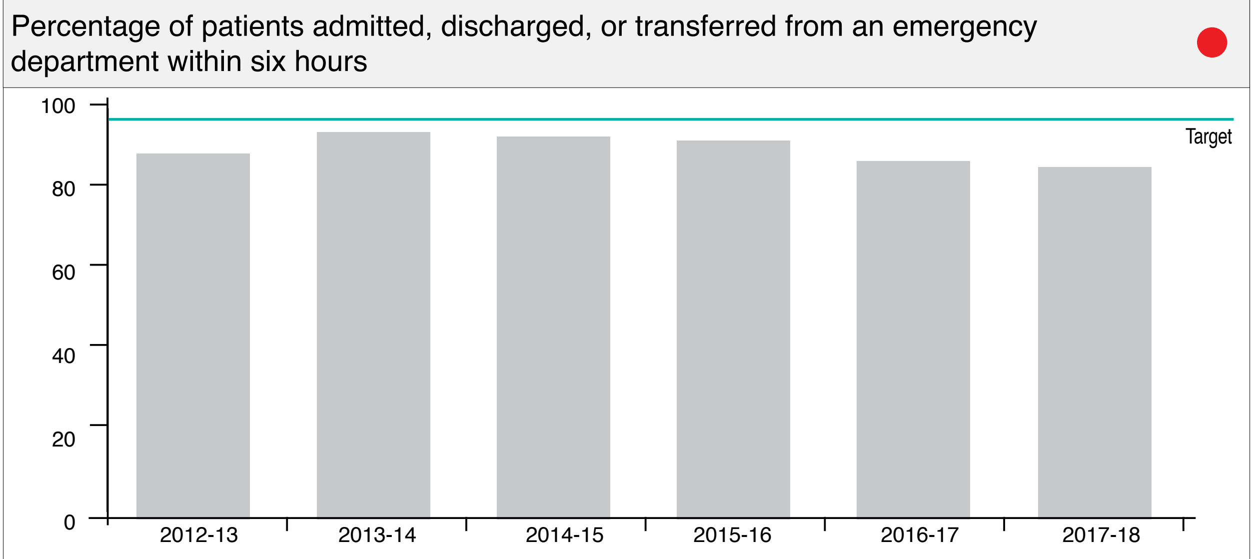
Achievement of this long term impact will improve the quality of life for our population through early diagnosis and intervention to avoid further deterioration, timely corrective actions to relieve pain or illness, and appropriate supports to manage end stage conditions.



People receive prompt and appropriate acute and arranged care

Impact measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	Māori 92% Pacific 91% Other 91% Total 94%	86%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 88% Pacific 76% Other 85% Total 85%	● ● ● ●

Our performance:



An increasing number of patients presenting to the emergency department (7.3 percent increase for the year) saw a drop in our percentage achievement despite extra resources employed.

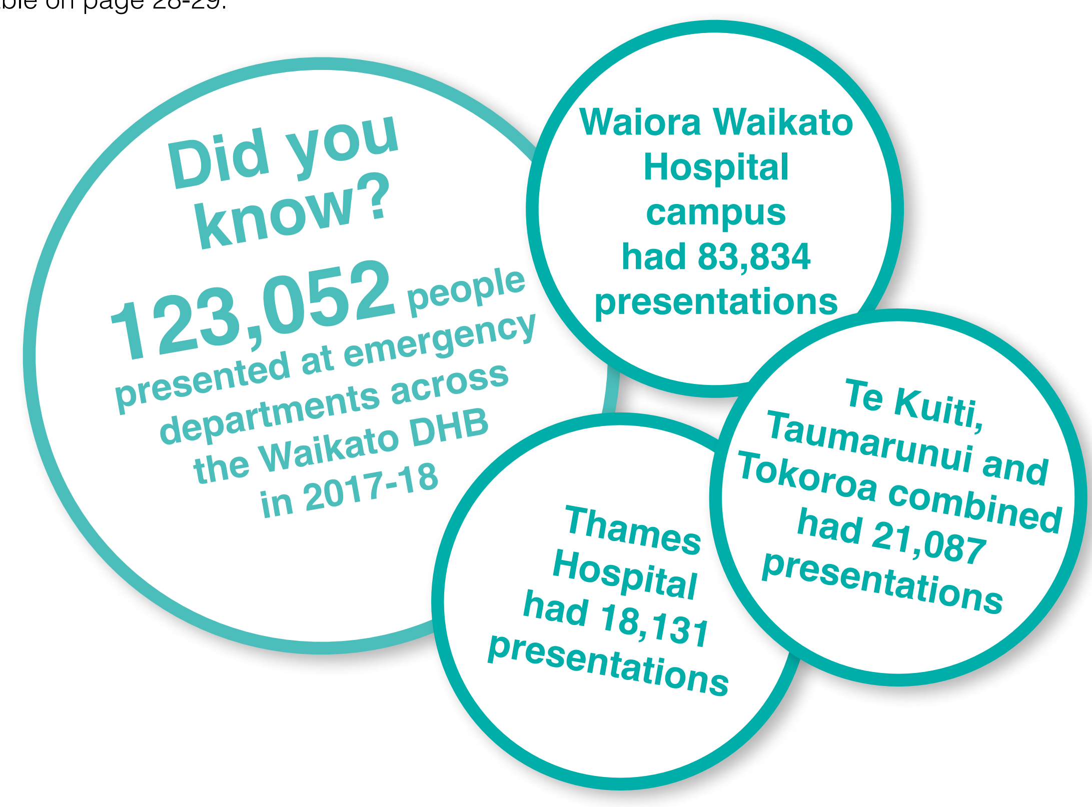
There were a number of initiatives undertaken during 2017-18 and they included:

- recruitment to the agreed $4 million additional staffing completed for the Emergency Department staff
- continued co-design work with ACC and mental health. Cost pressure business case approved for providing mental health nursing resource in the Emergency Department – recruitment to occur in 2018-19
- engagement with the Francis Health Group to trial and agree on the streaming process for all patient groups through the department
- changes in medicine to a ward based model, with emphasis on patient flow from the Emergency Department to the most appropriate ward
- opening of an additional 27 bedded ward in Ward OPR 5 to provide acute geriatric medicine ward. This included the recruitment of three acute geriatricians
- an eight-week pilot of a clinical nurse specialist-led model of care in the Emergency Department at Thames commenced in April
- a formal tender process to seek expressions of interest to establish a primary care presence within Thames Hospital has been concluded; and
- additional nursing resources have been established at Tokoroa Emergency Department to assist with the significant increase in workload at that facility and are currently being recruited.

The 2018-19 year will focus on:

- agreeing the streaming process from triage for all patient groups
- opening an Acute Surgical Assessment unit (25 beds)
- implementation of mental health nurse resource in the Emergency Department
- review of the staff-mix in the Emergency Department, in particular the nurse practitioner positions
- COPD pilot with the objective of keeping these high user patients from representing through good management plans
- single point of entry (SPoE) service model in Taumarunui continues to be on track for implementation of the new service model from 1 July 2018; and
- a project to implement an onsite general practice and SPoE at Thames has commenced (this will take most of 2018 to achieve).

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.



People receive timely and appropriate specialist care

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage 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%	86%	90%	95%	● (green)

Our performance:

2017-18 saw an achievement of 95 percent showing a great improvement from last year's result of 86 percent.

There were a number of initiatives undertaken during 2017-18 that contributed to this result, some of the highlights include:

- monitoring Faster Cancer Treatment (FCT) Health Target achievement for patients on lung cancer pathway ensuring gains of the one stop shop model were embedded and maintained
- management and clinical leadership continued working together to implement service improvement initiatives to ensure gynaecological patients met the FCT health target and indicator wait times
- transitioning the Urology Service to fully utilise the DHB management system and embedding FCT business rules into urology business as usual process
- monitoring the fast tracking processes to identify all FCT referrals for diagnostics, where there is a high suspicion of cancer a red stamp on referral the form is used; and
- engaging with Te Puna Oranga to minimise inequity in the cancer service, including and addressing 'did not attends' (DNAs) and identifying barriers.

In 2018-19 we will focus on:

- ongoing monitoring of lung cancer one stop shop mode
- rolling out the Early Detection of Lung Cancer pilot, with a specific focus on Māori
- ongoing engagement with Te Puna Oranga
- review, with the Midlands Cancer Network, the Sarcoma pathway across the region
- monitoring the fast tracking process to identify all FCT referrals for diagnostics with a high suspicion of cancer with the use of the red stamp on referral forms; and
- develop plans and proposals for improved and expanded Chemotherapy Day Stay facility to accommodate and treat the increasing number of cancer patients.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	Māori 5% Pacific 5% Other 9% Total 10%	10%	Māori <16% Pacific <16% Other <16% Total <16%	Māori Pacific Other Total 8.3%	NA NA NA ● (green)

Our performance:

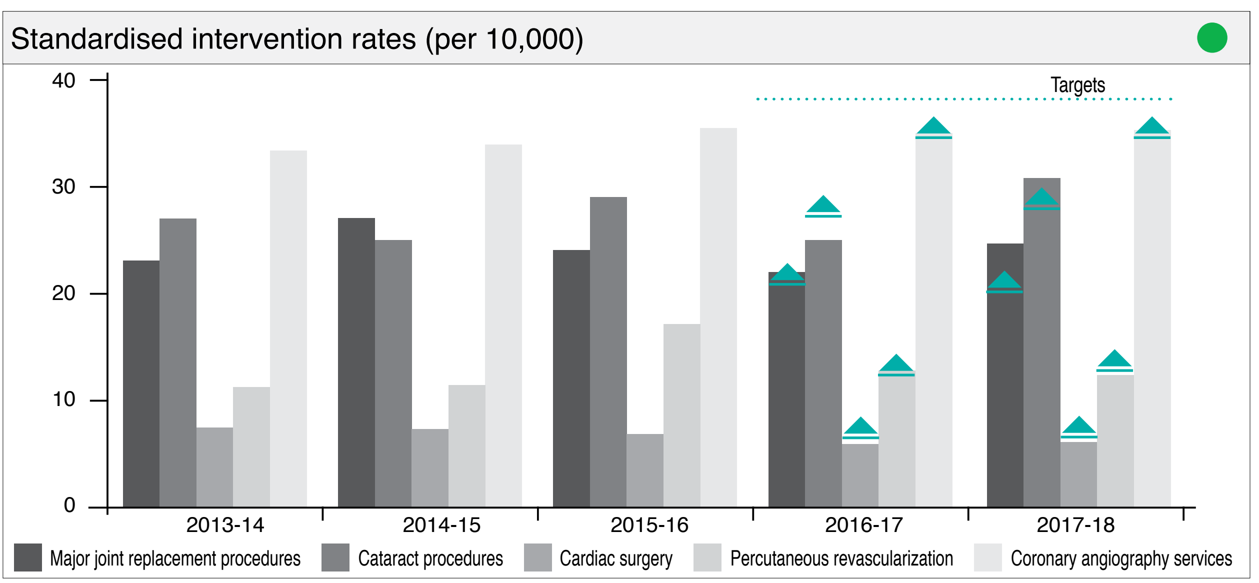
Caesarean sections have some significant associated risks including, increased maternal mortality, maternal and infant morbidity, and increased complications for subsequent deliveries. Through education and advice we wish to see the percentage of caesarean sections decrease over time. This appears to be working as we see a decrease from 10 percent in 2016-17 to eight percent in 2017-18. 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.

Our NGO providers are not currently reporting by ethnicity which means we can only report the total figure. Reporting by ethnicity will be a priority in 2018-19.

People have appropriate access to elective services

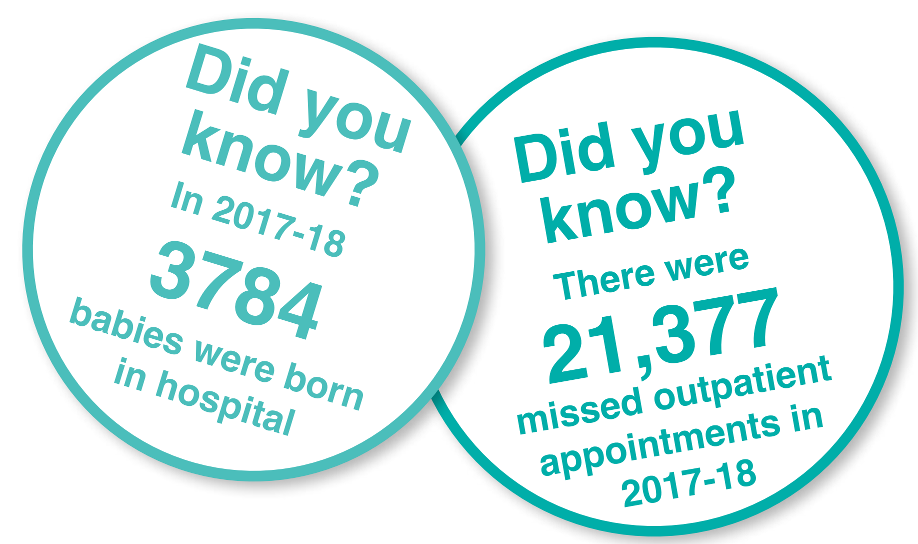
Impact measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures	27	22	21	27	● (green)
• Cataract procedures	25	25	27	31	● (green)
• Cardiac surgery	7.3	5.9	6.5	6	● (red)
• Percutaneous Revascularization	11.4	12.8	12.5	12	● (red)
• Coronary Angiography Services	33.9	35.0	34.7	35	● (green)

Our performance:



Although we did not meet the target for three of the Standardised Intervention Rates, the result is not significantly different from the target. Waikato DHB is committed to delivering timely access to elective services recognising that meeting standard intervention rates for a variety of types of surgery indicates 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.

The focus of 2018-19 will be on continuing to improve performance against this measure. Improving the result for this measure will also indicate increasing hospital productivity and effective use of resources so that wait times can be minimised and year-on-year growth is achieved.



People receive timely and appropriate specialist care

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of patients waiting longer than four months for their first specialist assessment	2.7%	0.4%	0%	0.2%	● (red)

Our performance:

Although we did not achieve the target the result is not significantly different from the target. During 2017-18, 9290 patients received specialist appointments with only 22 of these waiting longer than four months.

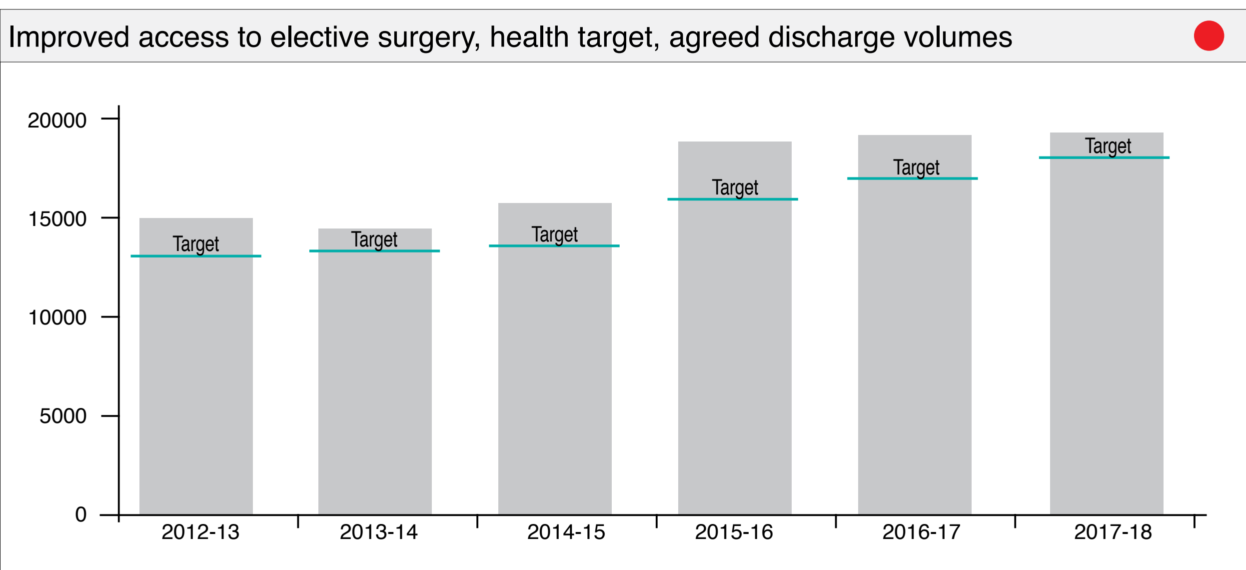
One major achievement for the year has been the Surgical Services Reinvention Project which is bringing together clinical staff and managers in surgical services to improve the end-to-end journey for people coming into our hospitals for surgery. This reinvention of our surgical services operating model is necessary for us to be able to meet current and future demand for surgery in the Waikato district. Some of the other key achievements for the year include:

- in the second half of the year Waikato DHB became compliant with the Elective Services Patient Indicators (ESPI) two; and
- the development of system management through a central operations centre approach.

We know that 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. Accordingly, we will continue to plan and implement initiatives that will help achieve this target in the future. This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 28-29.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Improved access to elective surgery, health target, agreed discharge volumes	15,693	19,179	17,475	18,362	● (green)

Our performance:



We are pleased to see that we have not only met the target but we have exceeded. Increasing the delivery of elective services should improve access and reduce waiting times, which should then increase public confidence that the health system will meet their needs.

The performance on this target is in part due to the Surgical Reinvention Project which aims to improve the end-to-end journey for people coming into our hospitals for surgery. We expect to see further improvement in our result as work on the project continues and the benefits become apparent.

Output measure	Baseline 2014-15	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Did-not-attend percentage for outpatient services	Māori 21% Pacific 18% Other 7% Total 10%	Māori 19% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 20% Pacific 17.5% Other 6.8% Total 9.8%	🔴 🔴 🟢 🟢

Our performance:

While we achieved the target for our 'Other' and 'Total' populations, we continue to miss meeting the target for our Māori and Pacific populations. This is now a Board mandated focus for 2018-19, Te Puna Oranga and the chief data officer are working together to understand the reasons for the high rate of DNA's among our Māori population and identify what we need to do to reduce the number. This work also includes engagement with the newly established Waikato DHB Consumer Council.

To help achieve a better result next year we are currently piloting a 'Patient Contact Centre' in the outpatient booking environment. This centre will provide a more accessible pathway for people to engage with, and have greater control over their own appointments.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Elective surgical inpatient average length of stay	1.71 days	1.62 days	1.54 days	1.57	🔴

Our performance:

Although we have not met the target we have improved from last years result of 1.62 days. The improved result has been achieved through the Surgical Reinvention Project, which is addressing the end-to-end system design for surgical patients. This project is also redefining the base operating model which has increased the focus on day surgery procedures.

The work that has started in the Surgical Reinvention Project will continue with the development of system management through a central operations centre approach.

We will continue to work towards shortening hospital length of stay (LOS) in 2018-19 while ensuring patients receive sufficient care to avoid readmission. Addressing the factors that influence a patient's LOS 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.

People receive timely and appropriate specialist care

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Acute inpatient average length of stay	3.89 days	2.46 days	2.4 days	2.42 days	●

Our performance:

Although we have not met the target the result is not significantly different from the target and is an improvement on last year's result of 2.46 days. One of the key initiatives that have contributed to improving this result is the Surgical Reinvention Project which is addressing end-to-end system design for surgical patients and redefining the base operating model, as a result, we are increasing the focus on acute surgery patient flow and decreasing unhelpful delays for surgery.

Another key initiative within the medical acute patient service has been bolstering the acute medical assessment unit function and early identification of "at-risk" elderly patients. The purpose of which is to avoid prolonged admissions or deconditioning.

Additional resource has also been allocated in the community through the Supported Transfer and Accelerated Rehabilitation Team (START) programme which aims to get patients back home sooner, and supports them to stay there.

We will continue to work towards achieving this target in 2018-19. It is desirable to continue making further reductions to the LOS 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.

Improve health status of those with severe mental health illness and/or addiction

Impact measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
28 day acute readmission rates	Māori 14%	12%	Māori ≤15%	Māori 13%	🟢
	Pacific 8%		Pacific ≤15%	Pacific 5%	🟢
	Other 12%		Other ≤15%	Other 9%	🟢
	Total 12%		Total ≤15%	Total 11%	🟢

Our performance:

The 28 day readmission rate for 2017-18 was 11.01 percent, similar to the previous years readmission rate of 11.83 percent. The only month in which there was a higher readmission rate than 15 percent was February 2018 where an increase to 16.10 percent was seen. A focus over the last year has been on developing models of care, flow through to community services, and linking clients to primary care.

We will continue to work towards achieving this target as it is an important means of stabilising and establishing, or re-establishing regimens for those with acute mental health and/or addiction issues. 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.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks	**3 weeks**	**3 weeks**	**3 weeks**	**3 weeks**	
	Māori 82%	77%	Māori 80%	Māori 75.3%	🔴
	Pacific 86%		Pacific 80%	Pacific 89.3%	🟢
	Other 72%		Other 80%	Other 69.4%	🔴
	Total 75%		Total 80%	Total 72.5%	🔴
	8 weeks	**8 weeks**	**8 weeks**	**8 weeks**	
	Māori 93%	91%	Māori 95%	Māori 92.1%	🔴
	Pacific 95%		Pacific 95%	Pacific 96.4%	🟢
	Other 90%		Other 95%	Other 86.9%	🔴
	Total 91%		Total 95%	Total 89.4%	🔴

Our performance:

Child and Youth Mental Health services within the DHB continue to face very high demand for their services and this is reflected in a deteriorating wait time result. However, work is ongoing to improve results, access and shorter waiting times. This will lead to earlier treatment in the progression of illness, which is linked to better outcomes.

Initiatives to address resourcing of these services are underway within the 2018-19 Annual Plan with further investment planned for the area with specific focus on the 0-19 category. Te Pae Tawhiti is a programme of work that encompasses new and re-vitalised models of care for mental health services that will take a fresh look at service delivery for communities and their whānau/families across the full social spectrum of their lives.

Work is well underway within the Te Pae Tawhiti child and youth mental health working group. This group includes those with lived experience, primary care representatives, and population health. The work spans the spectrum from prevention and promotion through to secondary care. This working group are developing their model of care and outcomes framework, it is hoped that the new model of care will have a positive impact on our result for this measure in the future.

People receive timely and appropriate specialist care

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of child and youth with a transition (discharge) plan	New measure – no baseline available	96%	Māori 95% Pacific 95% Other 95% Total 95%	Māori NA Pacific NA Other NA Total 37%	NA NA NA ● (red)

Our performance:

Due to data collection issues experienced during the establishment of this new measure we do not have the result available by ethnicity and are only able to report a total result. A contributing factor to this result has been the extensive changes in reporting for improving mental health services using wellness and transition (discharge) planning over the 2017-18 year.

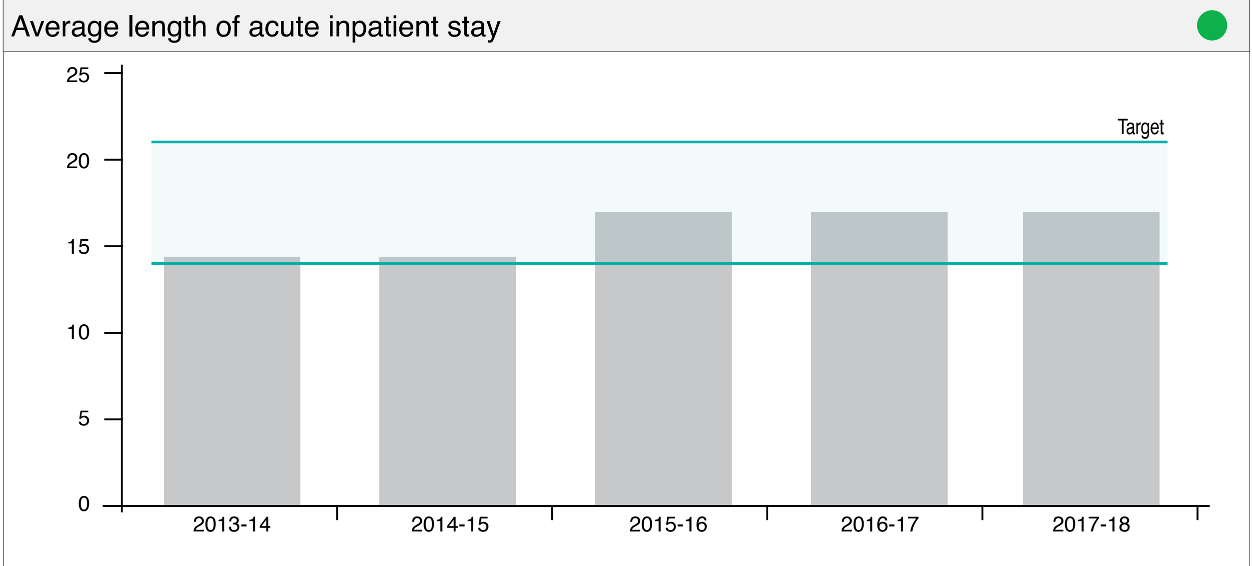
Waikato DHB has been working collaboratively to develop a mechanism that will enable all providers to complete the auditing of files against requirements and increase the percentage over time. We are confident that the rolling 12 month percentage of clients with a plan will track increasingly towards the desired 95 percent achievement figure.

A further piece of work is also underway to have an agreed standard best practice approach to plans and the subsequent quality evaluation of them.

As a baseline figure has now been established we are collectively able to review current methods of practice, and collation of data to best support, and increase the performance by both secondary and community providers in areas where 95 percent targets have not been met.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Average length of acute inpatient stay	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	17 days	Between 14 and 21 days	Māori 19.13 days Pacific 8.73 days Other 17.99 days Total 18.30 days	● (green) ● (green) ● (green) ● (green)

Our performance:



The average length of stay (ALOS) on adult inpatient wards for 2017-18 was 18.12 days. This is an increase of 1.09 days compared to the 2016-17 result of 17 days. The increase has been a trend over the last four years (13.63 2014-15, 16.22 in 2015-16) and is indicative of the growing complex nature of the presentations we are seeing to inpatient services.

The ALOS result is heavily skewed by a growing number of clients requiring long stays within adult wards. On average we have seen 30 people in the wards the first day of each month that have stayed longer than 14 nights. On average, 13 people have been in the adult facility between 30-90 days; approximately five individuals have stayed more than 90 days. For the remaining cohort of people whose needs are not currently well met in the community and mental health services, this is, in some cases, the only option to support them.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Rates of post-discharge community care	Māori 69% Pacific 73% Other 72% Total 87%	91%	Between 90% and 100%	Māori 78.10% Pacific 75.60% Other 83.60% Total 82.20%	🔴 🔴 🔴 🔴

Our performance:

During 2017-18 the Mental Health and Addictions service successfully followed up 83.81 percent of clients post discharge, a drop from 91 percent during the previous fiscal period. A number of changes were made to the way information is reported internally, which resulted in better accuracy and also identified issues with previous reporting methods. There were only two months during the fiscal period where the service managed to see over 90 percent of the clients, but the service did see over 85 percent of individuals within seven days during most months (8/12), with a very poor performance during the Christmas and New Year period heavily skewing the results (72.58 percent).

A number of issues have been identified throughout the year with processes being put in place to address:

- communication between inpatient and community
- erroneous entry of information into systems
- lack of visibility of discharges that have not been seen yet; and
- handover of work when individuals are away.

Subsequently, we will continue to retain a strong focus in this area and closely monitor all service users discharged from hospital to ensure appropriate follow up and engagement.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Improving the health status of people with severe mental illness through improved access:	**0-19 years** Māori 2.89% Pacific NA Other 3.07% Total 2.97%	**0-19 years** 3.99%	**0-19 years** Māori 4.41% Pacific NA Other 4.13% Total 4.23%	Māori 4.43% Pacific 3.16% Other 4.23% Total 4.25%	🟢 NA 🟢 🟢
	20-64 years Māori 7.12% Pacific NA Other 4.34% Total 4.33%	**20-64 years** 4.70%	**20-64 years** Māori 7.85% Pacific NA Other 3.86% Total 4.68%	Māori 8.77% Pacific 4.02% Other 3.78% Total 4.80%	🟢 NA 🟢 🟢
	65+ years Māori 2.12% Pacific NA Other 2.28% Total 2.27%	**65+ years** 2.01%	**65+ years** Māori 2.35% Pacific NA Other 2.00% Total 2.03%	Māori 2.26% Pacific 1.05% Other 2.09% Total 2.09%	🟢 NA 🟢 🟢

Our performance:

Specialist mental health and addictions services are funded for those people who are most severely affected by mental illness or addictions. As previously discussed, Te Pae Tawhiti is a significant programme of work encompassing work-streams across all Mental Health and Addictions services. There are four work-streams including: child and youth mental health; adult mental health; adult addictions; and mental health and addictions for older people. Each is tasked with the responsibility to deliver a new model of care that will be implemented over the next two to three years, it is anticipated that this will have a positive effect on access rates.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of aged residential care facilities utilising advance directives	100%	100%	100%	100%	●

Our performance:

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. 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.

Some key achievements for the year have been:

- 100% of long-term residents audited as part of residential care audits carried out in Waikato DHB in 2017-18 had an Advanced Directive in place and these were used as appropriate; and
- the Advance Directive icon has been added to the DHB Clinical Work Station signalling an Advance Directive is loaded into the system and facilities can email Advance Directives to the DHB for loading into the system.

Additionally, Waikato DHB will enable the electronic uploading and storage of Advance Care Plans from Primary Care in August 2018

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Number of new patients seen by the Waikato Hospital palliative care service	652	572	>650	1247	●

Our performance:

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 bulk of the work of the Palliative Care Consult Liaison service is attending inpatients on a ward under various specialties such as Oncology or Cardiology

As per the Common Counting standards, contacts taking place during an inpatient event are counted as part of the inpatient event and not counted separately under the purchase pnit of the specialty providing the liaison service (palliative care in this case). Previously we have included the direct purchase unit volumes added to the new referrals received by Hospice. We have decided that a better way to review activity of the Consult Liaison service is to count the volumes as defined above (revised figures). The baseline for 2016-17, the target, and actuals for 2017-18 have therefore been reset at a higher level.

A key risk for the programme is resourcing appropriate and sustainable senior medical officer coverage.

Māori represented 22 percent of patients seen, just shy of the 23 percent representation in the community.

Support services

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	94%	89%	95%	98%	● (green)

Our performance:

We are pleased to see we have not only met the target but have improved significantly on last year's result of 89 percent. While we have done well in meeting this target we have come under significant pressure to comply with the acute coronary standards which will be the main focus of attention in 2018-19.

Output measure	Baseline		Previous year 2016-17	Target 2017-18		Result 2017-18		Rating
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	Māori	92%	92%	Māori	95%	Māori	57%	● (red)
	Pacific	100%		Pacific	95%	Pacific	52%	● (red)
	Other	90%		Other	95%	Other	62%	● (red)
	Total	90%		Total	95%	Total	79%	● (red)

Output measure	Baseline		Previous year 2016-17	Target 2017-18		Result 2017-18		Rating
Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)	Māori	55%	88%	Māori	90%	Māori	57%	● (red)
	Pacific	53%		Pacific	90%	Pacific	55%	● (red)
	Other	52%		Other	90%	Other	60%	● (red)
	Total	48%		Total	90%	Total	60%	● (red)

Our performance:

The Waikato DHB is performing above the national average for access to Magnetic Resonance Imaging (MRI) and is the second best performing tertiary DHB for MRI and third best tertiary DHB for access to Computed Tomography (CT).

During this period the DHB has undertaken a significant replacement of its fleet of CT machines which has had an impact on access. The DHB indicated to the Ministry when preparing the district annual plan (DAP) that it would not achieve these two diagnostic targets during 2017-18.

The lack of Radiologists and unfilled vacancies at Waikato DHB have resulted in many CT and MRIs going unreported longer. We have 10.5 full time equivalent (FTE) staff and we are service sized for 23.0 FTE. A range of mitigations are in place ranging from active recruitment through to the use of offshore reporting for basic radiology as there is limited local reporting options and sessions. The target thresholds are unachievable for us given the lack of Radiologists and the increased referral rate. We have seen an increase in the number of patients done within the six week target both for CT and MRI, but at the same time the number of referrals and those waiting have increased. For example, in 2011 MRI would receive 700 referrals per month and in 2018 it has doubled to 1400. This is not sustainable. CT follows the same pattern of increased referrals.

MRI is a third party provider to us and has recently purchased another MRI scanner to handle the increased volume of work in the hope they can start to reduce the waiting times.

Approximately 95 patients are scanned on the three scanners at Waikato and Thames hospitals each day with only approximately 30 being able to be reported daily. To be able to reach the target and manage patients waiting over 147 days we would need to have resource and staffing to increase the outpatient hours on the scanner.

People receive timely and appropriate specialist care

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	78%	87%	90%	90%	● (green)

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	49%	53%	70%	60.9%	● (red)

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date	70%	70%	70%	71.9%	● (green)

Our performance:

We are pleased to see an improvement to 90 percent this year, up from the 87 percent reported in 2016-17, and an improvement to 61 percent for the 42 day target, up from reported in 2016-17.

There were a number of initiatives undertaken during 2017-18 which have contributed towards the achievement of this target, including:

- continued use of, and triaging standardisation due to the National Referral Criteria for direct access outpatient colonoscopy
- working regionally to improve access and timelines to colonoscopy procedures
- business case approval and implementation to staff; a fourth endoscopy room at Waikato Hospital including a clinical nurse specialist for quality improvements
- developing an analysis of demand versus current capacity at Waikato DHB, and procurement of funds to deliver an increased service
- introduction of a nurse endoscopist and gastroenterology fellow to enable us to increase capacity by 10 lists per week; and
- data cleansing of data entry errors, particularly in surveillance category.

During 2018-19 we plan to focus on:

- increasing capacity to meet demand including recruiting nursing staff to open a fourth room
- training of two nurse endoscopists for future workforce requirements
- recruiting a clinical nurse specialist to ensure quality of service is met through the global rating score compliance, which will also enable us to be compliant for the introduction of bowel screening in 2020-21
- continued work on data collection for measures currently not available (surveillance within 120 days)
- outsourcing of 500 colonoscopies to ensure capacity meets demand while awaiting the fourth room; and
- Active involvement by Waikato DHB with the Midland Cancer Network's Regional Bowel Screening Governance Group and the creation of a local DHB Bowel Screening Governance Group to enable Waikato DHB to be ready for locally implementing bowel screening as part of the wider national roll-out programme.

Output measure	Baseline	Previous year 2016-17	Target 2017-18	Result 2017-18	Rating
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	100%	100%	●

Our performance:

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.

Pathlab remains 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. This means that from the time the patient presented at a laboratory collection centre for tests to the time the results are reported to the referring practitioners is within 48 hours. As laboratory services are involved at multiple stages of the patient pathway it is generally accepted that approximately 70 percent of diagnoses rely on rapid turnaround of results such as those achieved by Pathlab.

As a Kaumātua and Cultural Advisor I speak from a cultural perspective. I believe that Ward OPR 2 has become a ward that is very interested in our cultural issues and I congratulate them. It's a beautiful thing when nurses ask for karakia (prayer) in the mornings and doctors wait respectfully until they are concluded.

Rangi – Older Persons and Rehabilitation patient

Part four:
Asset management

Asset performance information

Asset numbers

Our fixed assets

Fixed assets play an integral part in Waikato DHB achieving better health outcomes for patients.

Managed under three asset portfolio's, Property, Equipment and Information and Communication technology, Waikato DHB has in place robust asset management processes and programmes to:

- identify What and Why Fixed Assets are required, When to purchase or replace and from Whom we should purchase such assets;
- ensure existing Fixed Assets comply with local and International standards around operation, performance and servicing;
- ensure Fixed Assets are fit for purpose and the appropriate preventative maintenance programme is in place across all portfolios; and
- manage the risk profiles of all Fixed Assets.

The following table summaries our three portfolios,

Asset portfolio	Assets class within portfolios	Asset purpose	2015-16 Net Book Value	2016-17 Net Book Value	2017-18 Net Book Value
Property	Land, buildings, plant and equipment, fixture and fittings, vehicles	To facilitate the delivery of hospital services through the establishment of purpose built Infrastructure	$494 M	$658 M	$639M
Equipment	Clinical equipment	To facilitate the delivery of hospital services through the provision of fit for purpose clinical equipment	$51 M	$51 M	$52M
Information and communication technology	Computer hardware and software, other communication systems and devices	To facilitate the delivery of hospital services through the establishment of fit for purpose Information Technology and Communication systems	$24 M	$27 M	$31M

The 2017-18 Asset Performance Indicators (API's) identified for each portfolio are set out below along with targets which have been agreed at clinical, management and Board level.

Asset Performance Indicators

Property portfolio performance

Asset Performance Indicators	Indicator class	2015-16 Result	2016-17 Result	2017-18 Target	2017-18 Result
Waikato campus buildings relative earthquake risk -1	Condition	68%	68%	> 77%	68%
Waikato campus building core services down time as a percentage of total operating hours, per annum.	Condition	0.67%	0.67%	< 1%	0.52%
Waikato campus building core services net operating hours per annum -2	Utilisation	100%	99%	> 99%	99%
Waikato campus carparks as a percentage of total public carparking -3	Functionality	5%	5%	5%	5%
Waikato campus building energy efficiency savings as a percentage of targeted energy consumption -4	Functionality	3%	7%	> 7%	16%

Clinical portfolio performance

Asset Performance Indicators	Indicator class	2015-16 Result	2016-17 Result	2017-18 Target	2017-18 Result
Percentage CT Scanners and Linear Accelerators (Radiology and Oncology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%
For Waikato Hospital Radiology department, actual CT scanned patients versus planned patient scans.	Utilisation	101%	101%	> 90%	103%
For Waikato Hospital Radiology department CT scanners performing operationally to hospital requirements	Functionality	N/A	100%	100%	100%
Linear Accelerators (Oncology department) planned operating hours versus hours utilised -5	Utilisation	N/A	95%	> 86.4%	92%
For Waikato Hospital, planned theatre usage versus actual usage -6	Utilisation	75%	74%	100%	76%
For Waikato Hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	104%	100%	100.00%	100%
For Waikato Hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months.-7	Utilisation	92%	92%	< 93%	92%
For Waikato DHB, elective surgery completed as a percentage of MOH elective surgery targets for last 12 months.	Utilisation	103%	102%	100%	105%
For Waikato DHB, the weighted average age of clinical assets versus suppliers weighted average life expectancy of assets. -12	Condition / Functionality	N/A	N/A	New	89%

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator class	2015-16 Result	2016-17 Result	2017-18 Target	2017-18 Result
Percentage of computer hardware used by staff less than five years old.-8	Condition	91%	97%	> 90%	82%
The availability of Clinical ITC systems across Waikato campus as a percentage of total hours per annum	Condition	99.96%	99.95%	> 99.9%	99.80%
For Waikato DHB wide ITC systems, number of critical priority 1 faults, measured per annum.-9	Condition	N/A	N/A	< 24	9
Waikato Hospital staff able to access clinical - non clinical system platforms remotely	Utilisation	28%	17%	> 30%	29%
Percentage of data centre Server and Storage assets used.-10	Utilisation	N/A	N/A	> 85%	45%
Percentage of time ITC systems running at peak through Core Network switches.	Utilisation	N/A	N/A	< 30%	18%
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 -10 scale-11	Functionality	88%	86%	> 75%	92%
Percentage of ITC system incidents resolved within agreed department service levels	Functionality	N/A	94%	100%	93%

Addendum

1. Per Holmes 2011 assessment report, measuring earthquake risk against current building design and detail
2. Down time includes Plant and Equipment, Generators, Lifts and Boilers
3. There are 132 carparks designated for disabled parking at the Waikato DHB
4. Measured as Kwh/m2 per annum
5. Planned hours is net of Preventative maintenance programme.
6. For theatre day session Monday to Friday and includes acute list.
7. Includes all inpatient wards within CCTV/IM/Surgery/Orthopaedics/Oncology/Paediatrics/Womens Health but excludes Critical Care
8. Includes PCs/Laptops/Tablets
9. Priority 1 = Critical businerss imapct, key service area's unable to work or there is an IT security breach
10. All DHBs have moved to outsourcing server/storage Data storage thus inhouse storage utilisation will continue to decline over the next three years
11. Six monthly customer survey, target is 75% (7.5) or better, achieved 9.2

The specialists, doctors, nurses and dietitians were all very supportive and trustworthy. It felt like a partnership in which I was heard and my opinions, health aspirations and decisions were honoured. I'm still very grateful for the ways many DHB staff members went the extra mile on my behalf.

Nola – oncology patient

Part five: Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2018

	Note	Group			Parent	
		2018 Budget $000	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Revenue						
Patient care revenue	2	1,415,438	1,422,904	1,339,628	1,422,904	1,339,628
Other revenue	3	18,868	18,244	17,756	17,608	17,226
Finance revenue	4	1,169	1,714	1,839	1,538	1,675
Total income		1,435,475	1,442,862	1,359,223	1,442,050	1,358,529
Expenses						
Personnel costs	5	578,253	573,756	537,041	573,756	537,041
Depreciation	6	43,900	46,399	34,954	46,399	34,954
Amortisation and impairment costs	7	8,144	5,319	5,260	5,319	5,260
Outsourced services		78,121	92,926	78,419	92,926	78,419
Clinical supplies		136,778	144,849	135,538	144,849	135,538
Infrastructure and non-clinical expenses		52,644	75,996	75,491	76,187	75,491
Other district health boards		60,644	61,130	56,643	61,130	56,643
Non-health board providers		438,923	433,665	407,107	433,665	407,107
Other operating expenses	8	10,747	8,804	6,995	8,788	6,980
Finance costs	9	198	116	4,974	116	4,974
Capital charge	10	37,123	37,124	15,188	37,124	15,188
Total expenses		1,445,475	1,480,084	1,357,610	1,480,259	1,357,595
Share of associate surplus/(deficit)	11	-	-	(59)	-	(59)
Share of joint venture surplus/(deficit)	12	-	72	56	72	56
Surplus/(deficit)		(10,000)	(37,150)	1,610	(38,137)	931
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	13	-	-	176,237	-	176,237
Other comprehensive revenue and expense for the year		-	-	176,237	-	176,237
Total comprehensive revenue and expense for the year		(10,000)	(37,150)	177,847	(38,137)	177,168

Explanations of major variances to budget are provided in note 35.

The accompanying notes form part of the financial statements.

Statement of changes in equity for the year ended 30 June 2018

	Note	Group			Parent	
		2018 Budget	2018 Actual	2017 Actual	2018 Actual	2017 Actual
		$000	$000	$000	$000	$000
Balance at 1 July		622,280	622,676	236,111	622,394	235,761
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(10,000)	(37,150)	1,610	(38,137)	931
Other comprehensive income/ (expense)		-	-	176,237	-	176,237
Total comprehensive revenue and expense for the year		(10,000)	(37,150)	177,847	(38,137)	177,168
Owner transactions						
Debt equity swap from the Crown		-	-	211,659	-	211,659
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	23		(943)	(747)	-	
Balance at 30 June	13	610,086	582,389	622,676	582,063	622,394

Explanations of major variances to budget are provided in note 35.

The accompanying notes form part of the financial statements.

Statement of financial position as at 30 June 2018

		Group			Parent	
	Note	2018 Budget	2018 Actual	2017 Actual	2018 Actual	2017 Actual
		$000	$000	$000	$000	$000
Assets						
Current assets						
Cash and cash equivalents	14	7,385	7,855	9,577	-	2,718
Receivables	15	40,530	50,593	51,789	50,563	51,749
Prepayments	16	6,658	10,029	16,144	10,029	16,144
Inventories	17	10,862	11,452	11,006	11,452	11,006
Total current assets		65,435	79,929	88,516	72,044	81,617
Non-current assets						
Property, plant and equipment	6	724,269	691,371	708,995	691,371	708,995
Intangible assets	7	15,058	30,818	27,320	30,818	27,320
Investment in associate	11	59	-	-	-	-
Investment in joint venture	12	244	375	303	375	303
Total non-current assets		739,630	722,564	736,618	722,564	736,618
Total assets		805,065	802,493	825,134	794,608	818,235
Liabilities						
Current liabilities						
Cash and cash equivalents	14	-	10,829	-	10,829	-
Borrowings	19	324	313	324	313	324
Employee entitlements	20	107,419	118,924	103,990	118,924	103,990
Trade and other payables under exchange transactions	21	44,978	54,252	64,157	54,238	64,143
Trade and other payables under non-exchange transactions	21	7,600	12,983	12,088	12,983	12,088
Provisions	22	249	680	845	680	845
Total current liabilities		160,570	197,981	181,404	197,967	181,390
Non-current liabilities						
Borrowings	19	13,369	366	678	366	678
Employee entitlements	20	13,774	13,738	13,505	13,738	13,505
Provisions	22	268	474	268	474	268
Restricted trust funds	23	6,998	7,545	6,603	-	-
Total non-current liabilities		34,409	22,123	21,054	14,578	14,451
Total liabilities		194,979	220,104	202,458	212,545	195,841
Net assets		610,086	582,389	622,676	582,063	622,394
Equity						
Crown equity (Contributed capital)	13	284,043	284,543	286,737	284,543	286,737
Revaluation reserve	13	261,188	261,188	261,188	261,188	261,188
Retained earnings (Accumulated surplus)	13	64,471	36,332	74,469	36,332	74,469
Trust funds	13	384	326	282	-	-
Total equity		610,086	582,389	622,676	582,063	622,394

Explanations of major variances to budget are provided in note 35.

The accompanying notes form part of the financial statements.

For and on behalf of the board

Sally Webb – Board Chair
Waikato District Health Board

24 October 2018

Sharon Mariu – Chair of Audit and Corporate Risk Management Committee
Waikato District Health Board
24 October 2018

Statement of cash flows for the year ended 30 June 2018

	Note	Group			Parent	
		2018 Budget	2018 Actual	2017 Actual	2018 Actual	2017 Actual
		$000	$000	$000	$000	$000
Cash flows from operating activities						
Operating receipts		1,438,154	1,439,182	1,348,237	1,438,355	1,347,708
Interest received		1,170	1,727	1,969	1,541	1,813
Payments to suppliers		(783,026)	(818,989)	(762,200)	(818,974)	(762,198)
Payments to employees		(576,054)	(558,499)	(531,229)	(558,497)	(531,215)
Interest paid		(810)	(116)	(6,221)	(116)	(6,221)
Payments for capital charge		(37,124)	(37,124)	(15,188)	(37,124)	(15,188)
Goods and services tax (net)		53	1,488	1,207	1,488	1,207
Net cash flows from operating activities	24	42,363	27,669	36,575	26,673	35,906
Cash flows from investing activities						
Purchase of property, plant and equipment		(42,000)	(28,905)	(23,116)	(28,905)	(23,116)
Purchase of intangible assets		(13,055)	(8,817)	(9,091)	(8,817)	(9,091)
Receipts from sale of property, plant and equipment		-	20	31	20	31
Net cash flows from investing activities		(55,055)	(37,702)	(32,176)	(37,702)	(32,176)
Cash flows from financing activities						
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		12,792	-	600	-	600
Repayment of borrowings		(98)	(324)	(274)	(324)	(274)
Net cash flows from financing activities		10,500	(2,518)	(1,868)	(2,518)	(1,868)
Net increase/(decrease) in cash and equivalents		(2,192)	(12,551)	2,531	(13,547)	1,862
Cash and cash equivalents at beginning of year		9,577	9,577	7,046	2,718	856
Cash and cash equivalents at end of year	14	7,385	(2,974)	9,577	(10,829)	2,718

Explanations of major variances to budget are provided in note 35.

The accompanying notes form part of the financial statements.

1. Statement of accounting policies

Reporting entity

Waikato District Health Board ("Waikato DHB") is a DHB 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 20% share of its jointly controlled entity, HealthShare Limited, is equity accounted. The entities are incorporated and domiciled in New Zealand.

Waikato DHBs 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 2018, and were authorised for issue by the board on 24 October 2018.

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 Going Concern

The going concern assumption has been adopted in the preparation of these financial statements. The Board has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2017/18 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Operating and Cash flow forecasts

The Board has considered the current year's deficit of $38m and the forecasted deficit of $56.1m for next year together with forecast information relating to operational viability and cash flow requirements as well as the significant proposed capital spend in the future period. The Board expects that it will be able to use its working capital facility and access to additional funding, together with making adjustments to its capital spend to address the operational viability and cash flow for the coming year whilst still meeting expected patient demand and funding the required resources to deliver the relevant clinical services to meet such demand.

Borrowing covenants and forecast borrowing requirements

The Waikato DHB is subject to borrowing restrictions as detailed in the Ministry of Health Operations Policy Framework. The cash flow forecast for the next year prepared by the DHB reflects that equity funding or lease funding, together with the working capital facilities will be required to meet cash requirements. Whilst there is uncertainty regarding the mechanism that will be used to meet such cash requirements, the Board is confident that this can be achieved without breaching covenants or other borrowing restrictions.

Letter of comfort

The actions outlined above to address the operational viability and cash flow requirements are dependent on a combination of initiatives the Board intends taking over the next twelve months but there is still uncertainty of whether these actions will be successful and therefore the Board has received a letter of comfort, dated 2 October 2018 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

1. Statement of accounting policies (continued)

Statement of compliance

The financial statements of the group have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practices (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), other than remuneration disclosed in note 31 and the related party disclosures in note 30. The remuneration disclosures are rounded to the nearest dollar. The related party transactions are rounded to the nearest million or dollar.

Changes in accounting policies

There have been no changes in accounting policies since the date of the last audited financial statements.

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.

The Treasury has decided that the Financial Statements of the government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. Waikato DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Waikato DHB and group has not yet assessed the effects of the new standard. Based on initial assessment, Waikato DHB anticipates that the standard will not have a material effect on the Waikato DHBs financial statements.

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant and equipment into the impairment accounting standards. Previously, only property, plant and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements with early adoption permitted. The timing of the Waikato DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

1. Statement of accounting policies (continued)

Service Performance Reporting

In November 2017, the XRB issued PBE FRS48, a new standard for Service Performance Reporting. PBE FRS48 is effective for periods beginning on or after 1 January 2021 with early adoption permitted.

The main components under PBE FRS48 are information to be reported, presentation, comparative information and consistency of reporting, and disclosure of judgements.

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.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

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.

Budget figures

The group budget figures are made up of the Waikato DHBs 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 the Board in preparing these financial statements.

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.

Commitments and contingencies are disclosed exclusive of GST.

Foreign currency transactions

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

1. Statement of accounting policies (continued)

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. Other indirect costs are assigned to outputs based on responsibility centre.

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 6.

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.

2. Patient care revenue

Accounting policies

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 DHBs

Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHBs 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.

Patient care revenue breakdown	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Non-exchange transactions				
Health and disability services (Crown appropriation revenue)[1]	1,176,808	1,110,592	1,176,808	1,110,592
Other MoH and government revenue	28,217	27,773	28,217	27,773
Patient co-payments	1,561	1,575	1,561	1,575
Exchange transactions				
Health and disability services (MoH)	37,486	28,551	37,486	28,551
ACC contract revenue	16,995	14,084	16,995	14,084
Revenue from other DHBs	135,688	129,030	135,688	129,030
Clinical Training Agency revenue	11,495	11,357	11,495	11,357
Other patient care related revenue	14,654	16,666	14,654	16,666
Total patient care revenue	1,422,904	1,339,628	1,422,904	1,339,628

1 - Performance against this appropriation is reported in the Statement of Performance on pages 43 to 83.

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 relating to personal and public health services and management outputs for the current year is $1,150,497,000 (2017 - $1,088,800,000).

3. Other revenue

Accounting Policies

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.

Vested or donated assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Other revenue breakdown	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Non-exchange transactions				
Donations and bequests received	1,290	1,112	127	151
Grants received	-	-	527	431
Exchange transactions				
Rental revenue	1,266	1,193	1,266	1,193
Gain on sale of property, plant and equipment	-	29	-	29
Other revenue	15,688	15,422	15,688	15,422
Total other revenue	18,244	17,756	17,608	17,226

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

4. Finance revenue

Accounting Policy

Interest revenue

Interest revenue is recognised using the effective interest method.

Finance revenue (exchange transactions) - breakdown	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Interest revenue	1,714	1,839	1,538	1,675
Total finance revenue	1,714	1,839	1,538	1,675

5. Personnel costs

Accounting Policy

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

The group makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed by the board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.
Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus 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.

Personnel costs breakdown	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Salaries and wages	541,880	515,888	541,880	515,888
Increase/(decrease) in liability for employee entitlements	15,167	5,478	15,167	5,478
Defined contribution plan employer contributions	16,709	15,675	16,709	15,675
Total personnel cost	573,756	537,041	573,756	537,041

6. Property, plant and equipment

Accounting Policy

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 impairment losses.

6. Property, plant and equipment (continued)

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.

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.

6. Property, plant and equipment (continued)

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.

Movements for each class of property, plant and equipment are as follows:

Group Actual	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
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
Balance at 1 July 2017	44,476	595,971	220,136	8,228	868,811
Additions	-	-	-	28,905	28,905
Transfers	-	6,906	17,108	(24,014)	-
Disposals	-	-	(5,386)	-	(5,386)
Balance at 30 June 2018	44,476	602,877	231,858	13,119	892,330
Accumulated depreciation and impairment losses					
Balance at 1 July 2016	-	46,783	147,051	-	193,834
Depreciation charge and impairment losses 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

6. Property, plant and equipment (continued)

Accumulated depreciation and impairment losses	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Balance at 1 July 2017	-	-	159,816	-	159,816
Depreciation charge and impairment losses for the year	-	30,977	15,422	-	46,399
Disposals	-	-	(5,256)	-	(5,256)
Balance at 30 June 2018	-	30,977	169,982	-	200,959
Carrying amounts					
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
At 1 July 2017	44,476	595,971	60,320	8,228	708,995
At 30 June 2018	44,476	571,900	61,876	13,119	691,371

Parent Actual

Cost	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
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
Balance at 1 July 2017	44,476	595,971	220,136	8,228	868,811
Additions	-	-	-	28,905	28,905
Transfers	-	6,906	17,108	(24,014)	-
Disposals	-	-	(5,386)	-	(5,386)
Balance at 30 June 2018	44,476	602,877	231,858	13,119	892,330
Accumulated depreciation and impairment losses					
Balance at 1 July 2016	-	46,783	147,051	-	193,834
Depreciation charge and impairment losses 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
Balance at 1 July 2017	-	-	159,816	-	159,816
Depreciation charge and impairment losses for the year	-	30,977	15,422	-	46,399
Disposals	-	-	(5,256)	-	(5,256)
Balance at 30 June 2018	-	30,977	169,982	-	200,959
Carrying amounts					
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
At 1 July 2017	44,476	595,971	60,320	8,228	708,995
At 30 June 2018	44,476	571,900	61,876	13,119	691,371

6. Property, plant and equipment (continued)

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

Buildings

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

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

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

Restrictions

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

Titles to land transferred from the Crown to Waikato DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential Waitangi Tribunal claims under the Treaty of Waitangi Act 1975 cannot be quantified and it is therefore not reflected in the value of the land.

Finance leases

The net carrying amount of plant, equipment and vehicles held under finance lease is $0.5 million (2017: $0.5 million). Note 19 provides further information about finance leases.

Property, plant and equipment under construction

Buildings work in progress at 30 June 2018 is $5.2million (2017: $4.5million) and capital commitments is $3.4 million (2017: $5.5 million). Plant, equipment and vehicles work in progress at 30 June 2018 is $8.3million (2017: $3.7million) and capital commitments is $4.9 million (2017: $3.6 million).

7. Intangible assets

Accounting Policy

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. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with developing and maintaining the Waikato DHBs website are recognised as an expense when incurred.

Information technology shared services rights

The Waikato DHB has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the Waikato DHBs capital investment.

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 intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 6. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development. Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Movements for intangible assets are as follows:

Group 2018 Actual	Internally generated	Other	Work in Progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2016	876	52,982	9,758	63,616
Additions	-	-	9,091	9,091
Disposals	-	-	-	-
Transfers	92	1,584	(1,676)	-
Balance at 30 June 2017	968	54,566	17,173	72,707
Balance at 1 July 2017	968	54,566	17,173	72,707
Additions	-	-	8,817	8,817
Disposals	-	-	-	-
Transfers	532	3,720	(4,252)	-
Balance at 30 June 2018	1,500	58,286	21,738	81,524

7. Intangible assets (continued)

Accumulated amortisation and impairment losses

	Internally generated $000	Other $000	Work in Progress $000	Total $000
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
Balance at 1 July 2017	254	45,133	-	45,387
Amortisation charge for the year	29	5,290	-	5,319
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2018	283	50,423	-	50,706
Carrying amounts				
At 1 July 2016	631	13,100	9,758	23,489
At 30 June 2017	714	9,433	17,173	27,320
At 1 July 2017	714	9,433	17,173	27,320
At 30 June 2018	1,217	7,863	21,738	30,818

Parent 2018 Actual

Cost	Internally generated $000	Other $000	Work in Progress $000	Total $000
Balance at 1 July 2016	876	52,982	9,758	63,616
Additions	-	-	9,091	9,091
Transfers	92	1,584	(1,676)	-
Disposals	-	-	-	-
Balance at 30 June 2017	968	54,566	17,173	72,707
Balance at 1 July 2017	968	54,566	17,173	72,707
Additions	-	-	8,817	8,817
Transfers	532	3,720	(4,252)	-
Disposals	-	-	-	-
Balance at 30 June 2018	1,500	58,286	21,738	81,524
Accumulated amortisation and impairment losses				
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
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Amortisation charge for the year	29	5,290	-	5,319
Disposals	-	-	-	-
Reclassifications	-	-	-	-
Balance at 30 June 2018	283	50,423	-	50,706
Carrying amounts				
At 1 July 2016	631	13,100	9,758	23,489
At 30 June 2017	714	9,433	17,173	27,320
At 1 July 2017	714	9,433	17,173	27,320
At 30 June 2018	1,217	7,863	21,738	30,818

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

8. Other operating expenses

Accounting Policy

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.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Breakdown of other expenses	$000	$000	$000	$000
Net impairment of trade receivables	190	319	190	319
Audit fees for the audit of the financial statements - 2017-18	238	0	222	-
Audit fees for the audit of the financial statements - 2016-17	86	226	86	213
Audit related fees for assurance and internal audits	27	239	27	239
Board members' remuneration and expenses	330	337	330	337
Koha and donations	20	20	20	20
Operating lease expenses	7,803	6,058	7,803	6,056
Impairment on property, plant and equipment	-	-	-	-
Net change in fair value of forward foreign exchange contracts	0	(268)	0	(268)
Loss on disposal of property, plant and equipment	110	64	110	64
Total other operating expenses	8,804	6,995	8,788	6,980

9. Finance costs

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

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Interest and financing expenses	116	4,974	116	4,974
Total finance cost	116	4,974	116	4,974

10. Capital charge

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

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Capital charge	37,124	15,188	37,124	15,188
Total capital charge	37,124	15,188	37,124	15,188

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 2018 was 6% (2017:6% to 8%).

11. Investment in associate

Accounting Policy
The group's associate investment is accounted for using the equity method. 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 DHBs 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.

a) General information

Name of entity	Principal activities	Interest held at 30 June 2018	Balance date
Urology Services Limited	Provision of urology services	0%	30 June

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

	Assets	Liabilities	Equity	Revenues	Profit/(loss)
	$000	$000	$000	$000	$000
2018 Actual	-	-	-	-	-
Urology Services Limited	-	-	-	-	-
2017 Actual	27	26	1	1,605	(117)
Urology Services Limited	27	26	1	1,605	(117)

11. Investment in associate (continued)

c) Share of profit of associate (50%)

	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Share of profit before tax	-	(59)	-	(59)
Less: Tax expense	-	-	-	-
Share of profit after tax	-	(59)	-	(59)

d) Investment in associate (50%)

	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Carrying amount at beginning of year	-	59	-	59
Share of associate surplus/(deficit)	-	(59)	-	(59)
Carrying amount at end of year	-	-	-	-

e) Share of associate's contingent liabilities and commitments

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

Urology Services Limited was deregistered on 20 February 2018.

12. Investments in joint venture

Accounting Policy

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

The financial statements include Waikato DHBs interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases. When Waikato DHBs share of losses exceeds its interest in a joint venture, Waikato DHBs 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.

a) General information

Name of entity	Principal activities	Interest held at 30 June 2018	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b) Carrying amount of investment

	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Opening Balance	303	247	303	247
Share of joint venture surplus/(deficit)	72	56	72	56
Closing Balance	375	303	375	303

12. Investments in joint venture (continued)

c) Summary of Waikato DHBs interests in HealthShare Limited (20%)

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Current assets	1,435	642	1,435	642
Non-current assets	2,774	2,351	2,774	2,351
Current liabilities	(1,331)	(1,164)	(1,331)	(1,164)
Non-current liabilities	(2,503)	(1,526)	(2,503)	(1,526)
Net assets	375	303	375	303
Revenue	3,077	2,736	3,077	2,736
Expenses	(3,005)	(2,680)	(3,005)	(2,680)
Share of surplus/(deficit) of joint venture	72	56	72	56

13. Equity

Accounting Policy

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 unrestricted donations and bequests received.

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 2016	350	77,273	84,951	73,537	236,111
Total comprehensive revenue/(expense)	679	-	176,237	931	177,847
Contributed capital - Debt/Equity Swap	-	211,659	-	-	211,659
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(747)	-	-	-	(747)
Other movement	-	(1)	-	1	-
Balance at 30 June 2017	282	286,737	261,188	74,469	622,676
Balance at 1 July 2017	282	286,737	261,188	74,469	622,676
Total comprehensive revenue/(expense)	987	-	-	(38,137)	(37,150)
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(942)	-	-	-	(942)
Other movement	(1)	-	-	-	(1)
Balance at 30 June 2018	326	284,543	261,188	36,332	582,389

13. Equity (continued)

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.

Parent	Crown Equity	Revaluation Reserve	Retained Earnings	Total Equity
Reconciliation of movement in equity	$000	$000	$000	$000
Balance at 1 July 2016	77,273	84,951	73,537	235,761
Total comprehensive revenue/(expense)	-	176,237	931	177,168
Contributed capital - Debt/Equity Swap	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
Balance at 1 July 2017	286,737	261,188	74,469	622,394
Total comprehensive revenue/(expense)	-	-	(38,137)	(38,137)
Contributed capital - Debt/Equity Swap	-	-	-	-
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	-	-	-	-
Balance at 30 June 2018	284,543	261,188	36,332	582,063

14. Cash and cash equivalents

Accounting Policy

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short term highly liquid investments and bank overdrafts. Bank overdrafts are presented in current liabilities in the statement of financial position.

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in Note 22.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Cash at bank/(overdraft) and cash on hand	(1,311)	215	(1,311)	215
Advance to/(from) New Zealand Health Partnerships Limited	(9,518)	2,503	(9,518)	2,503
Trust funds	7,855	6,859	-	-
Total cash and cash equivalents	(2,974)	9,577	(10,829)	2,718

15. Receivables

Accounting Policy

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 group 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.

15. Receivables (continued)

	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Ministry of Health trade receivables	4,242	6,588	4,242	6,588
Other trade receivables	5,672	4,812	5,642	4,772
Total trade receivables	9,914	11,400	9,884	11,360
Ministry of Health accrued revenue	17,683	27,149	17,683	27,149
Other accrued revenue	22,996	13,240	22,996	13,240
Total receivables	50,593	51,789	50,563	51,749
Total receivables comprises:				
Receivables from non-exchange transactions	9,466	11,632	9,466	11,632
Receivables from exchange transactions	41,127	40,157	41,097	40,117

Receivables and accrued revenue are shown net of impairment losses (provision for doubtful debts) amounting to $1.13 million (2017:$1.05 million). The carrying value of debtors and other receivables approximates their fair value.

Receivables Breakdown

The ageing profile of receivables and their impairment is:

	Group		Parent	
Receivables - gross	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Not past due	44,316	43,878	44,286	43,838
Past due 0-30 days	2,195	1,398	2,195	1,398
Past due 31-120 days	3,869	6,184	3,869	6,184
Past due 121-360 days	628	385	628	385
Past due more than 1 year	718	994	718	994
	51,726	52,839	51,696	52,799

	Group		Parent	
Receivables - impairment	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Not past due	-	-	-	-
Past due 0-30 days	104	139	104	139
Past due 31-120 days	87	133	87	133
Past due 121-360 days	467	275	467	275
Past due more than 1 year	475	503	475	503
	1,133	1,050	1,133	1,050

	Group		Parent	
Net Receivables	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Not past due	44,316	43,878	44,286	43,838
Past due 0-30 days	2,091	1,259	2,091	1,259
Past due 31-120 days	3,782	6,051	3,782	6,051
Past due 121-360 days	161	110	161	110
Past due more than 1 year	243	491	243	491
	50,593	51,789	50,563	51,749

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.

15. Receivables (continued)

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.

Movements in provision for impairment of trade receivables are as follows:

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
At 1 July	1,050	1,027	1,050	1,027
Additional Provisions made/(reversed) during the year	190	11	190	11
Receivables written off during the year	(174)	(4)	(174)	(4)
Receivables recovered during the year	67	16	67	16
At 30 June	1,133	1,050	1,133	1,050

16. Prepayments

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Prepayments	10,029	16,144	10,029	16,144
Total prepayments	10,029	16,144	10,029	16,144

17. Inventories

Accounting Policy

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 or from cost to net realisable value is recognised as an expense in the period of the write-down.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Pharmaceuticals	1,159	1,077	1,159	1,077
Surgical and medical supplies	9,613	9,188	9,613	9,188
Other supplies	680	741	680	741
Total inventories	11,452	11,006	11,452	11,006

The amount of inventories recognised as revenue due to change in stock value during the year was -$104,543 (2017: -$210,524), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $161,329 for 2018 (2017 $32,000). 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 2018 was $Nil (2017 $Nil). No inventories are pledged as security for liabilities.

18. Derivative financial instruments

Accounting Policy

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.

The notional principal amount of outstanding forward foreign exchange contracts in NZ$ was $ Nil (2017: $Nil). The foreign currency principal amounts were $ Nil (2017: USD Nil).

19. Borrowings

Accounting Policy

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.

Finance Leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the ;lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest over 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 the group 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.

	Group		Parent	
Current portion	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Loan from Energy Efficiency and Conservation Authority	93	104	93	104
Finance leases	220	220	220	220
	313	324	313	324

	Group		Parent	
Non-current portion	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Loan from Energy Efficiency and Conservation Authority	76	169	76	169
Finance leases	290	509	290	509
	366	678	366	678

	Group		Parent	
Loan facility limits	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Crown loans	-	-	-	-

19. Borrowings (continued)

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 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.

Analysis of finance leases

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Minimum lease payments payable:	$000	$000	$000	$000
No later than one year	220	220	220	220
Later than one year and not later than five years	290	509	290	509
Later than five years	-	-	-	-
Total minimum lease payments	510	729	510	729
Future finance charges	(32)	(73)	(32)	(73)
Present value of minimum lease payments	478	656	478	656
Present value of minimum lease payments payable:				
No later than one year	217	214	217	214
Later than one year and not later than five years	261	442	261	442
Later than five years	-	-	-	-
Total present value of minimum lease payments	478	656	478	656

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 $478,000 (2017: $656,000). Fair value has been determined by using a discount rate of 2.07% (2017:2.6%).

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

Accounting Policy

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.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Current portion	$000	$000	$000	$000
Liability for long service leave	2,852	2,608	2,852	2,608
Liability for retirement gratuities	3,308	3,083	3,308	3,083
Liability for annual leave	71,676	65,967	71,676	65,967
Liability for sick leave	1,440	1,325	1,440	1,325
Liability for continuing medical education leave and expenses	10,337	9,826	10,337	9,826
PAYE payable	5,538	5,052	5,538	5,052
Salary and wages accrual	23,773	16,129	23,773	16,129
	118,924	103,990	118,924	103,990

Non-current portion				
Liability for long service leave	1,802	1,723	1,802	1,723
Liability for sabbatical leave	4,118	3,919	4,118	3,919
Liability for retirement gratuities	7,818	7,863	7,818	7,863
	13,738	13,505	13,738	13,505

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, 2.6% and 1.9%, respectively. (2017: 2.7% and 2.0% respectively) and a salary inflation factor of 3.0% (2017:3%) was used.

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

Accounting Policy

Short term payables are recorded at their face value.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Payables under exchange transactions	$000	$000	$000	$000
Creditors	53,727	60,285	53,713	60,271
Revenue received in advance	525	3,872	525	3,872
Total payables under exchange transactions	54,252	64,157	54,238	64,143
Payables under non-exchange transactions				
ACC levy payable	910	899	910	899
GST payable	9,035	7,547	9,035	7,547
Accrual - non exchange expenses	3,038	3,642	3,038	3,642
Total payables under non-exchange transactions	12,983	12,088	12,983	12,088
Total payables	67,235	76,245	67,221	76,231

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

Accounting Policy

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.

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	680	598	680	598
Motor vehicle repairs on disposal	-	247	-	247
	680	845	680	845
Non-current liabilities				
Motor vehicle repairs on disposal	474	268	474	268
	474	268	474	268

Movements for each class of provision are as follows:

	ACC Partnership Programme	Motor vehicle repairs on disposal	Total
	$000	$000	$000
Balance at 1 July 2016	512	488	1,000
Additional provisions made/released	499	(145)	357
Amounts used	(413)	172	(579)
Balance at 30 June 2017	598	515	1,113
Balance at 1 July 2017	598	515	1,113
Additional provisions made/released	495	(169)	326
Amounts used	(413)	128	(285)
Balance at 30 June 2018	680	474	1,154

22. Provisions (continued)

ACC Partnership Programme

Waikato DHB belongs to the ACC Accredited Employers Programme (the “”Full Self Cover Plan””) 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 four years and up to a specified maximum amount. At the end of the four 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, Simon Ferry from Aon Hewitt, provided the ACC actuarials valuation to 30 June 2018. 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% (2017:15%) 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 (2017:1.7%); and
- a discount factor of 2.3% for 30 June 2018 (2017:2.8%).

Any changes in liability valuation assumptions will not have a material effect on the financial statements.

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

Movements are as follows:	Group 2018 Actual $000 Waikato Health Trust	Group 2017 Actual $000 Waikato Health Trust
Balance at 1 July	6,603	5,856
Transfer from accumulated funds	942	747
Balance at 30 June	7,545	6,603

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.

The receipt of and investment revenue earned on, restricted trust funds is recognised as revenue and then transferred to the trust fund from accumulated surpluses/(deficits). Application of restricted trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to accumulated surpluses/(deficits).

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 2018 Actual $000	Group 2017 Actual $000	Parent 2018 Actual $000	Parent 2017 Actual $000
Net surplus/(deficit)		(37,150)	1,610	(38,137)	931
Add/(less) non-cash items:					
Depreciation	6	46,399	34,954	46,399	34,954
Amortisation and impairment cost	7	5,319	5,260	5,319	5,260
Bad and doubtful debts	15	190	11	190	11
Share of associate (surplus)/deficit	11	-	59	-	59
Share of joint venture (surplus)/deficit	12	(72)	(56)	(72)	(56)
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	3,8	110	35	110	35
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	17	(446)	(662)	(446)	(662)
(Increase)/decrease in gross receivables	15	1,006	(20,091)	997	(20,081)
(Increase)/decrease in prepayments	16	6,116	(9,740)	6,116	(9,740)
Increase/(decrease) in employee entitlements	20	15,167	5,478	15,167	5,478
Increase/(decrease) in trade and other payables	21	(9,010)	19,874	(9,010)	19,874
Increase/(decrease) in other provisions	22	40	113	40	113
Increase/(decrease) in derivative financial instruments	18	-	(270)	-	(270)
Net cash flows from operating activities		27,669	36,575	26,673	35,906

The termination and conversion to equity of all existing Crown loans in February 2017 amounting to $211.7 million (2016 $211.7m) was completed by a non cash transaction, other than interest due at the conversion date.

25. Capital commitments and operating leases

Capital commitments	Group 2018 Actual $000	Group 2017 Actual $000	Parent 2018 Actual $000	Parent 2017 Actual $000
Buildings	3,418	5,477	3,418	5,477
Plant, equipment and vehicles	4,893	3,628	4,893	3,628
Intangible assets	2,780	816	2,780	816
Total capital commitments	11,091	9,921	11,091	9,921

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 2018 Actual $000	Group 2017 Actual $000	Parent 2018 Actual $000	Parent 2017 Actual $000
Not later than one year	8,523	6,596	8,523	6,596
Later than one year and not later than five years	25,202	23,689	25,202	23,689
Later than five years	6,933	7,967	6,933	7,967
	40,658	38,252	40,658	38,252

25. Capital commitments and operating leases (continued)

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 the lease term. There are no restrictions placed on Waikato DHB by its leasing arrangements.

26. Contingencies

	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Contingent liabilities	$000	$000	$000	$000
Personal grievances	140	200	140	200
	140	200	140	200

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.

Compliance with Holidays Act 2003

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements.

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

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

Waikato DHB has not recognised a provision at balance date due to the uncertainty regarding baseline interpretation with key stakeholders. A reasonable estimate is not able to be identified until a detailed assessment is conducted against an agreed baseline interpretation. Based on analysis using potential outcomes, we do not expect to be exposed to a material impact.

Contingent assets

Waikato DHB has no contingent assets at 30 June 2018 (2017:$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.

	2018 Actual	2017 Actual
	$000	$000
Balance at 1 July	25	20
Receipts	74	82
Payments	(67)	(77)
Balance at 30 June	32	25

28. Financial instruments

Accounting policies for financial instruments have been applied to the line items below:

Financial Instrument categories	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
Loans and receivables	$000	$000	$000	$000
Cash and Cash equivalents	7,855	9,577	-	2,718
Receivables	50,593	51,789	50,563	51,749
Total loans and receivables	58,448	61,366	50,563	54,467
Fair value through surplus or deficit				
Derivative financial instrument liability	-	-	-	-
Total derivative financial instrument liability	-	-	-	-
Other financial liabilities				
Cash and cash equivalents	10,829	-	10,829	-
Trade and other payables	67,235	76,245	67,221	76,231
Borrowings - loans	679	1,002	679	1,002
Total other financial liabilities	78,743	77,247	78,729	77,233

Waikato DHBs 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 (42% and 5% respectively, at 30 June 2018). 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.

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.

Counterparties with credit ratings	Group		Parent	
	2018 Actual	2017 Actual	2018 Actual	2017 Actual
	$000	$000	$000	$000
Cash and cash equivalents				
AA	48	48	48	48
AA-	6,496	7,026	(1,359)	167
Total cash and cash equivalents	6,544	7,074	(1,311)	215
Counterparties without credit ratings				
New Zealand Health Partnership Limited	(9,518)	2,503	(9,518)	2,503
Receivables				
Counterparty with no defaults in the past	50,332	51,499	50,302	51,459
Counterparty with defaults in the past	261	290	261	290
Total receivables	50,593	51,789	50,563	51,749

28. Financial instruments (continued)

Liquidity Risk

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

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

	Group 2018 Actual $000's						
	Balance Sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Crown loans	-	-	-	-	-		-
Loans from Energy Efficiency and Conservation Authority	169	169	47	47	75	-	-
Trade and other payables	67,236	67,236	67,236	-	-	-	-
	67,405	67,405	67,283	47	75	-	-

	Parent 2018 Actual $000's						
	Balance Sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Crown loans	-	-	-	-	-		-
Loans from Energy Efficiency and Conservation Authority	169	169	47	47	75	-	-
Trade and other payables	67,221	67,221	67,221	-	-	-	-
	67,390	67,390	67,268	47	75	-	-

	Group 2017 Actual $000's						
	Balance Sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Crown loans	-	-	-	-	-	-	
Loans from Energy Efficiency and Conservation Authority	273	273	52	52	93	76	-
Trade and other payables	76,245	76,245	76,245	-	-	-	-

	Parent 2017 Actual $000's						
	Balance Sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Crown loans	-	-	-	-	-	-	
Loan 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	-

Market price 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 DHBs 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.

28. Financial instruments (continued)

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 2018, it is estimated that a general increase of one percentage point in interest rates would decrease the group surplus by approximately $30,000 (2017:$95,000).

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 DHBs 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 (2017: $ 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 DHBs capital is its equity, which comprises Crown equity, accumulated surpluses/(deficits), 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

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 $1.24 billion (2017:$1.14 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2018 was $21.9 million (2017:$33.7 million). Waikato DHB incurred a capital charge of $37.1 million (2017:$15.2 million) to the Government during the year.

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.

Significant transactions with government-related entities.

Waikato DHB has received funding from ACC for the year ended 30 June 2018 of $17.0 million (2017:$14.1 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 2018 was $135.7 million (2017:$129.0 million). Expenditure to other DHBs for their care of patients from Waikato DHBs district for the year ended 30 June 2018 was $61.1 million (2017:$56.6 million).

30. Related parties (continued)

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 2018 totalled $17.2 million (2017 $15.7 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 DHBs in the Midland Region under a joint venture agreement, which provides regional services for these DHBs. No dividends have been received from HealthShare Limited. As at 30 June 2018, HealthShare Limited had total assets of $21.044 million (2017:$14.940 million) and total liabilities of $19.168 million (2017:$13.453 million). During the year Waikato DHB received $1,030,000 (2017: $1,254,000) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $6,019,000 (2017:$5,640,000) for services provided. As at 30 June 2018 Waikato DHB owed Healthshare Limited $53,000 (2017: $ 705,000) and Healthshare Limited owed Waikato DHB $874,000 (2017: $710,000).

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 to October 2016. The company ceased trading in 2017 and was deregistered on 20 February 2018. No dividends have been received from Urology Services Limited. During the period Waikato DHB received inpatient urological services from Urology Services Limited of $0.0 million (2017: $1.6 million). Waikato DHB received facility and management service fees of $0.0 million (2017: $0.9 million) from Urology Services Limited. During the period Waikato DHBs share of revenue amounted to $0.0 million (2017:$0.8 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 2018 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 $0.527 million (2017:$0.431 million). There was $Nil owing to Waikato DHB at 30 June 2018 (2017:$Nil).

NZ Health Partnerships Limited

NZ Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2017:6,948,005) shares being 10.17% (2017:10.17%). Waikato DHB does not have a controlling interest in New Zealand Health Partnership Limited.

31. Key management personnel remuneration

Key management personnel

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

Compensations

There were no loans to Board members during the year ended 30 June 2018 (2017:$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 2018 (2017:$Nil).

Remuneration

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

Board members	2018 Actual $000	2017 Actual $000
Salaries and other short-term benefits	310	327
Contributions to superannuation schemes	-	-
Members	11	11
Executive management team		
Salaries and other short-term benefits	4,758	4,615
Contributions to superannuation schemes	174	159
Full-time equivalent members	17	18

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

	No. of Meetings Eligible to Attend	No. of Meetings Actually Attended*	Remuneration	
	2018	2018	2018 Actual	2017 Actual
Board members			$	$
Bob Simcock (Chairman) – *resigned November 2017*	13	11	22,875	54,750
Sally Webb (Interim Chair person)	25	21	46,321	30,156
Sally Christie	17	15	26,438	17,938
Crystal Beavis	21	20	27,000	27,813
Phillippa Mahood	17	17	26,250	26,750
Andrew Buckley			-	11,625
Martin Gallagher	21	20	27,083	27,250
Sharon Mariu	21	18	27,353	27,438
Clyde Wade	21	21	27,520	27,125
Ewan Wilson			-	6,875
Gay Shirley			-	11,750
Tania Hodges	17	15	26,000	26,250
Mary Anne Gill	17	17	26,250	15,625
Dave Macpherson	21	19	26,750	16,125
			309,840	327,470

* 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 2018	No. of Meetings Actually Attended 2018	Remuneration 2018 Actual	2017 Actual
			$	$
Alisa Gathergood			-	250
Anna Rolleston	4	2	500	250
Christine Rankin	1	1	250	-
David Slone	4	2	500	500
Fungai Mhlanga	4	2	500	1,000
Glen Tupuhi	6	4	1,000	250
Janise Eketone	4	2	500	500
John McIntosh	4	4	1,000	1,000
Judy Turner			-	250
Kahu McClintock	4	3	750	250
Ken Price			-	250
Mere Balzer	2	1	250	-
Mark Arundel	4	3	750	250
Mary Burdon			-	250
Paul Malpass			-	750
Rob Vigor-Brown	4	3	750	250
Ron Scott	4	1	250	250
Te Pora Thompson-Evans	10	8	2,000	500
Yvonne Boyes			-	250
			9,000	7,000

Termination payments to employees

During the year the Board made payments to 27 employees (2017:25) in respect of the termination of employment with Waikato DHB.

	2018 Actual $000	2017 Actual $000
Amount paid	1,301	700

Financial statements

32. Waikids early childhood centre – Waikato Hospital

	Group		Parent	
	2018 Actual $000	2017 Actual $000	2018 Actual $000	2017 Actual $000
Summary of transactions relating to Waikids:				
Subsidy Funding - Ministry of Education	219	259	219	259
Equity funding - Ministry of Education	26	41	26	41
Other income	-	1	-	1
Personnel costs	(197)	(117)	(197)	(117)
Minor equipment purchases	(15)	(16)	(15)	(16)
Administration costs	(2)	(2)	(2)	(2)
Surplus/(Deficit) for the year	31	166	31	166
Bank and cash	-	167	-	167
Receivables	-	2	-	2
Accounts payable	-	-	-	-
Net current liabilities	-	169	-	169
Accumulated surplus attributed to Waikato Early Childhood Centre				
Balance at 1 July	169	3	169	3
Surplus for year	31	166	31	166
Balance at 30 June	200	169	200	169

Waikids early childhood centre is a hospital based play specialist service operated by the Waikato DHB 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.

33. Subsequent event

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

34. Comparative information

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

35. Explanation of financial variances from budget

Waikato DHB recorded a net comprehensive deficit of $37.2 million against its budgeted deficit of $10.0 million. Explanations of major variances are:

Variances in comprehensive revenue and expenses

Waikato DHB recorded a $27.2 million unfavourable variance to budget. This includes:

- revenue was $7.4 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 $0.4 million favourable due mainly to lower depreciation due to slower capital spend and the timing of IS capitalisations, offset by unbudgeted impairment of identified fixed and intangible assets
- personnel costs are $4.5 million favourable mainly due to vacancies (offset in outsourced personnel costs)
- outsourced services and personnel are $14.8 million unfavourable mainly due to higher outsourcing to cover vacancies, and cost of contractors to cover specific external projects (offset in revenue)
- clinical supplies are $8.1 million unfavourable mainly due to unachieved budgeted savings targets and higher than planned spend on treatment disposables, pharmaceuticals and implant and diagnostic supplies
- infrastructure and non clinical supplies $23.4m unfavourable mainly due to unachieved central high risk savings targets held in this area
- other operating expenses are $6.7 million favourable due to variances against a wide range of costs.

35. Explanation of financial variances from budget (continued)

Variances in statement of changes in equity

The surplus was $27.2 million unfavourable to budget due to the statement of comprehensive revenue and expense explanations provided above.

Variances in financial position

Current assets are $14.5 million higher than budget. This includes:

- Prepayments higher than budget $3.4 million due to contracts entered into requiring payment upfront
- Receivables higher than budget $10.1 million due to timing of funds received against budget assumptions
- Other favourable variances across a number of areas $1.0m

Current liabilities are $37.4 million higher than budget. This includes:

- Cash held with New Zealand Health Partnership Limited is $10.3m lower than budget due mainly to unfavourable deficit for the year
- Payroll liabilities are $11.5 million unfavourable mainly due to accrual for liabilities arising from MECA negotiations
- Accounts payable and accrued creditors are $14.7 unfavourable due to a range of accruals for multiple creditors tracking higher than budget.

Non-current assets are $17.0 million lower than budget due mainly to slower than planned capital expenditure.

Non-current liabilities are $12.3 million lower than budget due to the deferment of planned finance leases.

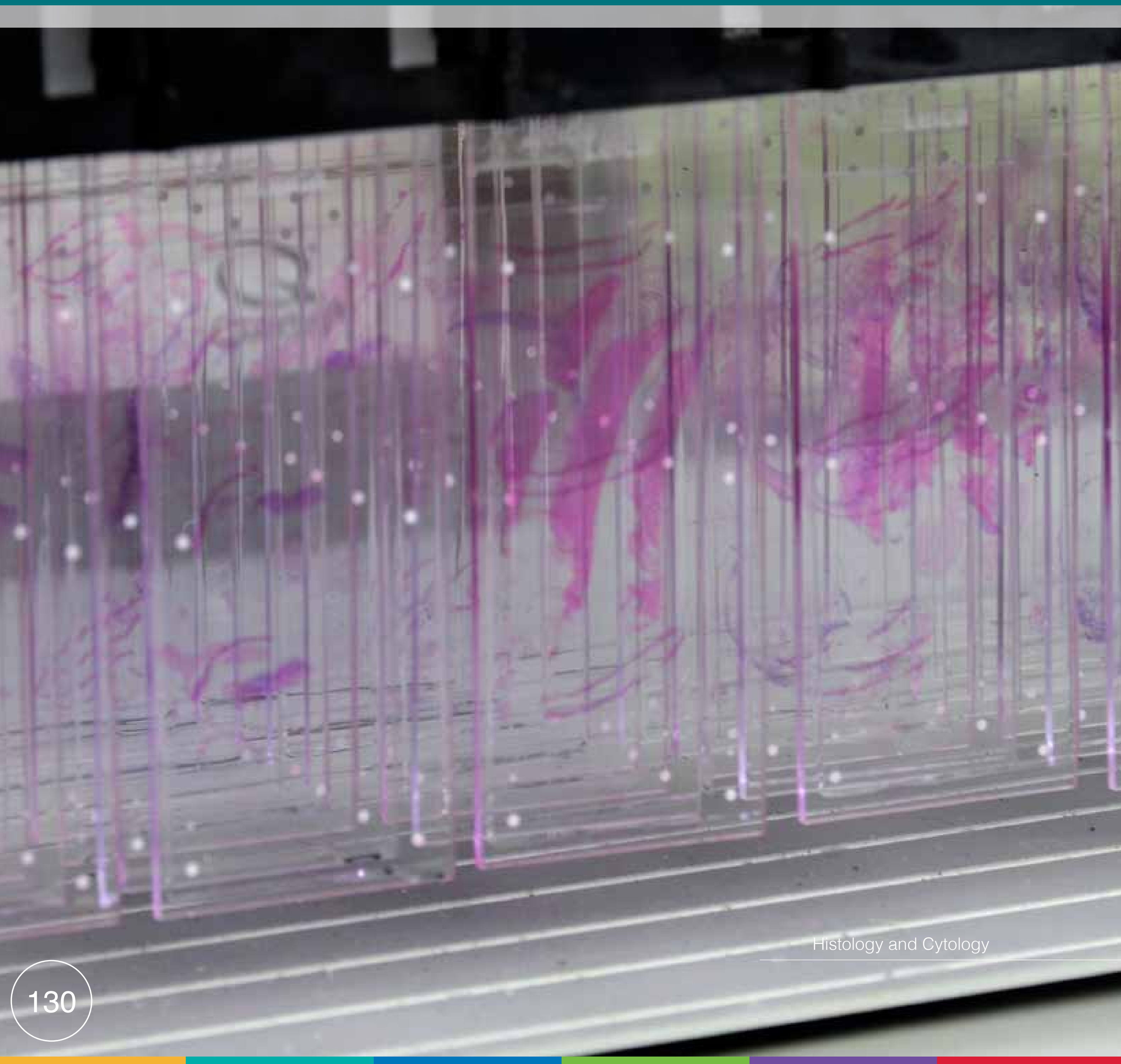
Variances in cash flows

- Net cash flows from operating activities are $14.7 million lower than budget due mainly to unfavourable deficit for the year.
- Net cash flows from investing activities are $17.4 million lower than budgeted due to slower than planned capital spend.
- Net cash flows from financing activities are $13.0 million lower than budgeted due to deferment of planned finance leases.

36. Statement of Performance Expectations for the 2018/19 year – Breach of Section 149C of the Crown Entities Act 2004

In terms of Section 149C of the Crown Entities Act 2004, a Crown entity must prepare a statement of performance expectations (SPE) before the start of each financial year. At 30 June 2018 the 2018/19 SPE was in draft format. It has been approved by the Board on 24 October 2018.

Part six:
Audit report



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 2018

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.

Opinion

We have audited:

- the financial statements of the Group on pages 90 to 129, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 28 to 29 and 44 to 83.

In our opinion:

- the financial statements of the Group on pages 90 to 129:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2018; 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 Standards; and
- the performance information of the Group on pages 28 to 29 and 44 to 83 :
  - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2018, including:
    - for each class of reportable outputs:
      - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the 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 24 October 2018.This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we highlight the appropriateness of the use of the going concern assumption and draw attention to a matter in relation to compliance with the Holidays Act 2003, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Appropriateness of the use of the going concern assumption

Without modifying our opinion, we draw your attention to the disclosure in note 1 on page 94 about the use of the going concern assumption for preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its forecast operating cash flows, equity funding and debt funding. The Board is of the view that it has adequate resources to operate for the foreseeable future. Nevertheless, there is uncertainty that all of the Health Board's cash requirements can be met, and the Board has received a letter of support from the Ministers of Health and Finance. The letter states that the Crown will provide the Health Board financial support where necessary to maintain viability. We consider these disclosures to be adequate.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 26 on page 121. Our opinion is not modified in respect of this matter.

Basis for our opinion

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

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

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

Responsibilities of the Board 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 it determines is necessary to enable it 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.

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 achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the 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 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 27, 30 to 43, 84 to 89 and 136 to 139, 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

I like coming to the hospital even though my treatment makes me feel unwell and I get headaches and feel sick for a few days afterwards.

I love the nurses because I know they care about me and they make me feel happy.

I don't want to be treated differently. I like being treated like a normal kid, and that's how the nurses treat me.

Tavanya – Waikids Day Stay patient

Part seven: Glossary of acronyms

Glossary of acronyms

At Waikato DHB and across the health system we often use acronyms to refer to common terms or services. Some of the more commonly used are listed below.

Acronym	Meaning
ACC	Accident Compensation Corporation
ALOS	Average Length of Stay • Refers to a patients time spent in hospital for either an acute or elective event
ASH	Ambulatory Sensitive Hospital Admissions • Hospital admissions that are considered as avoidable
CCM	Certified Care Manager Nurse
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CT	Computed Tomography
CVD	Cardiovascular Disease
DAP	District Annual Plan
DHB	District Health Board
DNA	Did Not Attend • When a patient does not attend their scheduled appointment without notification
ED	Emergency Department
FCT	Faster Cancer Treatment • A healthcare pathway
FTE	Full Time Equivalent • Refers to staffing levels
GP	General Practice
HPV	Human Papilloma Virus
iHub	Hauora ihub • A welcoming place for health & wellbeing information, advice, and some opportunistic health services. Located on level one of the Meade Clinical Centre, Waikato Hospital

Acronym	Meaning
InterRAI	International Resident Assessment Instrument • The primary assessment instrument in aged residential care and home and community services for older people living in the community
LMC	Lead Maternity Carer
MDS-HC	Minimum Dataset Homecare Assessment Tool
MHAS	Mental Health and Addictions Service
MHN	Midland Health Network
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment and Service Coordination
NGO	Non-Government Organisation
NHI	National Health Index Number • A unique identifier that is assigned to every person who uses health and disability services in New Zealand
NRT	Nicotine Replacement Therapy
OPR	Older Persons and Rehabilitation
PHN	Public Health Nurse
PHO	Primary Health Organisation
RN	Registered Nurse
SPoE	Single Point of Entry • A service that provides a single point of initial contact to streamline the way people are referred to all required services

Waikato District Health Board Annual Report 2018 ©

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