Waikato District Health Board

2018/19 ANNUAL REPORT

For the year ended 30 June 2019

Presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004

Statement of responsibility for the year ended 30 June 2019

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 2018/19 year with ratings on the outputs and impacts we intended to deliver in terms of national, regional and local priorities and as stated in the Waikato DHB's 2018/19 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 commissioner's 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 2019 and the judgements used in them.

The commissioner's 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 commissioner's of the Waikato District Health Board, the financial statements and the Statement of Service Performance for the year ended 30 June 2019 fairly reflect the financial position and operations of Waikato District Health Board.

Signed by:

Dr. Karen Poutasi
Commissioner
Waikato District Health Board
29 October 2019

Prof. Margaret Wilson
Deputy Commissioner
Waikato District Health Board
29 October 2019

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!'

Waikato DHB strategy

Foreword from the commissioner and acting chief executive for the period under review

Karen Poutasi
Commissioner

Neville Hablous
Acting Chief Executive

This past year has been another challenging one for Waikato DHB, but also one that will in future likely be viewed as a turning point.

It saw our budgeted and actual deficit move sharply upwards, continuing a trend from the previous year.

Demand for services continued to grow in all areas, with the pressure of more acute cases in hospital and mental health services. Our Waikato Hospital Emergency Department continued to have record numbers attending, Waikato Hospital was at full capacity many times, as was our inpatient mental health facility Henry Rongomau Bennett Centre.

We are proud of how our employees responded to these challenges.

We would like to acknowledge the work of the board members, elected and appointed, who served during this year and Derek Wright who stepped up as interim chief executive.

In May the board was replaced with a commissioner to address the DHBs deteriorating financial position, lack of strong governance, and ongoing performance challenges. Three deputy commissioners were appointed by the commissioner at the end of May.

The development of a 10 year Waikato Health System Plan, Te Korowai Waiora, the publication of an in-depth and independent Resource Review and more recently, the appointment of Dr Kevin Snee as chief executive, have given the organisation a stronger platform to make the significant changes required. In the next year we are going to be looking at different pathways of care and partnerships with collegial healthcare providers.

The year also saw very positive work done on sustained community consultation and engagement processes, including work with and by our Consumer Council and the Iwi Māori Council.

The Waikato Health System Plan, Te Korowai Waiora was developed through an extensive engagement process including iwi, community members, consumers, providers and other stakeholders. The plan sets out a 10 year direction for the Waikato health system. Its objectives are about achieving equity and improving health outcomes, particularly for Māori, and improving health status for all.

Waikato DHB completed a series of 'Let's Talk hui' to engage with our communities on mental health and addictions issues they are facing. The community engagement is summarised in the Me Kōrero Tātou report. The key themes informed Te Pae Tawhiti, a programme of work that encompasses new and re-vitalised models of care for mental health and addictions services.

This consultation confirmed how important it is for us to continuously engage with our communities and our service delivery partners. We have endeavoured to do this for projects as much as for strategy.

Examples of such project engagement include the following:

- Engaging with our primary partners in a review of our Primary Options for Acute Care Programme (POAC) in 2018 to reduce acute demand. The redesigned programme commenced on 1 July 2019 and was recognised at a Health Round Table conference in August.
- Engaging with our rural community to better support mothers, babies and their whānau better with the opening of the Te Kuiti Maternity Resource Centre, and a new birthing unit in Tokoroa.
- Engaging with individuals through the Hauora iHub in the Meade Clinical Centre at Waikato Hospital – free opportunistic health services and wellness advice, to improve access, particularly for Māori.

We are grateful to our staff for maintaining high levels of performance throughout the year and meeting challenges with integrity and passion. We thank our stakeholders and community partners for their patience and understanding, and look forward to building strong constructive and collaborative relationships as we work through our "reset". To our patients and service users, their families and whānau, our focus is very much on providing quality services that meet needs with the aim of improving access within the resources available to us.

Dr. Karen Poutasi

Commissioner
Waikato DHB

Date: 29 October 2019

Neville Hablous

Acting Chief Executive
Waikato DHB

Date: 29 October 2019

Waikato DHB board interests 2018/19

Sally Webb

Board Chair

1 July 2018 – 8 May 2019

- 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 was responsible to the Minister of Health and comprised 11 members, seven of which were elected and four of which were appointed by the Minister of Health. On 8 May 2019, the Board was replaced by a commissioner appointed by the Minister of Health.

Our 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

Prof. Margaret Wilson

Deputy Chair

1 September 2018 – 8 May 2019

- Law Professor, University of Waikato

Crystal Beavis

1 July 2018 – 8 May 2019

- Director, Bridger Beavis and 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

1 July 2018 – 8 May 2019

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

Martin Gallagher

1 July 2018 – 8 May 2019

- 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

1 July 2018 – 8 May 2019

- 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

1 July 2018 – 8 May 2019

- Director/Shareholder, Digital Indigenous.com Ltd (contracts with Ministry of Health and other Government entities)

Dave Macpherson

1 July 2018 – 8 May 2019

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

Pippa Mahood

1 July 2018 – 8 May 2019

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

Sharon Mariu

1 July 2018 – 8 May 2019

- 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

Dr Clyde Wade

1 July 2018 – 8 May 2019

- 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 and 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

Too much you staff.
I felt that I have been in good hands since the beginning of my treatment.
Ngā mihi aroha.

Comment about Oncology Radiation Therapy

Tamariki play at Lake Rotoroa in Hamilton

Part one: Overview

Introduction

Who we are and what we do

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2019. In the Statement of Performance (part three), we present our actual performance results against the non-financial measures and targets contained in our Statement of Performance Expectations 2018/19.

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 2018/19 year, we received approximately $1.3 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The amount of funding we receive is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status.

During 2018/19 approximately 60 percent of funding received by Waikato DHB was used to directly provide hospital services. The remaining 40 percent was used to fund contracted health services provided by non-government organisations (NGOs), primary health organisations (PHOs), Māori health providers, Pacific health providers, aged residential care, other DHBs, pharmacies and laboratories. These services were monitored, audited, and evaluated for the level of service delivery.

As well as the strategic direction at a local, regional and national level, the performance story diagram on page 16 shows the links between what we do to enable and support our performance (stewardship), and our service performance (output classes, outputs and impacts).

Functions of a DHB

DHBs plan, manage, provide and purchase health services for the population of their district, implement government health and disability policy, and ensure services are arranged effectively and efficiently. This includes funding for primary care, hospital services, public health services, aged care services and services provided by other non-government health providers, including Māori and Pacific health providers.

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 the 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

Waikato DHB is responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services.

Our hospitals provide a range of inpatient and outpatient services and are located across the district:

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

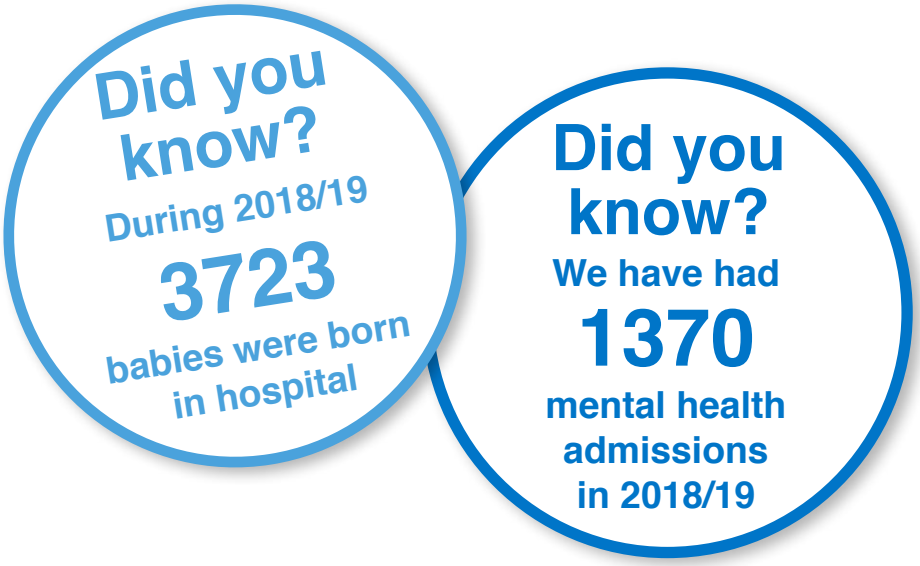
Waikato Hospital, will maintain its preferred tertiary provider status to the Midland DHB region. Waikato Hospital is the base for nursing, midwifery and allied health clinical trainees as well as medical trainees at the Waikato Clinical School. This is an academic division of the Faculty of Medical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

Our rural hospitals form an important part of Waikato DHB's health service delivery. The hospitals work closely with all health service providers 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 hour a day, seven days a week) and for planned hospital visits Monday to Friday
- Inpatient unit, maternity unit, maternity centre, day unit
- Outpatient clinics for a wide range of services including orthopaedics, medicine, surgery, paediatrics and women's health.

Strategic planning is an integral part of purchasing and providing healthcare services and is undertaken in partnership with key stakeholders. During 2018/19 the Waikato Health System Plan, Te Korowai Waiora was developed to provide a 10 year plan with implementation beginning in 2019/20. This is a plan to improve our Waikato health system and futureproof it for the challenges we will face in the coming years. It identifies key actions the Waikato health system can take to work as one cohesive, integrated and coordinated health sector and involve the community and whānau/families in its planning and delivery.

The Waikato Health System Plan, Te Korowai Waiora is published online at:
www.waikatodhb.health.nz/hsp



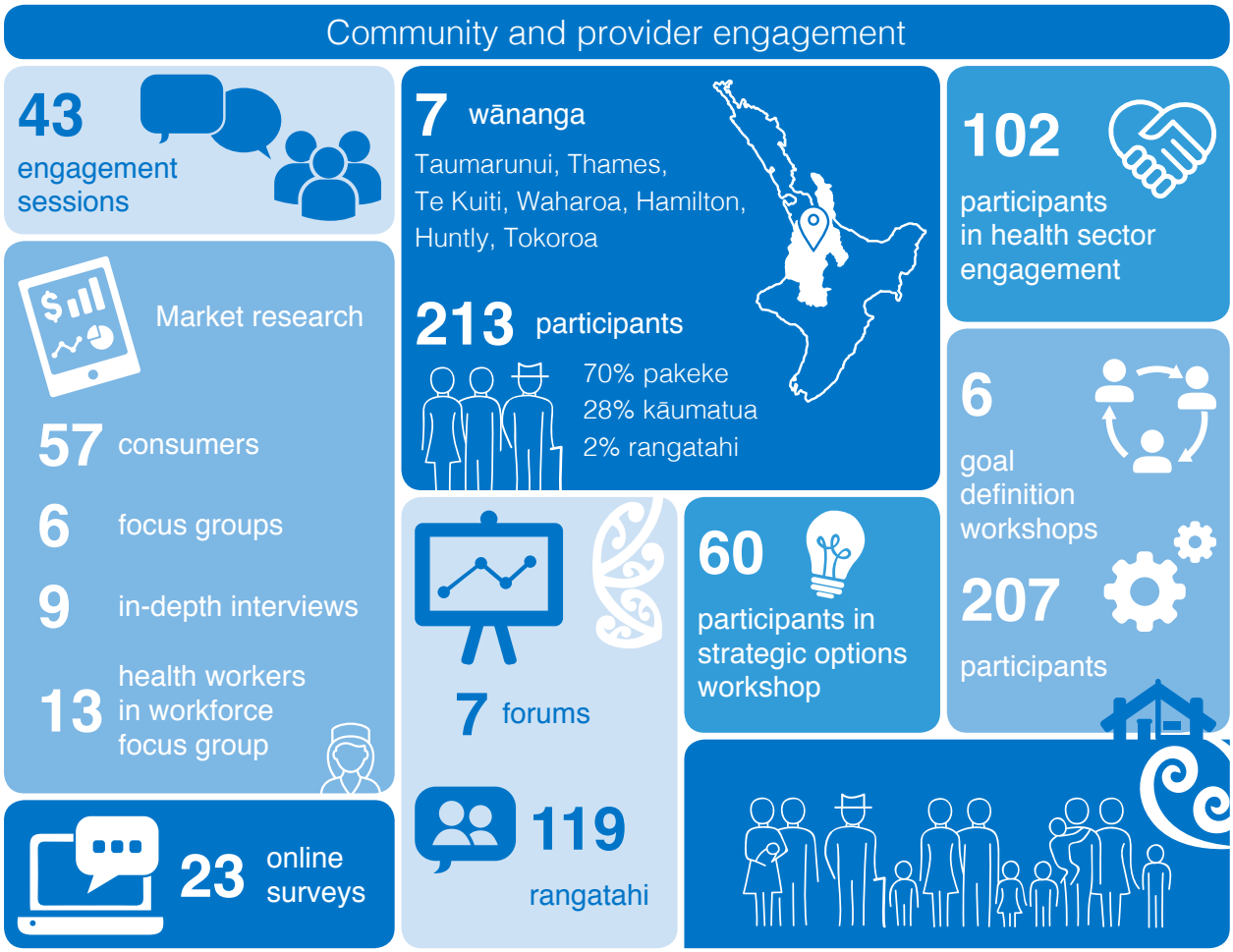
Engaging with our communities

For the health system to be more responsive consumers need to be more involved in their own healthcare and in planning. Waikato DHB is committed to engaging with our communities to ensure their needs are at the centre of all that we do. Some examples of community engagement in 2018/19 include the development of the Waikato Health System Plan, Te Korowai Waiora, the Let's Talk hui and Community Health Forums.

Waikato Health System Plan, Te Korowai Waiora

The development process began by engaging with the community about how care could be better provided in community settings. As part of the engagement process wānanga were held in seven Māori communities to ensure significant insights into Māori perspectives were incorporated. Rangatahi were engaged through separate hui. The feedback from these wānanga was analysed and incorporated into what became the Waikato Health System Plan, Te Korowai Waiora which will guide the Waikato DHB for the next 10 years.

Summary of the community and provider engagement that took place during the development of the Waikato Health System Plan, Te Korowai Waiora

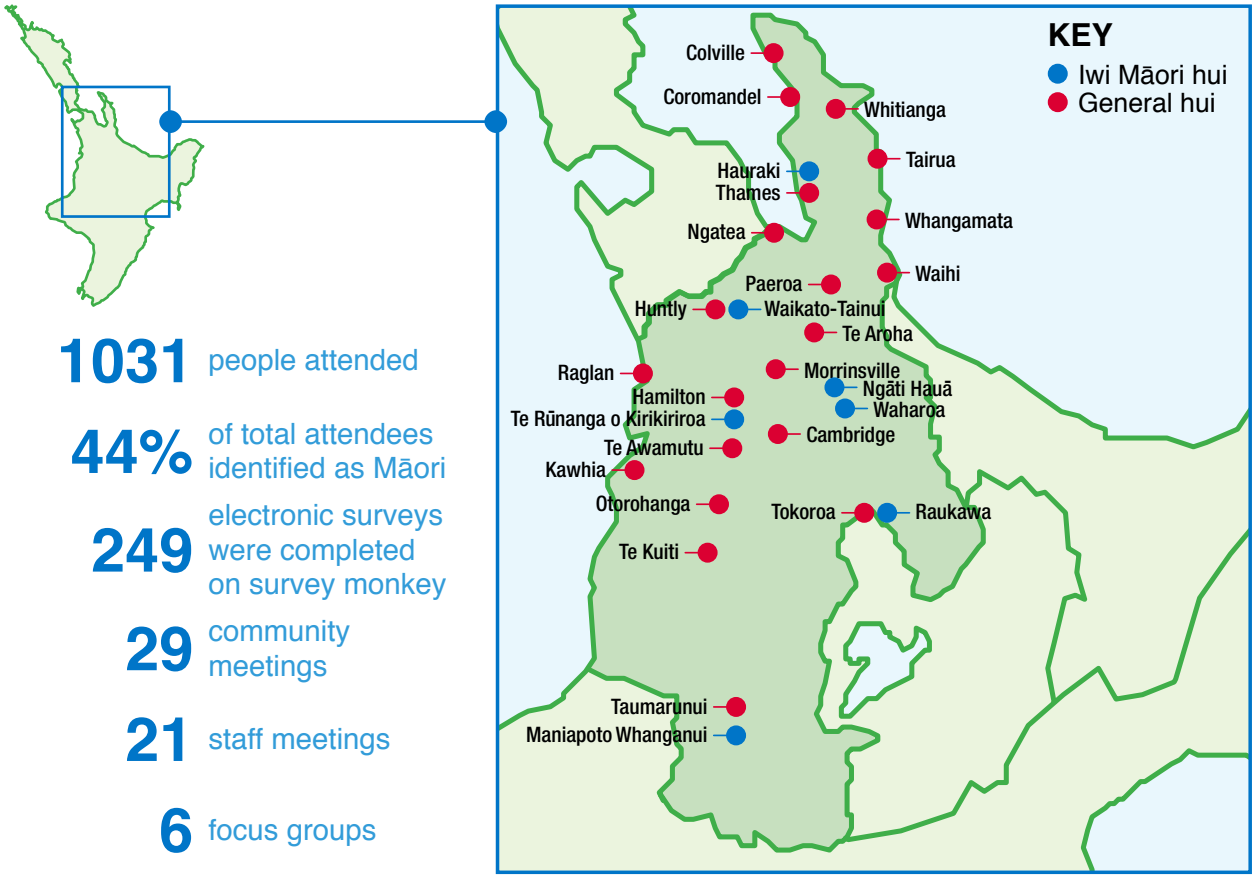


Let's Talk hui

Across eight months a series of 'Let's Talk' hui were held in 29 different Waikato communities to ask people to share their experiences, views and ideas that will help guide the new direction of mental health and addictions services in the Waikato. The consultation hui were a huge success with over 1000 people attending, 44 percent of which identified as Māori.

The aim was for anyone to have their say and the conversations included those experiencing mental health and/or addiction issues, whānau/families and friends who wanted support to help their loved ones and GPs talking about their experiences of trying to assist those who need extra help in a rural community. We wanted the community to have involvement in the entire process so we can get it right. Engaging with Māori was a priority and the DHB worked with local Māori service providers and their iwi to find the best way to reach them to hear their voice.

Summary and map showing Let's Talk consultation hui



1031 people attended

44% of total attendees identified as Māori

249 electronic surveys were completed on survey monkey

29 community meetings

21 staff meetings

6 focus groups

Community Health Forums

One way we ensure we are engaging with our diverse, wide spread and often rural population is through our Community Health Forums (CHFs).

The CHFs are used as a mechanism for ensuring our communities are kept involved and informed of Waikato DHB activities and issues occurring in their locality. The CHFs are held three times a year in eight different communities from Taumarunui in the south to Huntly in the north and Raglan in the west to Thames in the east. Advertisements on radio and in local papers help to extend the warm welcome to all members of the public who wish to come along.

The CHFs are not just an opportunity for us to keep the community informed, they also provide an opportunity for the local community to engage with the DHB face-to-face about local health issues, activities and priorities for their community. All issues or questions raised are followed up and a response provided.

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	Health equity for Māori	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	**Oranga** Health equity for high needs populations	**Haumaru** Safe, quality health services for all	**Manaaki** People centred services	**Ratonga a iwi** Effective and efficient care and services	**Pae taumata** A centre of excellence in learning, training, research and innovation	**Whanaketanga** Productive partnerships

Service performance

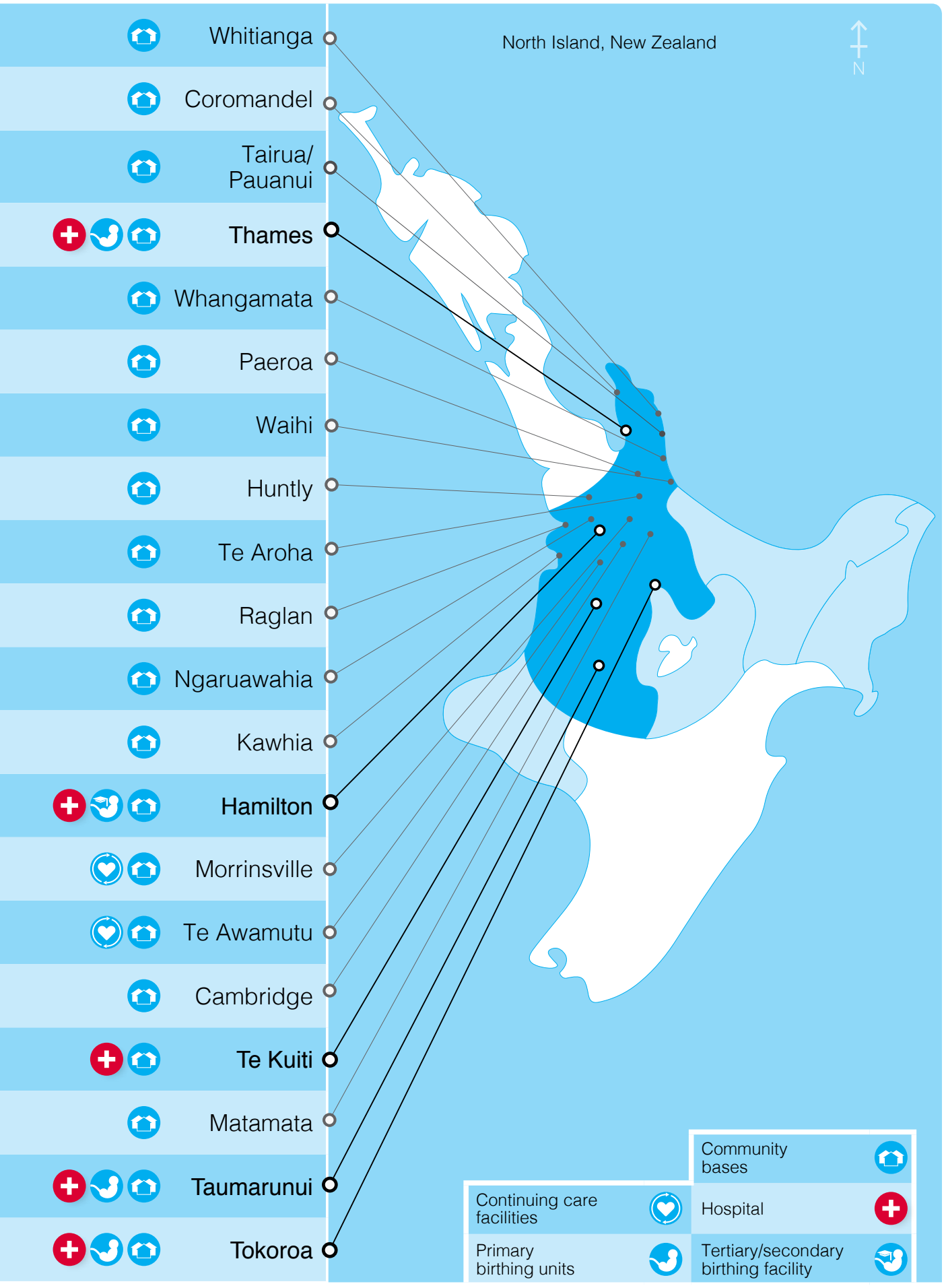
Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood 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 illness and/or addictions More people with end stage conditions are supported appropriately
Outputs*	Percentage of eight months 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

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

We retain strong links with neighbouring DHBs in the Midland region, which include Bay of Plenty, Lakes, Tairāwhiti and Taranaki. We are the tertiary provider for many services in the Midland region.

- 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.
- Sixteen percent of the Waikato population is aged 65 or over. Our population will continue to get proportionately older (the 65 and older age group is projected to increase 40 percent by 2028). This, coupled with the increase in chronic and complex health conditions, help to direct strategies and plans being put in place to meet future health needs.
- Twenty-three percent of the Waikato population is Māori. The Māori population is significantly impacted by many chronic conditions and are disproportionately represented in adverse health statistics. These facts, alongside the acknowledgement of the status of iwi in the Waikato, gives us a strong commitment to include and engage Māori in health service decision making; and to deliver health information and health services in a culturally appropriate way.
- Pacific people represent almost three percent of the Waikato population and are a group that require targeted health initiatives.

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

10
Territorial local authorities within our boundary

419,850
Our population in 2018/19

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

23%
Estimated Māori population compared to national average of 16%

Māori 23%
Pacific 3%
Other 74%

Our workforce at a glance

Understanding the workforce composition is essential to delivering equal employment opportunities (EEO). Without such knowledge progress towards a diverse workforce that represents all groups throughout the DHB cannot be accurately measured. The numbers are as at 31 May 2019 and 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. As at 31 May 2019, Waikato DHB had 7767 employees with 6484.5 full time equivalents.

Employee diversity

New Zealand European is 48 percent of the workforce and Māori is 9 percent.

Ethnic group	Headcount	Percent
NZ European	3728	48.0%
Asian	1846	23.8%
Other European	1143	14.7%
Māori	704	9.0%
Pacific Peoples	124	1.6%
Not identified	116	1.5%
MELAA	92	1.2%
Other ethnicities	8	0.1%
Refused to answer	5	0.1%
Not stated	1	0.0%
Total	7767	100.0%

Age range

The average age of all Waikato DHB employees is 43.6. The age distribution is shown below:

Age range	Total	Percent
<25	545	7.0%
25-34	1974	25.4%
35-44	1487	19.1%
45-54	1724	22.3%
55-64	1645	21.2%
>=65	392	5.0%
Total	7767	100.0%

Employment status

The majority of our employees are full-time (48.6 percent) and 47.5 percent are part-time. 3.9 percent are casual employees.

Status	Headcount	Percent
Full-Time	3777	48.6%
Part-Time	3686	47.5%
Casual	304	3.9%
Total	7767	100.0%

Employee type

Type	Headcount	Percent
Allied health	1360	17.5%
Medical	891	11.5%
Management/administration	1359	17.5%
Nursing	3745	48.2%
Support	412	5.3%
Total	7767	100.0%

Total employees **7767**

Employee diversity

48% NZ European
9% Māori
2% Pacific peoples
2% Not identified

Age range

7% <25
25% 25-34
19% 35-44
22% 45-54
21% 55-64
5% ≥65

Employment status

Full time 49%
Part time 47%
Casual 4%

Organisational and workforce development

Waikato DHB is committed to meeting its statutory, legal and ethical obligations to be a good employer, including providing equal employment opportunities at all ages and stages of our employees' careers. This is supported by policy and our good employer practices relating to the life cycle and work conditions of all employees.

Waikato DHB also has a set of values that reflect a more supportive, inclusive, positive and respectful culture.

We strive to:

- recognise the aims, aspirations and employment requirements of Māori people
- recognise the aims, aspirations, cultural differences and employment requirements of those from other ethnic or minority groups
- provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- ensure that employees maintain proper standards of integrity and conduct in accordance with our values
- provide a healthy and safe workplace
- provide recruitment, selection and induction processes that recognise the employment requirements of people with disabilities
- provide opportunities for individual employee development and career advancement.

The following programmes of work show our commitment to being a good employer and employing a diverse workforce to care for our district and regional populations.

Leadership, accountability and culture

We believe a high performance organisation begins with culture. This year we have completed the development of a Strategic Direction for Our People, Te Rautaki Mā Tātou Ki Mua – putting our people at the heart of everything we do. Four pou (pillars) describe our direction:

Mā tātou
OUR PEOPLE

Know who we need, who we want and bring them here.

This pou focuses on attracting the right people, using targeted strategies to find them and then bring them in in a welcoming, effective and efficient way.

Whakatinana tātou
OUR DEVELOPMENT

Make sure our people build the right skills, at the right time, and in the right way.

Here we address understanding the development needs of our people and providing appropriate learning at times and through channels that work for all our employees.

He iwi ahurea
OUR CULTURE

Build an inclusive, supportive and safe place to work.

This pou takes us on a journey to make sure our people feel safe in every way, physically, emotionally, psychologically and culturally.

Āhei mā tātou
ENABLE US

Create processes and information that are easy to access and use, and enable collaboration.

This part of the strategy leads us into using technology to provide HR and people management information that is consistent and accurate, meaning Human Resources and Organisational Development practitioners can support co-creating and implementing a forward plan for services to ensure that workforce issues are resolved (or avoided), and workforce opportunities are embraced, to make a significant difference in our people's employment experience – and in their trust of us as an employer.

Waikato DHB continues to take an active role in work at national, regional and individual DHB level to implement the State Services Commission's framework for leadership and talent development across the health sector.

Our contemporary, streamlined HR Operating Model has begun to improve Human Resources and Organisational Development services, with the addition of new functions, including systems, reporting and workforce and organisational development. These make available a depth of support to teams and managers that was previously lacking and are intended to be a valuable collaboration focus for the region.

Waikato DHB now has a flourishing self-service model, starting with myHR (for employee information) and myPeople (for people leader information) intranet pages and escalating to a professional HR service centre accessible to all employees by phone and email with strategic and complex matters dealt with in person by the team of HR business partners.

In October 2018, we ran an all employee survey to get a snapshot of the wellbeing of our organisation and to help us decide on actions to improve. The Health Round table survey was used. Fifty three percent of our people completed the survey with the top five responses being:

1. 83.3% of people have a trusted friend or colleague in their place of work.
2. 81.7% of people believe that patients are treated with respect and dignity.
3. 79.5% of people feel comfortable reporting any concerns about patient safety.
4. 78.2% of people believe they have had a positive influence on the culture of their workplace.
5. 75.9% of people intend to continue working here for the next 12 months.

Recruitment, selection and induction

All recruiting managers are required to adhere to the Recruitment and Selection Policy and to attend training on the Waikato DHB recruitment and selection process. This training specifies that those responsible for recruitment within the DHB must make fair, objective and informed selection decisions. Waikato DHB also complies with all relevant provisions contained in the legislation when conducting recruitment activities. All preferred candidates for a position will undergo pre-employment checks including:

- Health and safety screening
- Reference checks
- Verification of identity, qualifications and credentialing
- Eligibility to work in New Zealand
- Police vetting and criminal history check
- Children's worker safety check

Our recruitment processes comply fully with safety checking regulations. In order to create an organisation-wide culture of child protection, all interviews include specific Children's Act questions.

This builds on other DHB work with the Equal Employment Opportunities Trust to create a paragraph for inclusion in all job advertisements highlighting our commitment to a diverse workforce and encouraging applications from our Māori communities. The Executive Leadership Team have written to all managers outlining support for the mandatory shortlisting of all eligible Māori candidates, whatever the role.

Orientation and onboarding are being continuously improved with the introduction of Taleo Transitions, an automated onboarding process which allows all employment paperwork to be completed online and reduces the time to on-board.

Puna Waiora is a programme developed for Māori secondary school students to facilitate Māori student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. The DHB also works with Kia Ora Hauora to support rangatahi into health.

Organisational and workforce development
continued

Employee development, promotion and exit

Waikato DHB is committed to providing development opportunities for individuals, teams and services:

- A range of clinical, technical, and non-clinical internal training programmes and workshops are provided.
- Senior medical officers are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills or undertaking an approved course of study or research in matters relevant to their clinical practice. It is also a time for reflection and personal development.
- Exit interviews and surveys conducted with arriving and departing staff have been reviewed and improved to get more useful feedback for the organisation.
- Employee exiting information

  Waikato DHB's exit form allows us to capture exiting data from employees; they are able to provide more than one reason for leaving (or transferring from one service to another).

  Waikato DHB had approximately 1605 staff members resign during 2018/19 who logged a total of 1669 exit reasons in the Customer Portal. The top 10 reasons given for resigning are:

Reason	Total
Relocation	297
End employment agreement	213
More time with family	170
Better career prospects	168
Better challenges	165
New job higher salary	148
Closer to family	134
Retirement	103
Dissatisfied – manager	89
Better work life balance	89

Flexibility and work design

The DHB offers flexible rostering practices, subject to clinical requirements, and this is demonstrated by our large part time workforce.

Waikato DHB acknowledges that allowing people to strike a balance between their work and home life helps retain skilled people, reduce recruitment costs and raise employee morale. While being mindful of operational requirements, all requests for flexible working arrangements will be considered. Flexible working may come in the form of reduced or increased work hours, flexible hours or set shifts.

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

Remuneration, recognition and conditions

Waikato DHB recognises the valuable contribution our employees make to patient care through recognition programmes and/or awards:

- Staff service recognition programme

Remuneration and rewards are decided fairly and equitably within the boundaries of the Collective Agreements for the vast majority of employees or in line with relevant employment agreements and the Waikato DHB Remuneration - Individual Employment Agreement Employees policy. The DHB has regular meeting with unions at which views are exchanged and information shared.

The visibility of career opportunities at the DHB has significantly increased with targeted communications across multiple platforms. This is evident in monthly analysis received from KiwiHealth jobs positioning Waikato DHB at first or second spot in terms of candidate applications received compare to all nationwide DHBs.

Targeted communications on social media, a dedicated landing page for nursing applicants, and a focused approach to the delivery of recruitment has also proven successful with vacancies in nursing positions reducing from 110 in January to just 23 in April this year.

The formation of a recruitment working group has also allowed for the transparency needed to plan strategic delivery and facilitate change across the organisation.

- Employee remuneration

Remuneration	2019 Actual	2018 Actual
Employee remuneration over $100,000 ($10,000 bands)		
100,000 - 110,000	260	180
110,001 - 120,000	146	121
120,001 - 130,000	109	90
130,001 - 140,000	73	55
140,001 - 150,000	47	45
150,001 - 160,000	36	25
160,001 - 170,000	35	24
170,001 - 180,000	32	22
180,001 - 190,000	26	25
190,001 - 200,000	35	22
200,001 - 210,000	23	20
210,001 - 220,000	13	18
220,001 - 230,000	10	31
230,001 - 240,000	26	20
240,001 - 250,000	19	24
250,001 - 260,000	23	19
260,001 - 270,000	22	22
270,001 - 280,000	19	18
280,001 - 290,000	25	24
290,001 - 300,000	19	21
300,001 - 310,000	18	15
310,001 - 320,000	21	12
320,001 - 330,000	17	13

Remuneration	2019 Actual	2018 Actual
Employee remuneration over $100,000 ($10,000 bands)		
330,001 - 340,000	16	13
340,001 - 350,000	19	7
350,001 - 360,000	6	13
360,001 - 370,000	9	4
370,001 - 380,000	7	3
380,001 - 390,000	5	5
390,001 - 400,000	3	4
400,001 - 410,000	5	1
410,001 - 420,000	3	0
420,001 - 430,000	1	2
430,001 - 440,000	3	0
440,001 - 450,000	3	2
450,001 - 460,000	1	0
470,001 - 480,000	4	0
480,001 - 490,000	1	0
490,001 - 500,000	1	0
500,001 - 510,000	0	1
520,001 - 530,000	1	0
530,001 - 540,000	1	0
580,001 - 590,000	1	0
600,001 - 610,000	0	1
670,001 - 680,000	1	1
Total	1145	923

Of the 1145 (2018:923) employees shown above, 85 percent or 953 (2018:775) are or were clinical employees.

Futher information on commissioners, board member, key management and key personnel remuneration on pages 130-131 (Part five: Financial statements).

Harassment and bullying prevention

The Speaking Up for Safety programme was introduced this year. It is designed to support all employees to speak up when they experience or witness behaviour that may harm patient safety. Speaking Up for Safety was developed by the Cognitive Institute and has already been rolled out internationally as well as at other New Zealand DHBs. It supports our people to speak up whenever they are concerned about a patient's safety. More than 30 employees have become accredited presenters of the Speaking Up for Safety seminars which have started running across the organisation. The aim is for all of our employees to attend one of these one hour sessions.

A 40-strong group of voluntary Workplace Support Persons (WSPs) has been in place for three years and is going from strength to strength. These are employees who are trained in how to listen to the concerns other staff may have and provide some guidance on what action to take or just be a sounding board. The response to a recent request for expressions of interest will swell this group by approximately 50 percent.

Organisational and workforce development
continued

Safe and healthy environment

The Health and Safety team is now the Health, Safety and Wellbeing team with dedicated roles introduced for wellbeing and return to work.

Datix is a well-used system for recording health and safety incidents.

- Vaccinations for health care workers policy

  Waikato DHB ensures that our people, 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.

- Pre-employment health screening

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

  Environment that supports and encourages employee participation in health and safety

  The Waikato DHB has a Worker Participation Agreement in place, using the Canterbury agreement, in line with practice prescribed by the National Bipartite Action Group (between DHB and Union partners).

- Health and Safety training

  The DHB continues to support its employees to participate in DHB health and safety systems. There are currently 228 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. Employee wellness is supported through a number of initiatives, including Workplace Support Persons, WorkWell, the vaccination programme and smoking cessation programmes.

Governance and accountabilities

Waikato DHB has three statutory committees; Community Public Health Advisory Committee, the Disability Support Advisory Committee and the Hospitals Advisory Committee, which are made up of commissioner representation, members of Iwi Māori Council and members from the community.

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, Ngāti Maniapoto, Ngāti Tuwharetoa, Te Runanga O Kirikiriroa representing urban Māori, Pare Waikato, Ruakawa, and Whanganui iwi.

Ministerial directions

Directions issued by a Minister during the 2018/19 year, or that remain current are as follows:

- The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act.
- The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement , ICT and Property and the former two apply to DHBs.
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Local performance story

The following diagram is part of our wider performance story (see page 16). During 2018/19 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	**Oranga** Achieving health equity for high needs populations	**Haumaru** Safe, quality health services for all	**Manaaki** People centred services	**Ratonga a iwi** Effective and efficient care and services	**Pae taumata** A centre of excellence in learning, training, research and innovation	**Whanaketanga** 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. 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.

Implementation of the newly developed Waikato Health System Plan, Te Korowai Waiora will also help to put our strategy of Healthy people. Excellent care and our Iwi Māori Health Strategy, Ki te Taumata o Pae Ora, that is being developed, into action.

OUR **strategic imperatives**	OUR **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

Regional performance story

Waikato DHB is committed to being an active participant in our regional planning process. By working together at a regional level, DHBs are able to make best use of available resources, strengthen clinical and financial sustainability and increase access to services.

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	Health equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Regional service plan objectives

The Midland DHBs produced a Regional Service Plan (RSP) for 2018-2021. The strategic intent for the Midland region is described in our RSP and is presented as part of our performance story diagram.

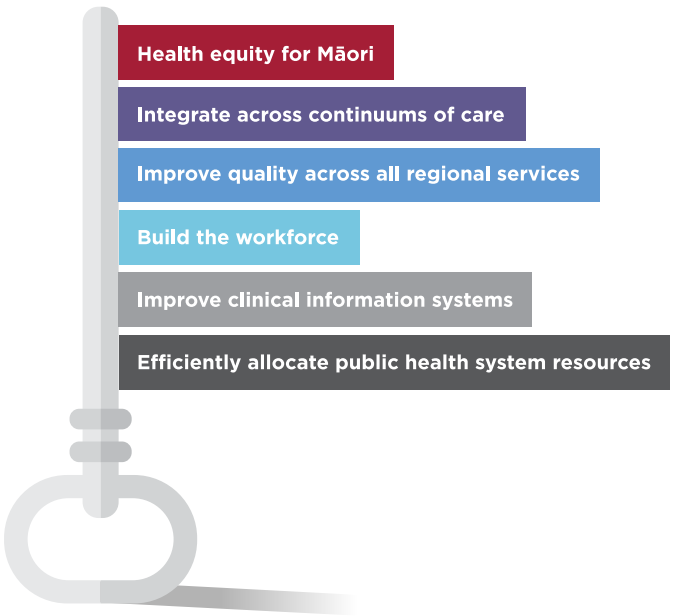
HealthShare produces the RSP annually on behalf of the Midland DHB region. The RSP details national and local priorities in the Midland region, setting out the region's collaborative efforts to support the planning, funding and implementation of health services at a regional level. The RSP has a specific focus on reducing service vulnerability and costs, and improving the quality of care to people within the Midland region.

The Midland region is committed to realising its two regionally-agreed strategic outcomes:

- Improve the health of the Midland populations.
- Achieve health equity.

The direction of the Midland region is also informed and supported by its six key regional strategic objectives:

Our six regional objectives



[1] The full 2018-2021 RSP is available online at https://healthshare.health.nz/our-priorities/enablers/planning-and-governance-support/regional-services-plan

[2] Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki and Waikato DHBs

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

Regional population profile

21%

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

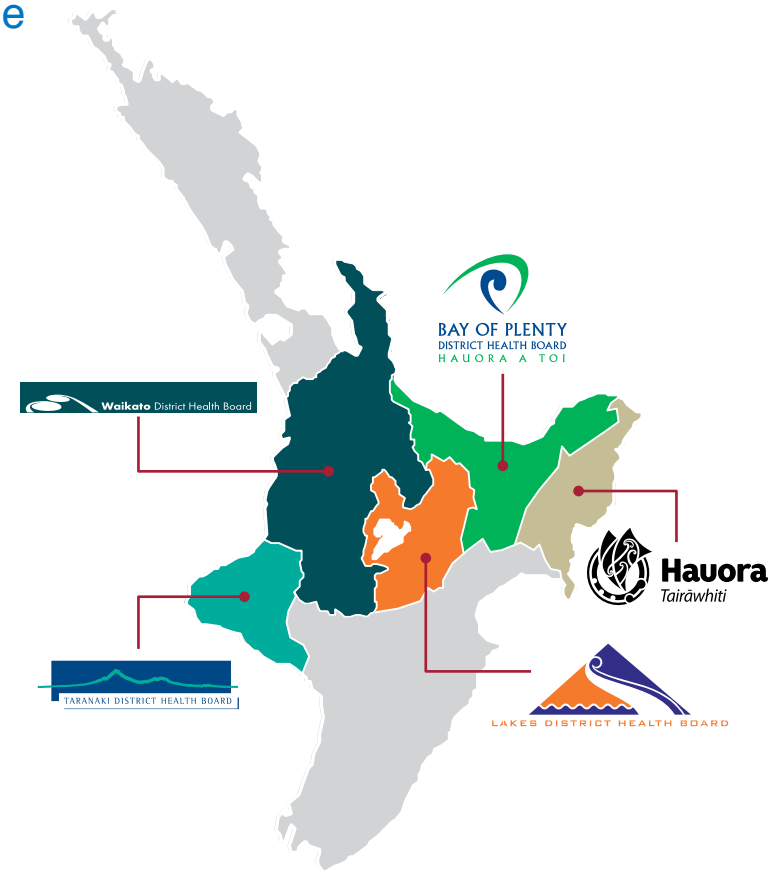
Stretches from Cape Egmont in the west to East Cape and is located in the middle of the North Island

5 DHBs

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

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

937,780 people (2018/19 population projections), including 241,030 Māori (26 percent) and 43 local iwi groups.



Midland region Iwi

Bay of Plenty DHB Population 25 percent Māori	Ngai Te Rangi, Ngāti Ranginui, Te Whānau ā Te Ēhutu, Ngāti Rangitihi, Te Whānau ā Apanui, Ngāti Awa, Tūhoe, Ngāti Mākino, Ngāti Whakaue ki Maketū, Ngāti Manawa, Ngāti Whare, Waitahā, Tapuika, Whakatōhea, Ngāti Pūkenga, Ngai Tai, Ngāti Whakahemo, Tūwharetoa ki Kawerau
Lakes DHB Population 35 percent Māori	Te Arawa, Ngāti Tuwharetoa, Ngāti Kahungunu ki Wairarapa
Hauora Tairāwhiti DHB Population 50 percent Māori	Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu
Taranaki DHB Population 25 percent Māori	Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngaruahinerangi, Ngāti Ruanui, Ngā Rauru
Waikato DHB Population 23% Māori	Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Waikato, 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

Accountability

Every New Zealander will, at some point in their lives, rely on our health and disability system. New Zealand's health and disability system is large and complex, with services delivered through a broad network of organisations. Each has its role in working with others across and beyond the system to achieve better health and independence for New Zealanders. Strong collaboration and cooperation across government agencies and local government are essential to achieving good health, social and economic outcomes.

The health and disability system's statutory framework is made up of over 25 pieces of legislation. The most significant are the New Zealand Public Health and Disability Act 2000 (the NZPHD Act), the Health Act 1956 and the Crown Entities Act 2004. The Minister of Health has overall responsibility for the health and disability system, and for setting the sector's strategic direction. The Minister's functions, duties, responsibilities and powers are provided for in the NZPHD Act, the Crown Entities Act 2004 and in other legislation.

DHBs have a range of accountability documents in place to guide and monitor their performance. Performance is monitored by the Ministry of Health and DHBs file (at a minimum) quarterly performance reports on a large number of Performance Priorities, Crown Funding Agreements, and what have been known as the 'Health Targets.' In addition to quarterly monitoring, DHBs also publish the Annual Report on how we have performed against our Statement of Performance Expectations which is tabled in Parliament at the beginning of the financial year.

National Health Target results

The Government has directed the Ministry of Health to develop a new set of performance measures to replace the current six Health Targets set by the previous Government.

The new performance measures will focus on population health outcomes and will ensure that health resources are used optimally. The objective is to give confidence the best decisions are being made to improve the health of New Zealanders.

While work is underway to develop these new measures DHBs will continue to report to the Ministry against five of the remaining health targets, as well as against a previously established suite of wider measures. Once new measures are announced and finalised, they will replace the Health Targets and be regularly reported on to the public.

National Health Target results

- 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		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Waikato DHB	89%	82%	80%	88%	89%	84%	88%	86%	88%	86%	84%	84%
All DHBs	93%	91%	89%	94%	93%	90%	94%	91%	90%	93%	91%	88%

- 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		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Waikato DHB	81%	98%	94%	86%	98%	95%	86%	97%	90%	86%	95%	88%
All DHBs	78%	92%	90%	82%	93%	90%	82%	91%	88%	81%	91%	86%

- Increased immunisation

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

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Waikato DHB	92%	88%	88%	92%	90%	88%	90%	89%	86%	89%	88%	88%
All DHBs	93%	92%	91%	93%	92%	91%	92%	92%	90%	92%	91%	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		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Waikato DHB	87%	88%	85%	87%	88%	85%	86%	88%	84%	88%	87%	83%
All DHBs	87%	89%	88%	86%	88%	87%	86%	89%	86%	89%	90%	86%

- 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		
	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Waikato DHB	47%	76%	100%	79%	100%	100%	84%	100%	100%	81%	100%	100%
All DHBs	49%	92%	98%	72%	98%	97%	86%	98%	97%	91%	98%	97%

The DHB achievement of the faster cancer treatment health target is calculated on a six month rolling data basis. This is consistent with the Ministry of Health guidelines.

Some highlights from the year

The Puna Waiora team L-R: Maungarongo Tito, Tamati Peni, Raukawa Newton, Wikiwira Pokiha, Erana Severne, Erana Tamati, Wahineata Smith, Sheryl Matenga.

The launch of Puna Waiora #makingsciencefun

Puna Waiora is a new kaupapa Māori support system offered by Waikato DHB. Puna Waiora offers support services to students from year 9 through to successful employment.

The Puna Waiora team aims to inspire rangatahi to be the future of our health system by supporting them with goal setting, hands on experience and pastoral care.

The first #makingsciencefun event was a huge success with hundreds of rangatahi being welcomed by pōwhiri to Wānanga Pūtaiao which was an interactive science expo offering exposure to real careers in health, with a variety of healthcare, science and technology experts. From testing rangatahi knowledge on PH levels with manikins and cola; hands-on education into radiation therapy; OMGTech stirring their interest in robotics and coding; resuscitating simulation races and the thrill and opportunities in first response; to making flour bombs with the University of Waikato – the event was packed with excitement, education and much, much more.

Our evaluations show that 55 percent of rangatahi had little or no knowledge in science or health before the expo. After the expo we saw a shift in the data where 86 percent of rangatahi felt they knew a good to very good understanding of science and health.

The rangatahi were buzzing, so were the teachers and exhibitors. This is one of the main events for the Puna Waiora team to get the students really excited about science. From here the team work with the schools and individual students to get them on track with their subject picking for their senior years' 11, 12 and 13.

Waikato invention could prevent skin injury in premature babies

Premature babies are covered in the most fragile and underdeveloped skin. Even with the greatest care, skin injuries are common. Premature babies, born at 30 weeks or earlier, have such fragile skin that around half will suffer some form of skin injury during their hospital stay. They are often too small to feed and need drips for fluids and medication. They're held in place by splints and sticking plasters, but even careful removal can cause problems. One of the really big problems with skin injury is that you open the baby up to infection.

It's a global problem, so the team at the Waikato Hospital Newborn Intensive Care Unit set about finding a solution. They joined up with industrial designer MWDesign, and after two years they came up with the Pēpi Splint.

The Pēpi Splint wraps around the baby's arm or foot to hold the drip in place, and the sticking plaster wraps around the silicone, not the babies skin. The hope is that the Pēpi Splint will lead to there being no plasters on the baby, at all.

They are about to launch a study, using 15 premature babies, to review the design.

If the concept proves successful, it could be used in hospitals around the world, and not only for newborns, but for fragile older patients too.

Respiratory Research team punches well above its weight in reputation and results

Waikato Hospital's Respiratory Research team is one of the first in the world to gather the supporting evidence that clearly shows the link between chronic respiratory disease and heart health.

This has been done through a number of different trials exploring the connection between respiratory disease and abnormal blood tests (which indicate strain on the heart), ultrasound imaging of heart size and function, and the impact on patient outcomes. Currently the focus is on what treatment might help. Its success is leading to additional research exploring how to increase access to crucial heart medications in the asthmatic population who often miss out on these treatments.

Over the years the unit has contributed to many internationally important clinical trials that have changed the treatment of asthma, COPD, bronchiectasis, and pneumonia. It is currently supporting a 36-month Waikato University research study to see if and how "sniffer dogs" can be used for lung-cancer screening. More than 200 patients attending Waikato Hospital's respiratory clinic have so far given breath and saliva samples for the research project.

L-R: Gail Ritchie (administration) Sandra Hopping (study coordinator), Dr Hollie Ellis (registrar), Chris Tuffery (study coordinator), Dr Cat Chang (principal investigator). Absent: Dr Miriam Bennett (Research Fellow).

Telehealth improving the power of speech for Waikato patients

The popularity of telehealth technology is revolutionising the way Waikato DHB speech language therapists deliver care to rural patients in need of vital treatment to help them communicate and lead more positive lives.

The arrival of telehealth technology delivered via a patient's smartphone, tablet, computer or a hospital mobile televisual unit means the team can now save on travel time and deliver more regular, sometimes even daily therapy to patients in need, providing improved continuity of care.

Patients love it, especially those with poor mobility or who live many hours from the hospital, as it allows them the convenience of being able to dial in for a consultation from home or work via their smartphone, tablet or home computer.

The telehealth system in action.

A group shot of the Maternity Resource Centre opening including the project team and community members (15 February 2019).

New maternity hub opens in Te Kuiti

The centre is the first of its kind in New Zealand, and also the first of three such centres [to come] across the southern rural district. The centre opening marks a significant change in the way Waikato DHB offer support services to mums, whānau and babies in the area.

Located in the heart of town, the centre is a product of a number of co-design workshops that happened last year with the community, mums and whānau who will be using the service. It will support women during their pregnancy, after baby is born and beyond to access a range of community resources and social services to improve their health with a strong focus on the wellbeing of the mums, babies and young children.

In addition to a room equipped for lead maternity carer (LMC) midwives, the centre will also house Well Child providers and other health and community workers including cookery classes, visiting lactation consultants and vision and hearing testers. The DHBs smoke-free, immunisation, nutrition and parenting education services will also be supported from the centre. There will also be linkages with the perinatal mental health service.

Minister David Clark with Community Oral Health manager Diane Pevreal in the mobile dental unit

Minister David Clark visits mobile oral health team

Minister David Clark visited one of Waikato DHB's mobile dental unit's in action at Waipa Primary School, Ngaruawahia.The mobile dental unit is a flagship service of Waikato DHB's Community Oral Health and is fully equipped to provide accessible free oral health care for 0-17 year olds and visits schools and kura.

The team on the unit have been leaders in taking new techniques and innovative service delivery to communities that need it most. The unit operates by its whakataukī (proverb): He awa kawe rau he orange niho, meaning: Oral health knowledge and understandings empowering communities – and that's just what this unit does from its fun-themed unit designs representing Waikato's river and the importance of water to health, to its welcoming staff who speak Te Reo with the children and whānau.

START wins award for outstanding Innovation

For the second year in a row, Waikato DHBs START (Supported Transfer and Accelerated Rehabilitation Team) has won an award for Outstanding Innovation at the Australasian Sub Acute Improvement meeting of Health Round Table.

The START model and its progress this year was one of more than 20 presentations from Australia and New Zealand health organisations at the Health Round Table meeting in Melbourne in late November 2018.

Health Round Table is a knowledge-sharing collective, drawing upon the experience of thousands of highly skilled clinicians and administrators across Australia and New Zealand, as well as top innovators from the UK, USA, and Canada.

The START service has grown in size significantly this year and it now supports as many as 147 patients every day in the community who would otherwise be in a hospital bed.

It has become the benchmark supported discharge model that other district health boards are attempting to emulate.

Charge nurse manager Raewyn Dean and some of the START team members proudly show off the Health Round Table award certificate for outstanding innovation.

> Giving the appearance of having time to treat me as a person by chatting with me and listening to me in an unhurried but professional manner, even though you have many patients to care for. I feel welcome when I come for my treatment.
>
> Comment about Meade Clinical Centre

Kidney donor Nicci (right) and recipient Te join together to promote live kidney donation

Part two: Quality and patient safety

Quality of healthcare can be defined as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (Institute of Medicine, US).

Our aim is to improve experiences for both patients and providers through the delivery of high value, best practice healthcare.

Current priorities – What we have done

Patient safety

Priority one: **Improve end of life care for patients and their family / whānau – year 2 of 3**

- Advanced Care Plans are now electronically viewable across organisations in the Waikato DHB region.
- The Advance Care Planning/Advance Directive guidelines and the Community Health Pathway are near completion.
- All people over 65 years of age undergoing Disability Support Link assessment are introduced and referred for support to complete their Advanced Care Plan/Advance Directive.
- Te Ara Whakapiri, the last days of life care plan documentation has been successfully implemented within Waikato Hospital, Hospice and community settings in the Waikato DHB region.
- Agreement by clinicians to improve completion of resuscitation plans for patients on admission to hospital.

Patient safety

Priority two: **Choosing Wisely – year 1 of 3**

- Choosing Wisely is a programme that aims to improve shared decision making between clinical staff (doctors, nurses, midwives and other professional groups) and their consumers / family / whānau, thereby improving choices around which investigations and tests are most appropriate.
- When consumers and health professionals have well-informed conversations about their treatment options, it leads to better decisions and outcomes. In a time where health care is increasingly complex, it is important to make sure that treatment and procedures provide the best benefit to the consumer and avoid harm from unnecessary investigations.
- The newly appointed Choosing Wisely coordinator will have a focus on working with clinicians and consumers to embed the Choosing Wisely focus on reducing low-value care.

Patient experience

Priority three: **Deteriorating patient programme – year 3 of 5**

This programme is about improving the recognition and response to patients who are deteriorating, allowing early and appropriate response and treatment to be put in place.

- The **National Early Warning Score** for adults was introduced across the DHB in February 2018.

  The aim is to improve patient safety through early recognition of clinical deterioration which allows early response, management and treatment. As a result, more patients are escalated sooner when their condition deteriorates, helping many to avoid more complex treatment and longer hospital stays.

  Plans are underway to implement an electronic system for entering patient observations, which further increases accuracy and visibility of patient monitoring, and improves patient safety through earlier intervention. It is anticipated this will be implemented over the coming year 2019/20.

- The **Sepsis Ready programme** was introduced across Waikato DHB in September 2018.

  Sepsis is the body's exaggerated response to an infection, which can cause it to injure its own tissue and vital organs. Sepsis is a life threatening condition that can lead to tissue damage, organ failure and death. Everyone can get an infection and almost every infection can lead to sepsis, with the very young and very old being more at risk. Sepsis affects more than 1 in 100 people in New Zealand every year with our Māori population being three to seven times more likely to be affected by sepsis during their life time.

  Prompt recognition and treatment will reduce the seriousness of the condition. With over 70 percent of patients with sepsis being admitted through the emergency department, it is important that everyone, including our medical and nursing staff, the public, our communities, GPs and other primary providers are able to recognise the symptoms of sepsis.

  Pathways and treatment regimes are now in use across all of our DHB hospitals and we know that recognition and management of patients with sepsis is improving. We continue to work across the hospitals to improve sepsis management, and are now working in the community to improve the understanding and recognition of sepsis.

  Our first public awareness campaign was at the Fieldays 2019, where over 25,000 people passed through the Health and Wellbeing hub. We had the opportunity to speak with many people, over 50 percent of whom had never heard of sepsis. This was a great education and awareness opportunity that comes with the message:

If you or your loved one suspects sepsis or has an infection that's not getting better or is getting worse,
JUST ASK your doctor or nurse

"COULD IT BE SEPSIS?"

Consumer engagement

Priority four: **Listening to our patients and community**

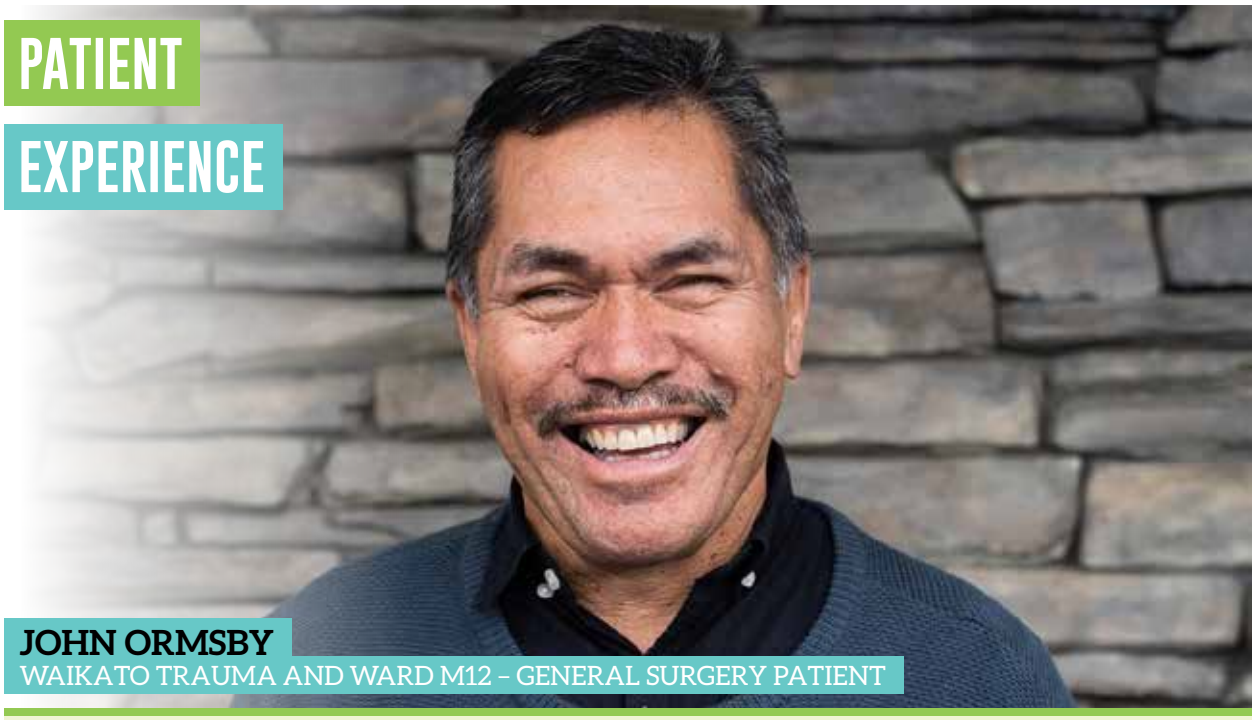
- Supporting the **Consumer Council** as they work through their Priority Plan. Their priorities align well with the Waikato Health System Plan, Te Korowai Waiora and are about equity for Māori, those in rural areas, and those living with disability. Examples include:
  - Improving the transition from paediatric to adult services for young people with complex needs.
  - Ensuring there is adequate Kaitiaki support available when it is needed.
- **Co-design work**: over 120 DHB staff have now received training in running co-design projects. Co-design is an approach for the design of services and products that involves people who use or are affected by that service or product. Some of the projects underway include:
  - Developing a service for trauma patients to assist them when they have memory loss
  - Improving the engagement rates with the Diabetes service
  - Providing better access to the hospital and a dedicated area for women and their families following the loss of a baby, when they need to come back to the hospital for follow up appointments.
- Developing a wider **consumer network** to support the DHB on a less formal basis, utilising social media and remote input. Over 120 people who expressed interest in being on the Consumer Council have been invited to join.
- **Using feedback effectively**: using the feedback from Health and Disability Commissioner complaints, DHB compliments and complaints, and the inpatient survey to provide services with information and insights from hundreds of consumers every quarter.

Patient Experience Week – feedback from some of our patients

"Maree is such a special person. She gave me faith in myself and is just a really nice and decent person. All of the district nurses are special; there is not one that I wouldn't have back. They almost become part of your family."

"We came to know our awesome paediatric homecare nurse Renee after Maanas had a bad seizure. She has been so supportive of Maanas and our whole journey. I just can't say enough about her; she is the best nurse we have had so far."

PATIENT EXPERIENCE



JOHN ORMSBY
WAIKATO TRAUMA AND WARD M12 – GENERAL SURGERY PATIENT

> Thank you for your work in putting me back together again so I could return to my whānau and mokopuna.

On the 22nd of April 2018, at 62 years old, I had a serious motorbike crash while heading home to a tangi in Mangapeehi. I reflect on the accident now and believe I almost made it to my own tangi!

During the crash I swapped places with my 250kg bike as we slid down the road. I only remember patches of the helicopter ride to Waikato Hospital, and was confused when I woke up looking at the air vents in the ceiling, thinking I was looking through the portholes on the Titanic and that we were sinking. I told a nurse to climb on the bed to avoid the water. I blame the medication!

I got pretty smashed up with broken ribs, broken clavicle, a bleed on the brain, nerve damage due to head trauma and a hole in my knee. Unfortunately, my spleen also gave out and I needed emergency surgery.

I was discharged after almost a month and during my time, I would ask my wife to make notes of my experiences as a patient.

I want to thank Waikato Hospital and the professional, caring staff who treated my whānau and I with respect. I am eternally grateful to the trauma team: Damien, Christo, Jenny, Bronwyn and others who I believe saved my life. Thank you for your work in putting me back together again so I could return to my whānau and mokopuna.

Thank you, Jenny, for giving me your hand to hold when I was confused and Ashok for informing my whānau of my condition.

Thanks Willy, for showering me and helping me to feel more human, and Linda for talking to me about the green eyes my family shares. To Hannah, Emma and Amy, I thank you for looking after me through the nights but there are so many other staff members that I am indebted to who cared for me. I apologise if I haven't mentioned you here.

My thanks also to Bevan for your clinical help, to the tea lady, bed straighteners and cleaning staff who all took the time to talk and ask how I was doing. Thank you for making the effort to engage and make my stay more comfortable.

To my roommates: thanks for keeping me company.

I commend you, Erin, for your humility and professionalism when dealing with that difficult patient. Your words of wisdom 'he is sick and not well, my job is to care for him', remind me of the work we often do that goes unnoticed. I hope this goes some way toward acknowledging people who are committed to the care of others.

I sincerely thank all the staff who helped in my return home to my whānau. My work colleagues say 'it wasn't my time and I still have work to complete'.

I am thankful I have the opportunity to carry on my work of helping others, not too dissimilar from the work I witnessed while a patient in Ward M12, Waikato Hospital.

Quality improvement around the organisation

How small changes can make a big difference

Medical wards – a signaling system to reduce patient falls

Following the Health Quality and Safety Commission's strategy to reduce falls, the medical wards are using a signalling system to help ward staff easily see what specific assistance patients need in order to mobilise safely. The symbols signal to health care providers, support staff, families/whānau and friends that a person may require help to ensure they are safe when walking.

The traffic light colours of the symbols indicate how much assistance may be needed. The signals are a cue for action, not an action in themselves; therefore health care providers must ensure the symbols are not seen as the only thing that needs to be done to prevent falls.

The aim is to:

- increase awareness of falls safety
- increase communication with the wider patient care team regarding patient mobility
- increase visibility to ALL staff of patients mobility status
- increase patient/whānau involvement/participation in mobility and falls safety
- decrease falls and harm caused from falls

We are doing this by using:

- mobility flip charts with detailed mobility information.
- coloured mobility wrist bands identifying the level of assistance required.

	Message to staff	Patient message to others
	Full assist and supervision	*I need help*
	Some assistance and/or supervision	*I need some assistance*
	Independent	*I'm independent*

Public health nurses – equipment ready to go

The public health nurses in the southern rural team cover the large rural area surrounding the Tokoroa, Te Kuiti and Taumarunui areas. Nurses need to transport heavy bulky equipment to schools and homes to carry out school based vaccination programmes and B4 School Checks.

They needed to find a better way to safely manage moving all their heavy gear in and out of buildings, schools, homes and community facilities.

The nurses went on a hunt for ideas and found some ideal trolleys in use by other departments within the Waikato DHB. They purchased enough trolleys and extra baskets for each base –across the three areas. The baskets have been set up to contain all the equipment they need for immunisation and B4 School Checks. There are enough baskets to swap over and fit to the trolleys as they need to, so there is time saved from hunting for equipment and re-stocking. The added bonus is that the trolleys fold up and fit easily into the nurse's car. A simple idea and solution that has made nurse's work easier, safer and more efficient.

Priorities for 2019/20

Improving the end of life care for patients and their family / whānau: Year three of a three year programme.

1. Recognising the last phase of life: Supporting clinicians and patients to make shared decisions about emergency resuscitation and treatment plans, which place the patient, and their family/ whānau, at the centre of discussions.
2. Bereavement care: Ensuring systems are in place to provide quality end of life care for dying patients and their families/whānau, organised around the needs of the patient.

Deteriorating patient: Year four of a five year plan with a continued focus on improving the recognition and response to patients who are deteriorating clinically.

1. Transitioning to an electronic observations system over the coming two years which will enhance visibility of patients who are deteriorating.
2. Improving recognition and response to patients with sepsis and spreading out processes to include primary providers and the community.
3. Initiating a patient and family activated escalation process, to be called 'Speaking Up for Me'.
4. Introducing the national Maternity Early Warning score chart and working with paediatrics to review and update their Paediatric Early Warning score chart.

Choosing Wisely: Year two of three, where all clinicians are encouraged to engage effectively with their patients to make informed decisions about tests and investigations. Improving understanding around treatment options and benefits reduces the risk of harm from unnecessary tests and improve patient outcomes.

Listening to our patients and community: Ongoing work to improve the partnership between providers and consumers that include:

1. Enhancing the involvement of consumers across the DHB.
2. Working as a pilot site for the Health Quality and Safety Commission's Quality and Safety marker for consumer engagement.

Consumer engagement is known to enhance quality and safety in health services and improves the outcomes from health care.

Ensuring an equity lens to all we do

Equity in health care means that people receive the care that they require, whatever their social background, ethnicity or location. We know that currently there are differences in health outcomes for different groups of people. Our key priority is radical improvement in Māori health outcomes, by eliminating inequalities for Māori.

It is crucial that every new service or process development considers what impact it will have on the populations it serves, ensuring it meets the needs of our most vulnerable consumers. An equity impact assessment will be applied to all our programmes.

Having a sense of humour, being very understanding of the needs of a disabled patient who makes the ordinary demands extraordinary.
A very stress free visit.
Thank you.

Comment about Day of Surgery Admission

Nina waits for her 15 month immunisations at Hauora iHub

Part three: Statement of performance

Introduction

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 DHB's 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.
3. People receive timely and appropriate specialist care.

Our outputs

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 2018/19 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 2018/19. Output class allocations are based on specific 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 for the Waikato DHB Group.

Output class reporting is a different way of slicing information. We do not have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2018/19 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code.

Cost of service statement by output class for the year ended 30 June 2019

	Parent 2019 Actual	Parent 2019 Budget	Parent 2018 Actual
Revenue	$000's	$000's	$000's
Prevention	25,636	28,111	27,057
Early detection and management	305,097	279,786	301,341
Intensive assessment and treatment services	1,068,670	1,023,717	976,055
Rehabilitation and support	121,764	167,333	137,597
	1,521,167	1,498,947	1,442,050
Expenditure			
Prevention	24,640	24,559	23,327
Early detection and management	304,266	260,616	282,516
Intensive assessment and treatment services	1,173,552	1,104,985	1,037,416
Rehabilitation and support	139,438	164,858	137,000
	1,641,896	1,555,018	1,480,259
Share of associate surplus/(deficit)	-	-	-
Share of joint venture surplus/(deficit)	68	-	72
Surplus/(deficit)	(120,661)	(56,071)	(38,137)

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 PHO 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 LMC 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 month 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 five years of age
		Percentage of eligible 12 year old girls have received HPV dose two
		Seasonal influenza immunisation rates in the eligible population (65 years and older)
	Improving health behaviours	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
		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, while placing significant pressure on the health system in terms of demand for health services.

The likelihood of developing a long-term condition increases with age and these conditions are more prevalent amongst Māori and Pacific Island populations. With our higher than national average Māori population (23 percent) and a predicted 40 percent increase in 65 and older 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 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 has 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 2017/18	Target 2018/19	Preliminarily result 2018/19	Preliminarily rating
Percentage of Year 10 students who have never smoked	74%	80%	≥ 80%	80%	●

Our performance:

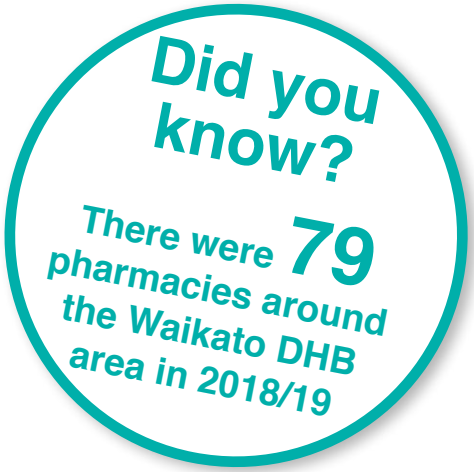
Waikato DHB utilises ASH (Action for Smokefree 2025) Year 10 Snapshot surveys to gain a perspective as to how well we compare to national averages for the percentage of students who have never smoked. The results are by calendar year to line up with the school calendar year.

At the time this report was published only preliminary Waikato DHB results were available with final results expected in November 2019. While Waikato results are pending we do have final national results which in the past have been similar to our local year 10 population. When final results are available they will be published online at www.ash.org.nz/ash_year_10

The national results show approximately 52 percent of schools participated across the country receiving 28,756 survey responses, from these responses 81 percent of year 10 students report having never smoked a cigarette. This result drops when split by ethnicity with only 63 percent of Māori and 75 percent of Pacific year 10's reporting to have never smoked. This is an equity gap that will need a targeted approach moving forward.

Past trends of the national results being similar to local are expected to continue. Preliminary Waikato results show 2644 students completed the survey with 80 percent of total year 10 students reporting to have never smoked. This is slightly lower than the national result of 81 percent, no preliminary result for Māori or Pacific is available. ASH notes limitations for the survey include potential for bias, with lower participation rates for wharekura (Māori medium schools).

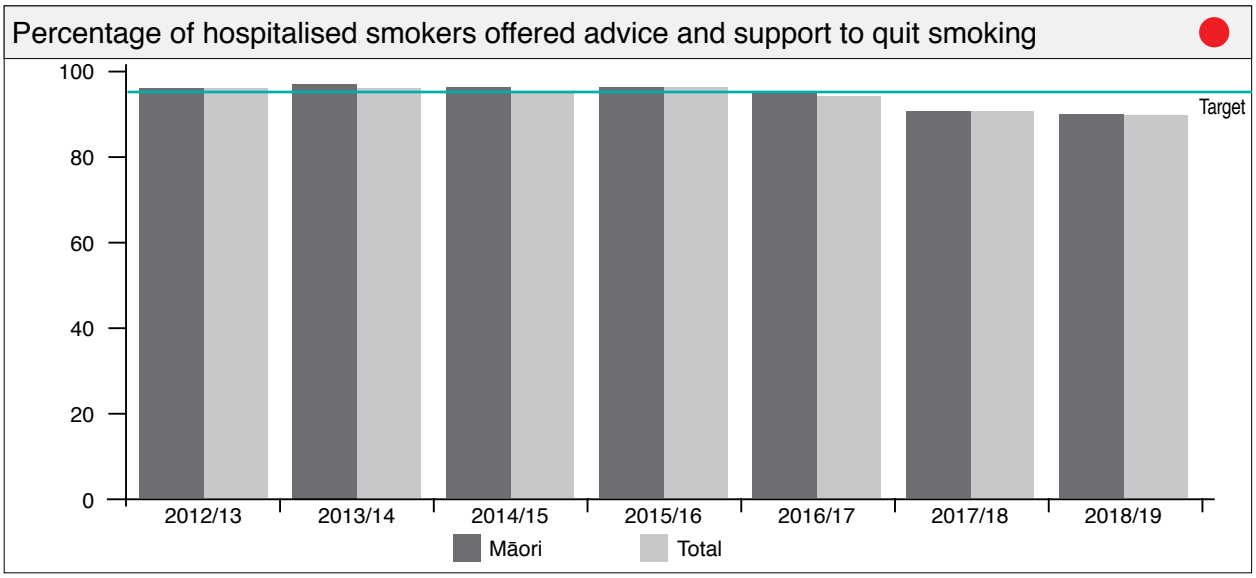
The increasing rates of year 10 students who have never smoked show the effectiveness of the many interventions we have in place to move New Zealand towards the smoke-free 2025 goal. The achievement of 80 percent of year 10 students having never smoked is significant as evidence shows if our tamariki/children are smokefree 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 2017/18	Target 2018/19	Result 2018/19	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 92% Pacific 92% Other 91% Total 92%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 90% Pacific 92% Other 88% Total 89%	●

Our performance:



It is disappointing to see a decline in results. While we have not achieved the annual target, the recent data from quarter four shows that results are no longer declining and we are now tracking positively towards the target. We hope this continues and is reflected in our results next year.

Clinical staff offer interventions (brief advice, withdrawal orientated treatments and referral) to people who smoke during their admission. Such interventions often require high levels of complexity, skill and commitment. Working with the current paper based system creates a challenge when trying to accurately document these interventions while keeping up with clinical practice. We continue to look for opportunities to improve on the documentation process.

Given referral provides the best possible outcome, we are very pleased to see the rate of referral to stop smoking services increase by 15 percent for Māori, 42 percent for pregnant Māori, and an overall increase of 39 percent (compared to 2017/18). When intervention does result in a request for referral to the community Stop Smoking services, we are achieving over 54 percent quit rate in the Waikato. Māori pregnant women referred reach up to 62 percent some months. This is a result of close contact with frontline staff in Women's Health also including LMCs who provide ongoing promotional and educational work.

All the achievements gained in the 2017/18 revamp of the smokefree policy will continue to be sustained and particularly pleasing are results from the 'opt off' referrals and the 'stop for your op' initiatives.

Collaborative planning with NGOs and PHOs working on System Level Measure 'Babies living in smokefree homes at six weeks' will contribute to continuous improvements and it is expected to result in more referrals from the primary care sector in the future.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	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% Pacific 91% Other 89% Total 90%	Māori 85% Pacific 83% Other 88% Total 87%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 81% Pacific 75% Other 85% Total 83%	

Our performance:

The target has not quite been achieved. However, we are pleased to report that a number of collaborative activities are in place and are expected to contribute towards achieving the target in the future.

Following ABC (Ask, Brief advice and Cessation), referrals are received from general practice and maternity providers to cessation services such as “Once and For All” which is provided by Midlands Health Network. We are pleased to report that we have increased the number of hospital and primary care referrals by over 10 percent for Māori.

In 2018/19 we increased the number of tobacco control staff employed at Waikato DHB. We recruited a smokefree ambassador and a smokefree coordinator for maternity services. A smokefree Sudden Unexplained Death in Infants (SUDI) coordinator has been appointed to Te Puna Oranga (Waikato DHB Māori Health) to support the Hapū Wānanga programme. We intend to increase staff numbers under the Waikato DHB Tobacco Control Action Plan in 2019/20. This action plan will focus on delivering equity and improved health outcomes for Māori and achieve Smokefree Aotearoa 2025.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 31.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking	Māori 64% Pacific N/A Other 70% Total 66%	Māori 83% Pacific NA Other NA Total 87%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 87% Pacific NA Other NA Total 81%	 NA NA 

Our performance:

We are disappointed to have not met the target however we are encouraged to see the increase in Māori women offered brief advice and support to quit smoking compared to last year. We have seen our highest number of referrals for pregnant women to stop smoking services since data has been collected, with Māori women accounting for 64 percent of referrals, which has led to more women setting a quit date and successfully stopping smoking.

This has been achieved by having a focus on referring all pregnant women who smoke to stop smoking services with the understanding they can opt off if they choose to do so. Once and For All continue to offer incentives for pregnant women who remain smoke free at the end of the programme which encourages the women and partners to accept a referral.

Children who have a parent who smokes are seven times more likely to become smokers compared to those without a parent that smokes. These children are also at greater risk of SUDI, premature births, low birth weight and serious respiratory infections. Due to this association, we have provided stop smoking services at the local Hapū Wānanga classes to support the whole whānau to be smokefree.

Data is derived from the Ministry of Health and is only available for the whole population group and Māori women. The Ministry of Health only collect data from the Midwifery and Maternity Providers Association (MMPO) system, however the majority of LMCs in the Waikato use the “Expect” system. Despite this, we will continue to prioritise referral rates and will work closely with health professionals and whānau in communities which have higher rates of maternal smoking.

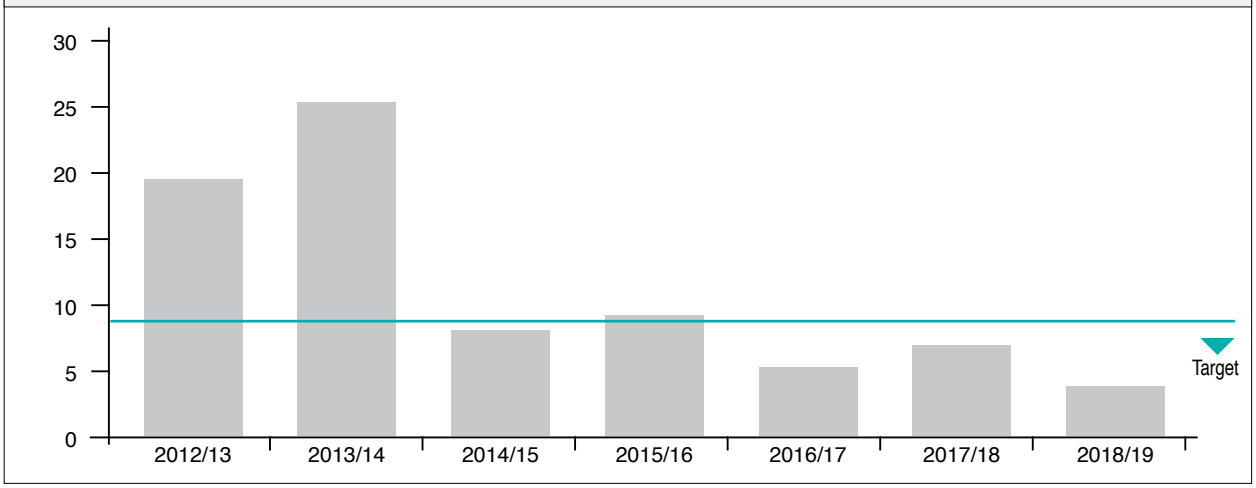
People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	Māori 19.4 Pacific 0.0 Other 4.5 Total 8.8	Māori 6.4 Pacific 0.0 Other 7.9 Total 6.9	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori 4.3 Pacific 0.0 Other 3.9 Total 3.9	● ● ● ●

Our performance:

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



The rate of vaccine preventable disease continues to reduce significantly across both Māori and the total population with the best result yet being 2018/19. The number of Pacific people is so low it produced a result of zero.

Although the reducing rates are very pleasing, it must be seen against a background of relatively low immunisation rates in the Waikato and across New Zealand. Significant work continues with all major partners to help raise the immunisation rates and reduce the risks of serious diseases which can have deadly consequences for particularly the young, weak and immune compromised in our community.

Did you know?
In 2018/19 there were **4793** immunisations for 8 month olds

Did you know?
In 2018/19 there were **4992** immunisations for 2 year olds

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Māori 90% Pacific 95% Other 83% Total 91%	Māori 83% Pacific 94% Other 83% Total 87%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 81% Pacific 88% Other 92% Total 88%	

Our performance:

We are disappointed that immunisation rates are so low across Aotearoa New Zealand and particularly in the Waikato. Despite continued hard work by all the key partners in this area, we are seeing children at risk of vaccine preventable diseases that present a significant health risk and even death.

We continue to work with partners to identify all areas in the system that can be improved to reduce barriers and increase the chances of timely immunisation. This starts with information for parents before birth, through enrolment with general practices, support and monitoring of each of the immunisation events.

The Newborn Enrolment and Missing Events service is focused on improving the immunisation rates for Māori babies. Through close monitoring and swift engagement with parents and whānau we aim to reduce the current inequalities in immunisation and increase the overall rate to achieve 'herd immunity' which will help protect the most vulnerable in our community who are unable to be vaccinated themselves due to age or having medically compromised immune systems.

Our approach will continue to focus on general practice as the most significant provider of immunisation. However, we will investigate alternative approaches to immunise children where general practice has not been able to engage. Currently this is mainly through outreach services and some opportunistic immunisation in places like Hauora iHub. These services may need to be reconfigured and/or supplemented.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 31.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of two year olds are fully immunised and coverage is maintained	Māori 91% Pacific 95% Other 91% Total 90%	Māori 89% Pacific 93% Other 91% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 83% Pacific 91% Other 90% Total 88%	

Our performance:

Our performance remains lower than we wish to see.

The focus remains on timely immunisation of eight month olds. The activities in the eight month immunisation target are designed to protect our most vulnerable as early as possible to reduce the risks of vaccine preventable diseases and the risks associated.

A healthy child has more time to play, go to school and undertake all the activities that help them develop into healthy adults. Healthy children mean that parents and whānau require less time off work for caring. Immunisation is one of the safest and simplest methods to improve health.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of eligible children fully immunised at five years of age	Māori 73% Pacific 78% Other 76% Total 73%	Māori 85% Pacific 86% Other 88% Total 87%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 82% Pacific 85% Other 87% Total 85%	

Our performance:

We continue to work hard with all partners in this area to improve immunisation rates at each milestone (eight months, two years, five years).

Midlands Health Network have indicated a new approach to achieve B4 School checks earlier in a child's fifth year. This will allow greater opportunities to co-ordinate an immunisation catch up before children turn five.

We will continue to work with a wide range of partners on a variety of approaches to improve immunisation rates at each milestone and provide children with a better start and healthier future.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of eligible 12 year old girls have received HPV dose two	Māori 70% Pacific 106% Other 62% Total 66%	Total 66%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 72% Pacific 79% Other 53% Total 62%	 

Our performance:

HPV immunisation aims to protect young people from HPV infection and the risk of developing cervical cancer and genital warts later in life. The vaccine has been shown to be very effective in preventing infection from the types of HPV it targets. We are disappointed to have not met the target for Māori, Other and Total this year but are encouraged to see the result for Māori has increased from the previous year.

A significant achievement this year has been gaining the consent of a kura that has declined the HPV vaccination since it started. The kura is now fully engaged with the programme. The other three schools in this area that do not participate are actively encouraged to reconsider this next year.

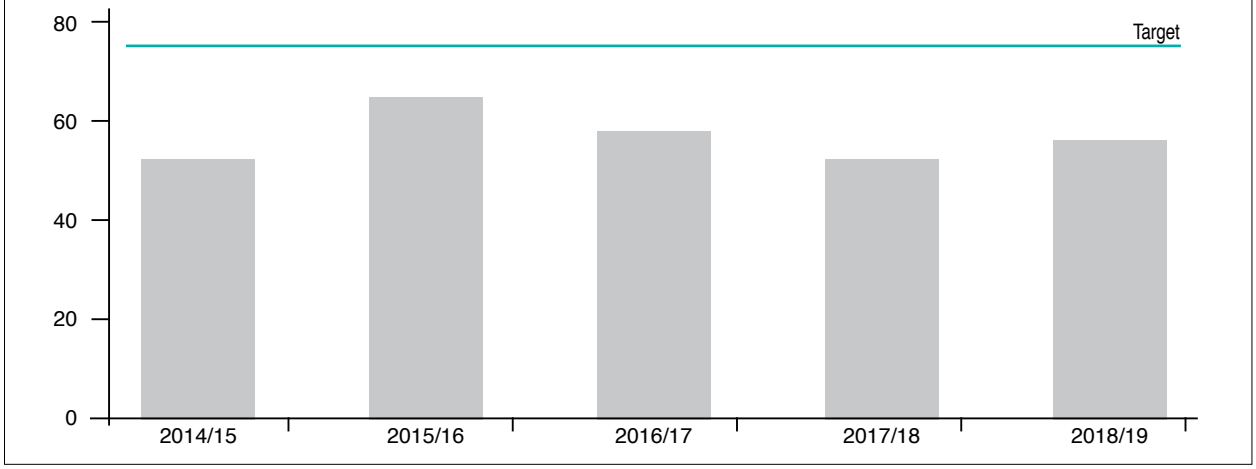
The school based HPV vaccination programme delivered by Waikato Public Health continues to be an excellent mechanism in achieving the greatest coverage. Service records show 63 percent consent for the eligible population group for this immunisation. It has been noted that the anti-vaxxer movement promoters aim their programme nationally for the beginning of the year at the time when Waikato Public Health nurses are gaining consent for immunisation from parents. Consent numbers do not appear to be increasing. Giving this vaccination in year 7 may be a solution if it separates the sexual connotation for parents/caregivers.

Going forward, it would be beneficial to report on the vaccinations in a school year period ending in December. This would mean that dose one given at the start of the year will be reported in the same year as dose two given at the end of the year. Currently this is not the case when we report in financial years.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Seasonal influenza immunisation rates in the eligible population (65 years and older)	Māori 46% Pacific 49% Other 53% Total 52%	Total 52%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 48% Pacific 49% Other 58% Total 56%	

Our performance:

Percentage of the eligible population (65 years and older) who have received the seasonal influenza immunisation 



Influenza is a significant public health issue causing ambulatory sensitive (avoidable) hospital admissions and significant work force disruption. Around 70 percent coverage of influenza immunisations is needed to reduce the incidence and spread of the virus in the community especially for those most at risk. Immunisations are provided by general practices and most Waikato pharmacies. All PHOs have annual recall and reminders in place and the pharmacies have national television advertising campaigns.

In the reporting period 1 January 2018 to 31 December 2018 (the 2018 influenza season) our results are slightly higher than the national average. Fifty-six percent of the total eligible population in Waikato were immunised with 48 percent of Māori immunised. This means 37,479 people presented for their seasonal influenza immunisation, of which 2801 were Māori over 65.

We will continue to work with our Māori NGOs, PHOs, pharmacy partners and aged related residential care services to increase uptake.

Did you know?

37,479

influenza vaccinations were given to people 65 years of age and older in 2018/19

People are supported to take greater responsibility for their health

Improving health behaviours

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
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	Māori 7% Pacific 19% Other 8% Total 9%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 100% Pacific 100% Other 100% Total 100%	● ● ● ●

Our performance:

Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of premature onset of illness. It can also affect a child's immediate health, educational attainment and quality of life. The health target is just one part of a multifaceted approach to reduce childhood obesity and we have invested in a number of early intervention health promoting and lifestyle programmes to support whānau/families to make healthy lifestyle changes.

Waikato has consistently achieved a 100 percent referral rate over the year and maintained a lower referral decline rate than the national average across all ethnicities. To meet the demand for services, Waikato developed a new programme for tamariki/children and their whānau/families in early 2018. The programme is called Whaanau Kori, Tamariki Ora (Active Families, Healthy Kids) and is a free programme across the Waikato region. We have met the 200 volume target over the year.

Whaanau Kori, Tamariki Ora focuses on supporting whānau/families to make healthy lifestyle changes including food options, ideas to keep kids moving and active, reducing screen time and improving sleep. We will be continuing the programme in 2019/20 and carrying out a programme evaluation to ensure our programme is effective, accessible and meeting the needs of our communities. A key component of the programme is Waikato's BeSmarter resource to guide conversation. Waikato DHB is working with MidCentral DHB to complete a bicultural version of BeSmarter called Tinana Ora mō nga Tamariki (Physical Wellbeing for Children) that will be completed in 2019/20.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 31.

Did you know?
In 2018/19
5183
B4 School checks were completed

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
The number of people participating in Green Prescription programmes	5802	5784	6700	4997	

Our performance:

Green prescriptions are usually issued by a GP or practice nurse but adults can also self-refer through the Sport Waikato website. Green prescriptions are offered when a GP or practice nurse believes a patient and/or their whānau would benefit from increased physical activity and healthy eating advice, as part of a total health plan.

Waikato DHB has been working closely with Sport Waikato to redesign how Green Prescriptions are delivered. This will allow for a more focused approach based on client needs and their support requirements. The new service will allow longer engagement with the service. The current short intervention has not always been long enough to embed habit changes into everyday life and make on going and lasting health and nutrition improvements. This has particularly been identified as an issue for Māori clients who make up 26 percent of participants.

Both Sport Waikato and Waikato DHB are excited about moving to a more flexible and intensive supportive environment for Green Prescriptions.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	100%	100%	100%	100%	
Output Measure	**Baseline 2014/15**	**Previous year 2017/18**	**Target 2018/19**	**Result 2018/19**	**Rating**
Percentage of total primary schools participating in Project Energize	100%	100%	100%	100%	

Our performance:

The result is for the 2018 calendar year to line up with the school calendar year.

We continue to have 100 percent engagement with primary schools and Kura Kaupapa Māori and Project Energize. This continued engagement with the programme demonstrates the value that it represents to all the schools involved, the students and the wider school community. Project Energize services the 240 primary and intermediate schools in the Waikato DHB district.

The team of Energizers from Sport Waikato work with each school to tailor support and assistance to increase physical activity and improve healthy eating and drinking habits at both school and home. These simple changes can often have lasting impacts on children's ability to concentrate and learn during lessons leading to generational changes in educational attainment.

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 (DMFT)
		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 to 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 will help free 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 vary across the economic spectrum, 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 community settings.

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

An improvement in childhood oral health

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Mean decayed missing and filled teeth score of Year 8 children (DMFT)	Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.69 Pacific 0.71 Other 0.34 Total 0.58	Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69	Māori 0.88 Pacific 1.05 Other 0.40 Total 0.56	

Our performance:

With past decay being a proven indicator of the likelihood of experiencing future decay it is disappointing to see the mean DMFT for year 8 children has increased compared to 2017/18 results. Children who identify as Māori are more likely to have decayed, missing and/or filled teeth. The cohort of Pacific children is statistically too small (166 children) for meaningful results.

To eliminate the equity gap we will continue the preventative focus which has proven results in reducing decay and continue with targeted initiatives that support children and their whānau to provide children with the best oral health outcome possible.

The Community Oral Health service has many positive initiatives currently in place that will help to achieve the DMFT target in future, including:

- 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 is a key part of sustaining oral health improvements. Parents who want to be a part of the system are being sent text messages of the time and date of their child's appointment.
- Parents are invited to assessment appointments with their children. This compares to previous generations of children who were taken from class with no parental involvement. Parents' health literacy and the home environment is critical to good oral health.
- An in-school brushing programme is now available in many low decile schools where they already have other healthy policies and processes to improve child health and oral health.

The fluoride varnish programme will be reviewed with the intent of increasing the number of children who get fluoride varnish applied and increasing the frequency of application.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of children (0-4) enrolled in DHB funded dental services	Māori 72% Pacific 72% Other 72% Total 72%	Māori 58% Pacific 57% Other 87% Total 74%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%	Māori 85% Pacific 76% Other 98% Total 92%	

Our performance:

This result is sourced from the new Community Oral Health electronic information platform, Titanium. While we have not achieved the target we are pleased to see an improvement on results from last year. This improvement has occurred despite the transition from paper based records to Titanium which slowed the service during 2018. Inclusions and appointment durations have also changed as the service is transitioning to oral health therapists.

Recruitment continues to be challenging, especially for rural vacancies. The multi-employer collective that restricts hours of work for therapists and affects salaries has resulted in Waikato DHB being a less favoured employer in a competitive market. The Human Resources team have assisted the service in changing to the standard contract for new staff recruited from 2019 onwards.

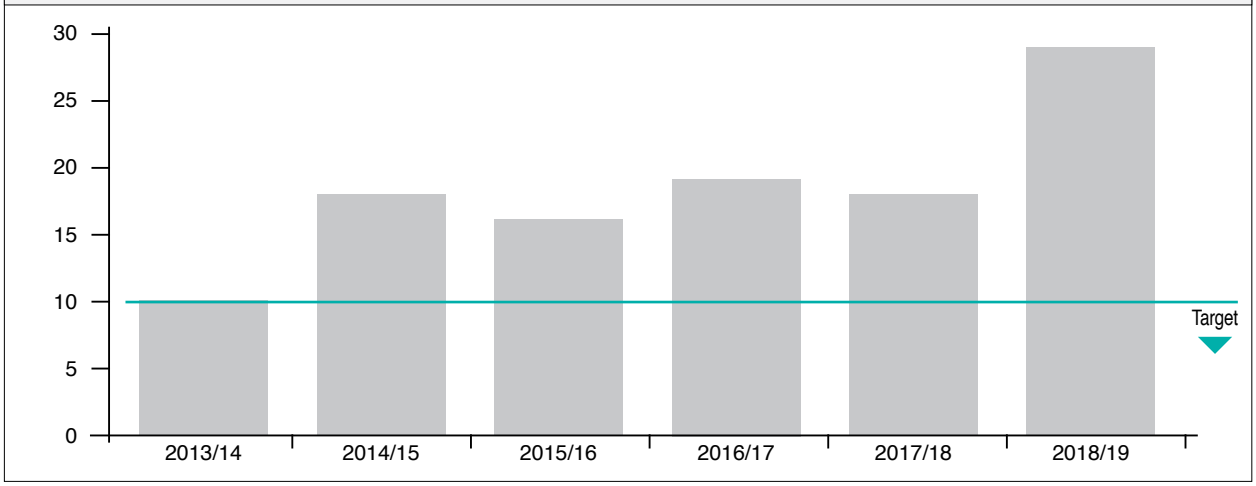
The service will employ future staff on an eight hour day and four weeks of annual leave per annum. The service has changed its management structure with the appointment of an operations manager, pod leaders and an educator. Once the new structure is embedded, it will assist with achieving targets. We will continue to provide opportunities for under-graduates to gain work experience at Waikato DHB in an effort to attract them back as graduates.

Community Oral Health is continuing its focus on productivity and achieving targets through providing and using reporting services. Community Oral Health has been offering enrolled pre-schoolers an appointment from nine months of age. The number of appointments that are failed to attend remains high and runs 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 clinics are being implemented at selected locations and have been very well received. Selected low-risk patient groups will be seen on a 15 month rotation thereby freeing time and resource for high risk patient groups.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori 18% Pacific 20% Other 25% Total 18%	Total 18%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori 21% Pacific 22% Other 33% Total 29%	

Our performance:

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



It is disappointing to see results have deteriorated further compared to last year. To try increase engagement in the service for this population group we are using the electronic patient record and management system, Titanium, which provides an easier way to manage recalls based on risk, sends automated text messages of appointment times and is a key part of sustaining oral health improvements. Parents who are wanting to be a part of the system are being sent text messages of the time and date of their child's appointment.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of adolescent utilisation of DHB funded dental services	Māori 45% Pacific 53% Other 80% Total 70%	Māori 50% Pacific 56% Other 85% Total 70%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 47% Pacific 53% Other 79% Total 67%	

Our performance:

The result is for the 2018 calendar year to line up with the school calendar year. It is disappointing that fewer adolescents received dental care than the previous year and the equity gap for Māori remains high. Adolescent engagement with dental services remains a challenge across New Zealand. Waikato's rates remain comparable with the New Zealand averages.

We remain committed to increasing adolescent utilisation of DHB funded services knowing good oral health during childhood and adolescence is an important indicator for good lifelong oral health.

Early engagement with advice and services is the key to establishing good life long oral health behaviours such as twice daily brushing and regular dental check-ups. Local coverage with services in rural towns also remains high to allow access as close to home as possible.

Effective partnerships are an essential part of providing the best service possible, discussions with regional colleagues at annual meetings remain an effective means of sharing approaches, successes, challenges, and opportunities to learn from each other about how uptake can be improved.

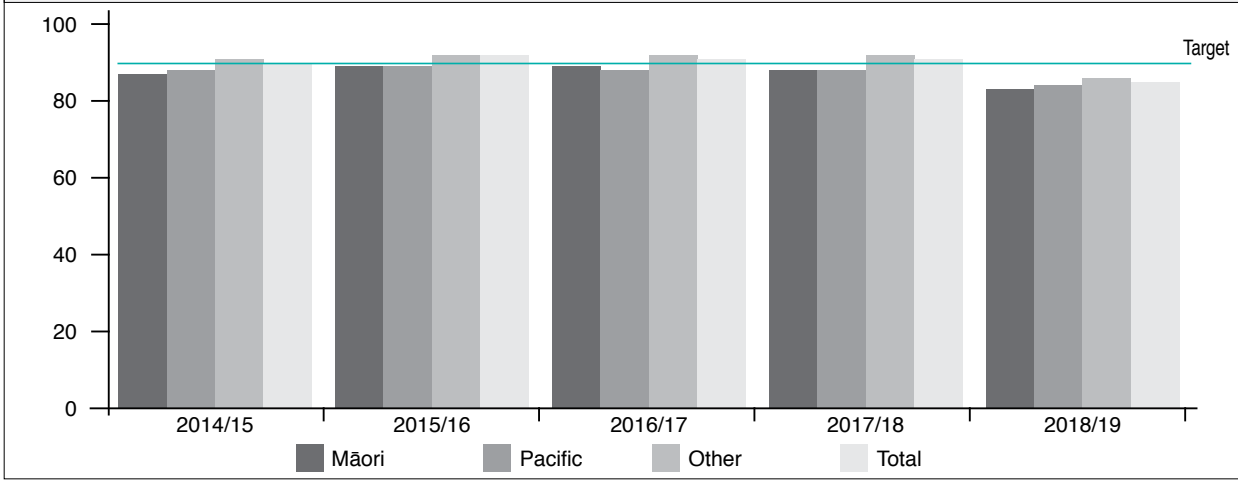
People stay well in their homes and communities

Long-term conditions are detected early and managed well

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percent of the eligible population who have had their cardiovascular risk assessment in the last five years	Māori 87% Pacific 88% Other 91% Total 90%	Māori 88% Pacific 88% Other 92% Total 91%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 83% Pacific 84% Other 86% Total 85%	●

Our performance:

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



While we are pleased our three PHOs have worked together and engaged with us effectively we have not reached the 90 percent target which would have meant that 90 percent of people have had a Cardiovascular Risk Assessment (CVDRA) within the last five years.

There has been a higher level of activity in general practices to identify and develop activities to reach out to Māori men aged 30 to 44 years through innovative approaches and processes such as checks being undertaken in work places.

The PHO and DHB Clinical Advisory and Working Group remain in place to agree key elements of the national specification to meet the needs of the Waikato population. The focus remains on working with high risk populations and targeting specific initiatives which support the best chance of early detection. Early detection often leads to more cost effective treatment options and better long term health outcomes. We will continue to work collaboratively with our PHO partners to improve performance in the coming year.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	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%	88%	90%	66%	

Our performance:

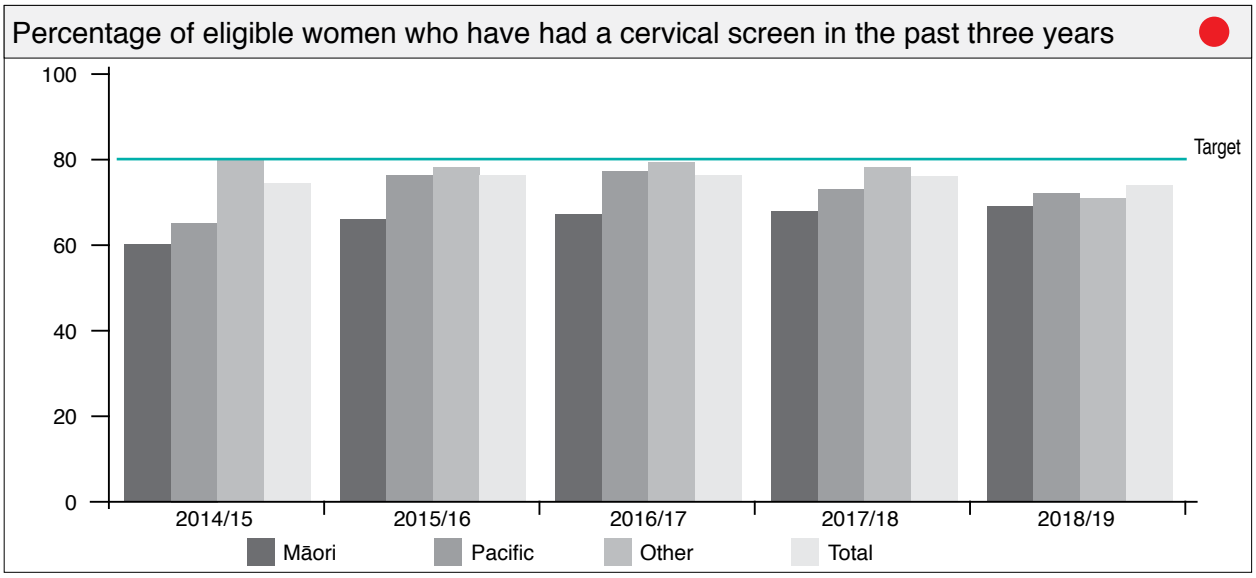
Waikato DHB continues to work collaboratively with our PHO partners to achieve this target. To ensure early detection of cardiovascular disease in our high risk population in the next year the age group for this measure has been lowered to include Māori men aged 30-44 years. There have been many positive initiatives in this space including PHO development of a new mobile health service to address inequities of care in workplaces including CVDRA checks for workers in shearing gangs and people who live in rural localities as well as having clinical staff at events such as Kapa Haka.

The well received Manawanui Whai Ora Kaitiaki (MWOK) programme has also been a success. MWOK provides a registered nurse and kaiawhina linked to general practice for patients with diabetes who need access in their own homes or communities for socially complex care.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	Māori 60% Pacific 65% Other 80% Total 74%	Māori 68% Pacific 73% Other 78% Total 76%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 69% Pacific 72% Other 71% Total 74%	

Our performance:



While we have not achieved the target this year many activities have taken place to improve results and many opportunities have been identified for 2019/20.

Improving results requires engagement with our target population and stakeholders. We have been holding and attending events for this purpose including: led the North Island Cervical Screening Hui, attended by over 85 delegates including the Ministry of Health, held the 2019 Cervical Screening Annual Update with 159 attendees, participated in Mana Wahine day, sent quarterly newsletter updates to all general practices, attended a Poukai to provide advice and screening and continued to support the #SmearYourMea campaign.

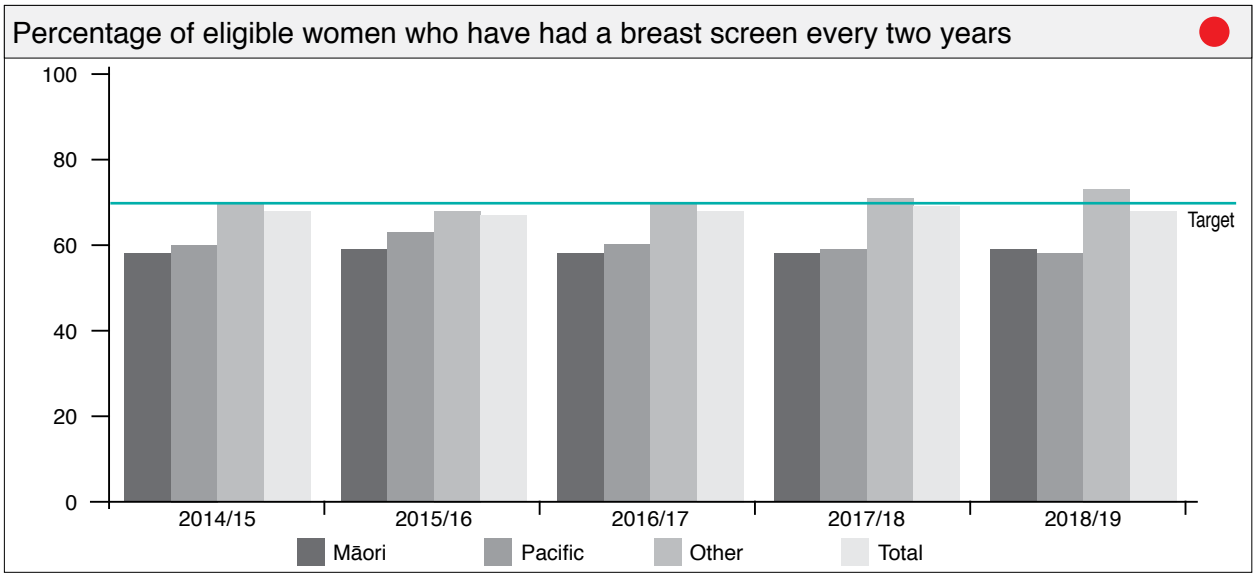
Our primary care providers have a focus on improving screening participation of Māori, Pacific and Asian priority populations. To assist PHOs we have been providing monthly data reports and training general practices on the use and benefits of the reports. Support to PHOs in screening overdue and significantly overdue women has also been provided. In 2019/20 we will trial providing dedicated support to at least two rural general practices with low Māori participation rates and monitor the effectiveness of this.

Improving access to services is a priority and as a part of this work we have increased the number of joint breast and cervical screening clinics performed compared to 2017/18. There has been an increase in opportunistic cervical screening to Māori, Pacific and Asian priority populations in the Hauora iHub based at Waikato Hospital and support in providing 'pop up' screening clinics in rural areas such as Te Kuiti. In 2019/20 we aim to increase opportunistic screening 'Closer to Home', through collaboration with Hauora iHub and primary care providers.

In 2019/20 we will be implementing a referral process with inpatient Henry Rongomau Bennett Centre and Mothercraft to cervical screening.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	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 59% Other 71% Total 69%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 59% Pacific 58% Other 73% Total 68%	🔴 🔴 🟢 🔴

Our performance:



While we did not achieve the target we did reach capacity within our current service equipment and facilities. We have screened 800 less women in 2018/19 due to an increased need to use our current facilities and equipment for diagnostic purposes. In 2019/20 we will seek approval to install a third mammography machine to meet the service demands for breast screening in the Waikato.

To try and increase screening rates a number of engagement activities took place including: the co-ordination of well attended Mana Wāhine days, staff attendance at public events to promote breast screening, supporting targeted awareness campaigns to improve screening participation and strengthening of community engagement in South Waikato. Going forward we will be improving Kaitiaki support during the mobile visits in Te Kuiti and Tokoroa and continue community engagement in areas of highest need.

Opportunities to make the service more accessible were identified and implemented. Some of the key actions include: reviewing the BreastScreen Midland invitation process, an additional text messaging service to Māori first time screeners, providing opportunistic screening through the Hauora iHub and more convenient parking facilities outside the Breast Care Centre. Work on improving the service from enrolment to screening for wāhine Māori will continue as a key focus for 2019/20.

We have been working with the Ministry of Health on the strategic policy for breast screening, focusing on opportunities to improve rescreening rates for priority women. Collaboration with, and the providing of training and support to PHOs for their Support to Screening service contracts has been successful and will continue.

Did you know?
We performed
33,878
breast screening tests in the two years to June 2019

People stay well in their homes and communities

Fewer people are admitted to hospital for avoidable conditions

Impact measure	Baseline 2017	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for the following age group: 45-64 year olds	Māori 9314 Pacific 6636 Other 3426	Māori 9434 Pacific 6844 Other 3471	Māori 8942 Pacific 6371 Other 3357	Māori 9508 Pacific 8945 Other 3298	🔴 🔴 🟢

Our performance:

Waikato DHB has been working with communities, general practice and hospital services to enable people to stay well in their homes and communities. The aim is to have fewer people admitted to hospitals for avoidable conditions. Early intervention and a reduction in risk factors help ensure patients who need services can have these provided in community settings rather than in hospital. A reduction in the Ambulatory Sensitive Hospitalisation (ASH) rate reflects better management and treatment across the whole of system and is indicative of better, sooner, more convenient healthcare being delivered for Waikato residents.

Waikato DHB has not met the target for the 2018/19. More work is required in this space to improve access to services as early as possible. Health promotion is essential through different mediums to obtain a wider audience. There have been efforts undertaken in 2018/19 to create a COPD 0800 line for General Practice to call when help or advice on care pathways is required. This will be rolled out in key localities during the course of 2019/20. The system and service will be reviewed to gauge the effectiveness before other localities are added.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of eligible population who have had their B4 School Check completed	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 91% Other 90% Total 90%	🟢 🟢 🟢 🟢

Our performance:

The B4 School checks are an important Ministry of Health programme which aims to identify health, behavioural and developmental issues before a child starts school. This is a crucial check to allow children to have the best possible start to their formal education.

The targets of 90 percent have again been achieved for both the total population and the high needs population. This has been achieved through a coordinated approach across primary care and Public Health. Midlands Health Network have coordinated the services, working closely with their primary care practices, practices with other PHOs and the public health nurses.

The focus for 2019/20 will be to achieve the checks earlier. This will allow corrective actions to be taken before tamariki start school at five. This will provide an even better start to formal education and lifelong learning.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	3.9/100,000	3.6/100,000	1.2/100,000	2.9/100,000	●

Our performance:

During the 2018/19 year, there were 12 notified cases of acute rheumatic fever in the Waikato district. While there is a decrease on last year's number, this is likely to be natural fluctuation of a relatively rare disease rather than a trend. All but one of the cases is of Māori ethnicity, reflecting ongoing inequities in health care quality and access, and also differential access to underlying social determinants of health.

While 12 cases does not seem like a large number, the impact an episode of acute rheumatic fever has on an individual and on their whānau is colossal and lifelong, which demonstrates how important it is to resource rheumatic fever prevention and management initiatives sufficiently. Current Ministry of Health directed funding agreements remain in place and are directed at increasing rheumatic fever awareness, providing free sore throat swabbing services (pharmacies), and supporting Whare Ora programme to improve housing conditions.

A public health registrar has completed a review of the Waikato DHB rheumatic fever secondary prevention programme, and we are working through the recommendations in order to improve our service going forward.

People stay well in their homes and communities

More people maintain their functional independence

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Average age of entry to aged related residential care: • Rest home • Dementia • Hospital	Resthome 85 years Dementia 83 years Hospital 86 years	Resthome 84 Dementia 82 Hospital 85	Resthome >84 years Dementia >80 years Hospital >85 years	Resthome 84 Dementia 81 Hospital 85	

Our performance:

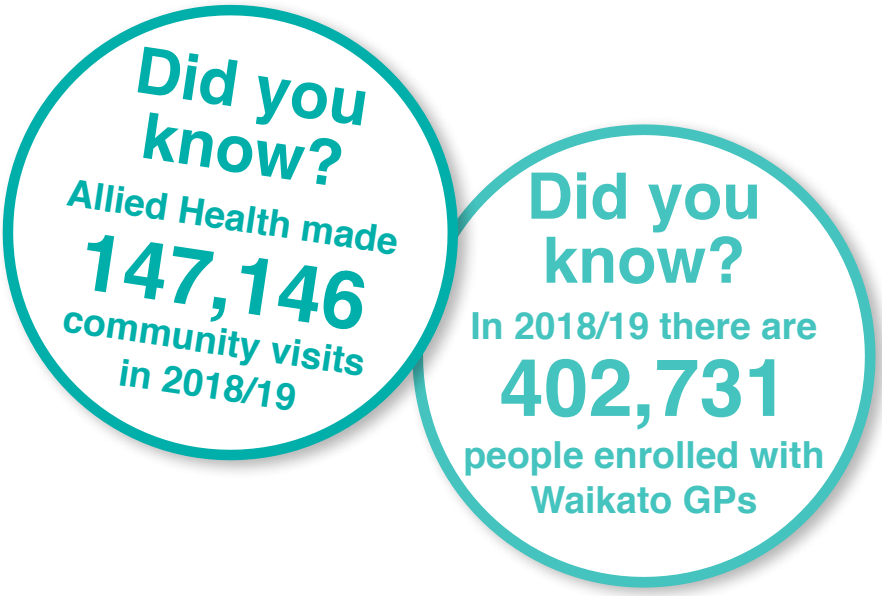
Our target for entry to secure dementia facilities has been achieved. Although extremely close to the target the resthome and hospital level care target was not achieved.

It is possible that age-of-entry data is skewed by the increase use of age-related residential care facilities for the provision of end-of-life care in the younger old (65 and older). When these people do not pass away within six weeks, they are then transferred to the age related residential care funding stream and therefore are counted in respect of this target.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	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%	

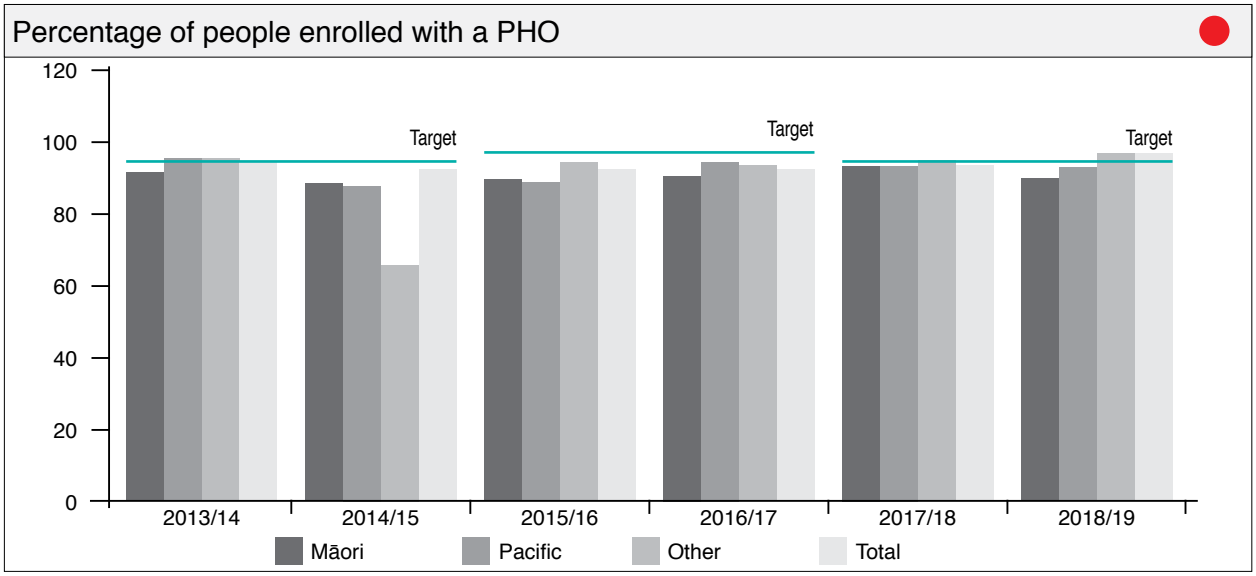
Our performance:

We have maintained throughout the year the target of 100 percent of clients having a care plan in place. This target is based on the outcome of an International Residential Assessment Instrument (InterRAI) with the minimum data-set homecare assessment tool (MDS-HC). InterRAI is a comprehensive clinical assessment tool that enables staff to select appropriate support requirements for older people needing home-based support services. Any care plan that is put in place is tailored to the individuals needs and enables the older person to access the assistance they need while maintaining their independence.



Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of people enrolled with a PHO	Māori 91% Pacific 88% Other 66% Total 95%	Māori 94% Pacific 94% Other 95% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 90% Pacific 93% Other 97% Total 97%	🔴 🔴 🟢 🟢

Our performance:



While the target has not been achieved for all ethnicities we are pleased that 97 percent of all people who live in Waikato are enrolled with our PHOs and 90 percent of Māori have joined a PHO.

Initiatives to increase enrolment in PHOs during 2018/19 have included ongoing communication with Anglesea Accident and Medical Clinic and all hospital emergency departments of the importance of encouraging people to join a PHO. The Hauora iHub based in Waikato Hospital also plays a key role and enrols inpatients and outpatients to join a PHO and nominate a general practice of their choice.

The key initiative for newborn enrolment was establishing the Newborn Enrolment and Immunisation Improvement service at Waikato DHB which is co-located with the National Immunisation Register (NIR), engaged with the National Enrolment Service (NES) and provides a Missing Event Service which follows up with families and whānau whose babies are not enrolled by six weeks of age.

With the switch over to NES there has been an adverse impact on ethnicity coding on General Practice/ PHO registers. PHOs are working with their practices to ensure the data on their Capitation Based Funding (CBF) register is the same as what's on the NES-NHI system.

We will continue to encourage people to join PHOs as this has been shown to have positive benefits in maintaining good health.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days	62%	94%	100%	96%	●

Our performance:

For the year 2018/19, there were 13,534 interventions provided by Disability Support Link. Ninety-six percent of clients were assessed within the 20 days. The target of 100 percent of all clients being assessed within 20 days remains unachieved due to the external factors that are beyond our control. Examples of these include:

- Social and family, for example, availability of client or family to be at the assessment
- Not ready for assessment when the referral is received, for example, under another service providing short-term care and/or a rehabilitation service
- Hospital readmission.

Disability Support Link continues to build upon its existing services. Rest and Recuperation is a new and developing service where clients can go from the hospital for a short period of respite care within their own community, prior to going home. Clients are then followed up by Disability Support Link for assessment of existing long term care or Supported Transfer Accelerated Rehabilitation Team (START) for six weeks of rehabilitation. Acute home based supports now come under the suite of available long-term and short-term services. This links clients with one referral into the most appropriate service, with all services working collaboratively and flexibly, enabling a person-centred approach.

All high risk or urgent clients are prioritised, assessed and have services coordinated within five working days. Additional to this, those clients that are in hospital awaiting assessment for rest home placement are assessed by a dedicated team that completes assessments within 48 hours of receiving the referral.

Disability Support Link – Māori Needs Assessment and Service Coordination (NASC) continue to strengthen relationships with iwi and Māori health providers through regular hui. This provides an avenue for communicating with Māori who may benefit from long-term supports, within a culturally appropriate and supportive environment for the assessment to take place. Disability Support Link continues to provide the option for Māori to request a Māori needs assessor, Māori service coordinator and Māori service provider.

Did you know?

That **756,794** hours of home based support services were provided for older people in 2018/19

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
		90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
	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 three 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. This approach 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 deliver 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.

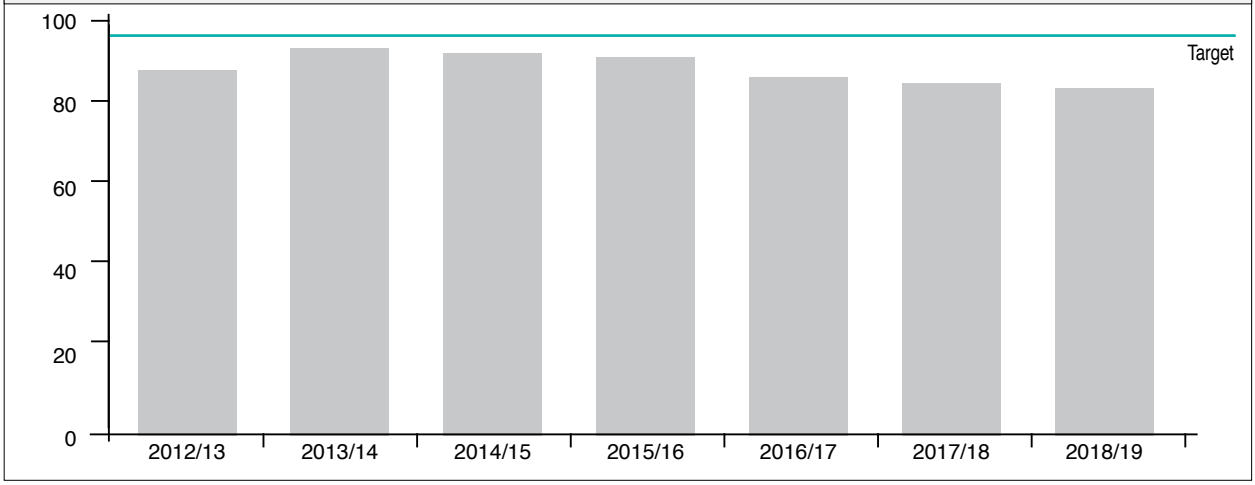
We've achieved the target	We've not met the target

People receive prompt and appropriate acute and arranged care

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	Māori 92% Pacific 91% Other 91% Total 94%	Māori 88% Pacific 76% Other 85% Total 85%	Māori 95% Pacific 95% Other 95% Total 85%	Māori 86% Pacific 86% Other 83% Total 84%	●

Our performance:

Percentage of patients admitted, discharged, or transferred from emergency departments within six hours ●



We are disappointed to have not met the target for 2018/19 despite undertaking many improvement initiatives over the year. We are continually working towards reducing wait times in emergency departments.

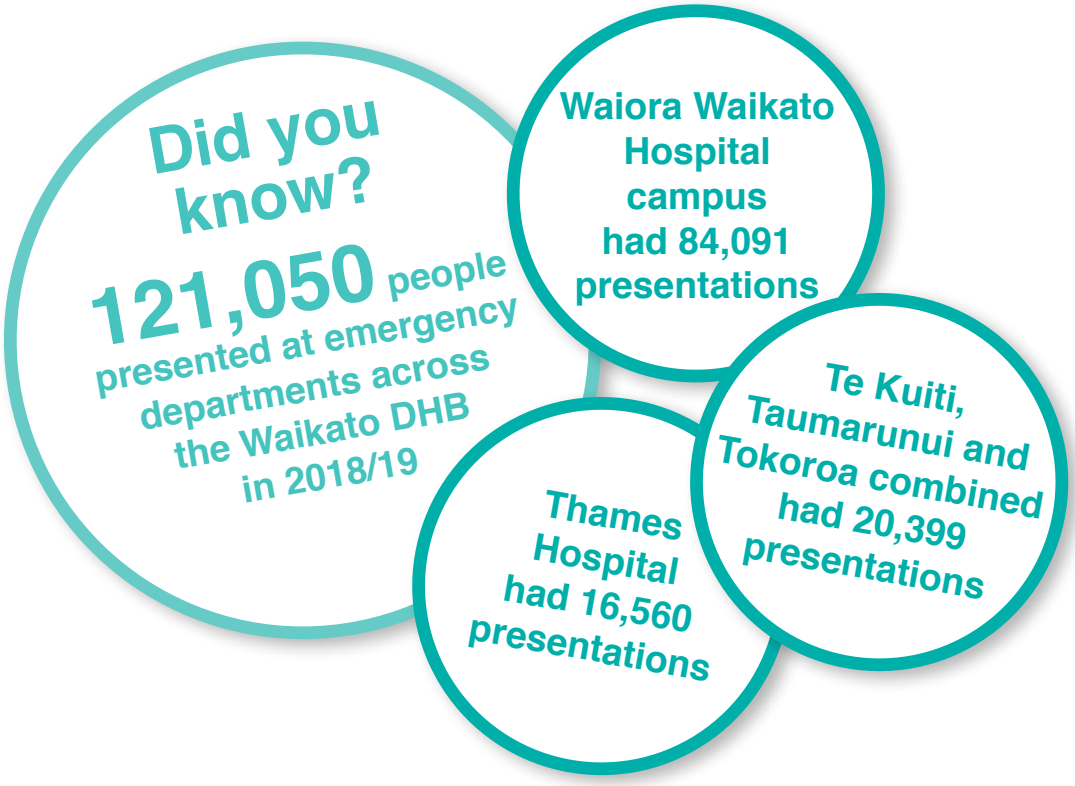
The Waikato Hospital Emergency Department has an eight percent increase in presentations compared to last year and we are seeing an increase in patients with high acuity and complex needs combined with the continued challenge of bed access, especially with cardiology, respiratory, paediatrics and the High Dependency Unit. When there are no beds available, these patients end up in the emergency department.

Introduction of the trial for the "Emergency Q" software will assist with education to the general public about where to source appropriate care and allow them to view wait times of our Emergency Department and urgent care; this should see an approximate reduction of 10 percent of presentations per day. In 2019/20 we aim to further embed the "Emergency Q" software into primary care.

The acute surgical unit is now open 24 hours a day, seven days a week and will receive direct admissions who have bypassed the Emergency Department completely; these admissions will be the sub-surgical specialities such as plastics, orthopaedics and urology. In 2019/20 we will be revising the service level agreements between all the specialities accessing the Emergency Department for their patients and the terms of engagement for working in the Emergency Department; length of stay, escalation and access to bed block. Escalation plans will be completed for all Emergency Department staff, duty nurse managers and hospital managers.

A model of care has been completed for the Emergency Department with zones in the department and staff models defined to improve the patient flow. The geriatrician led model out of the Emergency Department is working well and we would like to increase this to seven days a week from the current five day a week model. The Mental Health in the Emergency Department team has also been implemented five days a week. Extra resource is to be allocated to make the team operational 24 hours a day, seven days a week.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 31.



People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	56%	95%	90%	91%	●

Our performance:

We are pleased to report a result of 91 percent which exceeded the Ministry of Health target of 90 percent. A lot of work has taken place to reduce the number of "Did Not Attend" (DNA) appointments, ensuring patients receive treatment within 62 days. Through the work on reducing DNAs, data analysis has shown an increase in patient choice and clinical considerations, this is due to the clinical nurse specialist of equity and access, working with patients and enabling patients who would DNA through the pathway. Potential DNA patients are highlighted to the clinical nurse specialist of equity and access, who will then work with the patients to ensure they attend appointments.

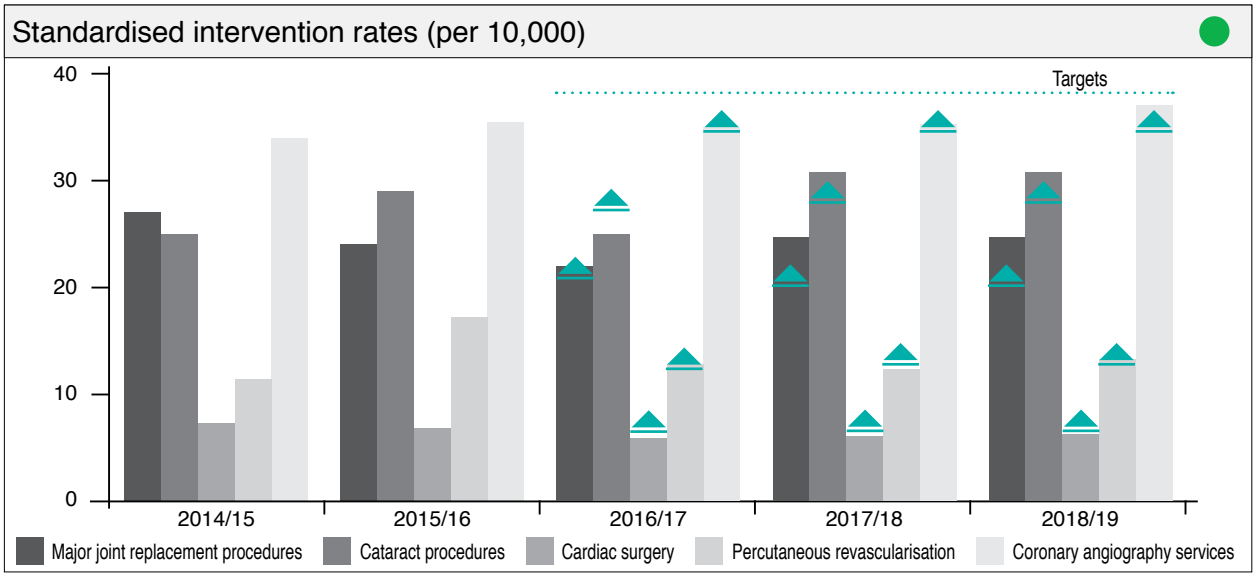
As well as this pre-emptive approach, daily reports are being generated to highlight any DNAs for faster cancer treatment (FCT) patients through all parts of their pathways. These patients are followed up and offered any support required to be able to access treatment. It was important to identify why people would DNA in order to reduce the rate. To help identify the reasons behind why people DNA the FCT team worked with Te Puna Oranga to help find ways to minimise inequity in FCT. This included addressing the DNAs and identifying the barriers. There will be ongoing monitoring of FCT achievement by ethnicity, investigating breaches to identify further opportunities for improvement. To increase our result further for this target the FCT business manager and FCT nurse tracker will continue to work closely with cancer care coordinators and clinical nurse specialists, to monitor patient pathways from the initial date of referral. In 2019/20 a weekly coordinated meeting with the gynaecology clinical nurse specialist will take place to discuss individual patients and tracking pathways to ensure patients are discussed at the Auckland multi-disciplinary meetings in a timely manner. A weekly urology waitlist meeting to discuss any patients triaged onto the 62 day pathway will also be held along with ongoing monitoring of respiratory triaging and time to first specialist appointment.

This is one of the national Health Targets. Full results on how we performed throughout the year are available on page 31.

People have appropriate access to elective services

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures	27	27	21	27	
• Cataract procedures	25	31	27	31	
• Cardiac surgery	7.3	6	6.5	6.4	
• Percutaneous revascularisation	11.4	12	12.5	13.3	
• Coronary angiography services	33.9	35	34.7	37	

Our performance:



Timely access to these services is considered a measure of the effectiveness of the health system. Elective surgery is important as these are essential services to reduce pain or discomfort, and improve independence and wellbeing. This is particularly the case for surgery such as cardiac, cataract, and major joint replacement procedures. Standardised Intervention Rate (SIR) targets are set by taking into account the volume of patients seen relative to the Waikato DHB population base and health needs. Waikato has attained four of the targets, and is just shy of achieving the fifth.

The result this year has been impacted by a number of industrial actions that have taken place during the 2018/19 year. We are committed to achieving this target and to progress towards this ophthalmology and cardiology are working on production plans and theatre utilisation plans that will see improved throughput in hospital facilities. A lot of work has also taken place to strengthen the workforce in these departments to ensure additional outcomes which will help to improve results in the future.

Did you know?
In 2018/19 we performed **26,516** elective operations

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of patients waiting longer than four months for their first specialist assessment	2.7%	0.2%	0.0%	3.6%	●

Our performance:

We are disappointed to have not achieved the target for 2018/19 for the percentage of patients waiting longer than four months for their first specialist assessment.

Resident Doctor Association industrial action in early in 2019 impacted this result with a significant loss in capacity, and we are yet to fully recover. A recovery plan was provided to the Ministry of Health in March 2019 and we report against this monthly. Improvements are being achieved and we continue to plan and implement initiatives that will help us achieve the target in future.

We have continued to develop systems of management through the central operations centre approach, with weekly Outpatient Operational Group meetings implemented to ensure capacity is maximised. This has improved visibility, structure and service accountability for planning and monitoring.

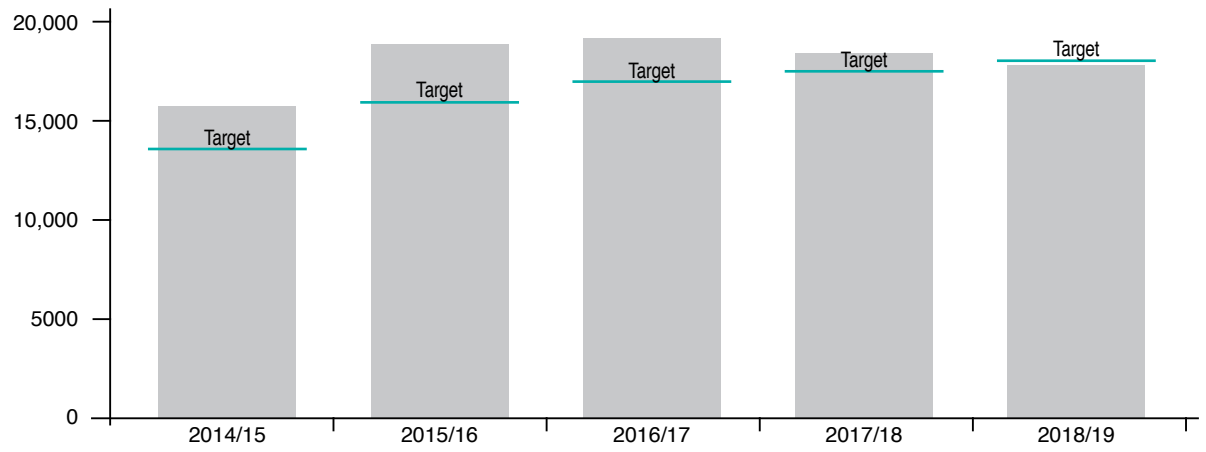
There is a lack of robust production planning reports and the ability to model and monitor demand against capacity. The Production Planning team have plans to develop these, which are critical to managing demand more effectively.

A key achievement has been the improved monitoring of attendance by ethnicity and age. This has resulted in the implementation of strategies to proactively address low attendance rates for Māori and other groups identified. This includes recruitment of nurses with an equity and access focus, education of staff in partnership with Te Puna Oranga, and the use of ethnicity to influence booking practices. Additionally the outpatient appointment reminder system is being used to report and investigate failed modes of appointment communication with patients.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Improved access to elective surgery, health target, agreed discharge volumes	15,693	18,362	18,037	17,764	●

Our performance:

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



It was a particularly challenging year following significant disruption to elective services as a result of the ongoing Resident Doctors Association industrial action throughout early 2019. As a result we fell slightly short of the target, achieving 99 percent.

Building on processes put in place under the Surgical Re-invention Project we continue to focus on the end to end patient journey for those people coming to our hospital for their surgery. With this work we expect to see an improvement in results for the 2019/20 year.

Did you know?
We had
756,386
outpatients attend appointments in 2018/19

Did you know?
There were
38,506
missed outpatient appointments in 2018/19

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Did-not-attend percentage for outpatient services	Māori 21% Pacific 18% Other 7% Total 10%	Māori 20% Pacific 17.5% Other 6.8% Total 9.8%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 20% Pacific 17% Other 6% Total 9%	

Our performance:

A DNA occurs when a service user does not attend an arranged appointment and does not make contact at any point prior to the appointment to either cancel or reschedule. There can be many reasons as to why this occurs including demographic influences, administrative processes and relational factors. What we do know is that when patient contact details are incorrect and we cannot contact them prior to their appointment, experience tells us they will likely DNA. This is the group we are targeting. What the data shows is that we are tracking downwards (although not statistically significant) and can now explain variance in DNA rates throughout the year. April is an example where the industrial strikes took place and then the public holidays plus school holidays all played a role in a 'spike' of DNA rates. We are committed to reducing DNAs as it is important for improving health outcomes, improving access and helping to make best use of clinicians' time.

Over the last year we have been working on many initiatives to reduce the DNA rate. Administration teams in charge of booking appointments now ensure that if a patient domicile code is outside of Hamilton city then the patient is rung and an appointment date and time discussed.

The Meade Clinical Centre partnered with Te Puna Oranga to bridge the knowledge gap for the administrative team with the goal of enabling new equity-focused initiatives to drive system change for booking processes. Booking clerks are now working around iPM constraints to provide an at a glance view of ethnicity to identify any patient who has identified as Māori and if appropriate will make verbal contact, rather than just sending an appointment letter.

A clinical escalation pathway has also been established for booking clerks to seek support from nursing (CNCs and ACNMs) to help mitigate any constraints patients may have to attend their appointments. When required, nursing will use their networks and connections with outside agencies and public health to seek support to make contact with patients. This approach is having positive results, especially in orthopaedics and ophthalmology.

To keep momentum going in 2019/20 we will be partnering with the Waikato DHB Consumer Council to further demonstrate to relative Meade Clinical Centre staff the reality of navigating the health system and the opportunities that exist to make the journey more user friendly.

The Patient Service Centre (PSC) provide a responsive, single point of contact for patients wanting information regarding their referral, specialist procedure and follow up appointments. PSC currently ring all of the on-boarded services clinic patients the day prior to their appointment to confirm attendance and help trouble shoot any issues (transport, new date required). To improve this further, contact with patients will now take place two weeks prior to the appointment so that any issues can be resolved early on.

The outpatient appointment reminder system (OARS) was implemented October 2018. This is an opt-in service that will send automated SMS or email appointment reminders at two weeks, then two days prior to appointment.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Elective surgical inpatient average length of stay	1.71 days	1.57 days	1.50 days	1.59 days	●

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Acute inpatient average length of stay	3.89 days	2.42 days	2.30 days	2.40 days	●

Our performance:

Waikato DHB did not meet the target set by the Ministry which represents the 75th percentile of the national performance for acute and elective average length of stay (LOS) over the period of 1 April 2018 to 31 March 2019.

The reduced target posed a significant challenge considering previous performance and our status as a tertiary hospital. Another challenge this winter has been the ever increasing presentations to our emergency departments. Despite these challenges we remain committed to achieving the target and are pleased to see some improvement in the acute LOS.

A number of positive actions have been achieved during 2018/19 in an effort to reduce LOS. Geriatric services involvement in the Emergency Department is one such example, with frail patients receiving a geriatric assessment and a plan for ongoing care in the community where appropriate.

Collaboration with colleagues in Mental Health and Addictions services has been successful and will continue to ensure the appropriate processes exist for safe disposition of clients with a predominant mental health issue occurring.

A responsive acute theatre management service has enabled patients to access acute theatres in a timely and safe manner.

Waikato DHB has, and will continue to focus on reducing inappropriate presentations to emergency departments, while ensuring the right patient, receives the right care, in the right place, at the right time. The Alliance Leadership Group is facilitated by Strategy and Funding, and provides the opportunities to partner in the collaboration and management of emergency departments.

Utilisation of the short stay acute medical assessment service and acute surgical assessment service has also been a focus during 2018/19 – with a particular emphasis on developing these services to be 24 hours a day, seven days a week, if demand requires.

People receive timely and appropriate specialist care

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

Impact measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Reducing acute readmissions to hospital	Māori 14% Pacific 8% Other 12% Total 12%	Māori 13% Pacific 5% Other 9% Total 11%	Māori ≤13% Pacific ≤13% Other ≤13% Total ≤13%	Māori 13% Pacific 6% Other 11% Total 12%	

Our performance:

The 28 day readmission rate for 2018/19 was 12 percent. This remains similar to the previous year readmission rate of 11 percent and 12 percent in 2016/17. The demand for mental health and addictions services in the Waikato region has increased significantly across the same time span and the acute adult inpatient facility has experienced ongoing challenges, in terms of high occupancy and increasing complexity and acuity.

Against this context, it is somewhat pleasing to note there has not been an increase in readmission rates, however we remain committed to working to the target, as keeping readmission rates as low as possible (without compromising care) demonstrates a focus on recovery for service users. Our current work on developing models of care that support service users in the community, such as the Closer to Home project and the additional supports now available at discharge (housing support and enhanced residential support services), along with close monitoring of discharge planning and readmission rates are focused on reducing readmission rates and following best practice during and post admission.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	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** Māori 82% Pacific 86% Other 72% Total 75%	**3 weeks** Māori 75% Pacific 89% Other 69% Total 73%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80%	**3 weeks** Māori 68% Pacific 55% Other 61% Total 63%	
	8 weeks Māori 93% Pacific 95% Other 90% Total 91%	**8 weeks** Māori 92% Pacific 96% Other 87% Total 89%	**8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**8 weeks** Māori 88% Pacific 78% Other 87% Total 87%	

Our performance:

Child and youth mental health services within the DHB provider arm and NGO sector continue to face very high demand for their services and this is reflected in the result for both the three week and eight week targets.

A post implementation review of the Waikato DHB Infant, Child and Adolescent Mental Health services began in early October 2018 and is now complete. The report identified strengths and weaknesses in the unique Cluster Models based in both urban and rural communities, resulting in a recommendation that Waikato DHB utilise the Choice and Partnership Approach (CAPA) model – a continuous service improvement model that combines personalised care and collaborative practice when partnering with service users and their family/whānau. The CAPA model is based on providing client-centered services that are accessible and outcome-focused while acknowledging the importance of young people and families/whānau being actively involved in each stage of their care. Experience has shown that such services can help reduce wait times and DNAs.

Waikato DHB remains committed to providing recovery-focused services and increasing access rates will drive our future focus. Once implemented, it is expected CAPA will be an effective tool to help us achieve our targets and enhance service delivery.

Output measure	Baseline 2017/18	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of clients discharged from community mental health and addiction services with a transition/wellness plan	37%	Māori NA Pacific NA Other NA Total 37%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 92% Pacific 96% Other 92% Total 92%	🔴 🟢 🔴 🔴

Our performance:

Across both community and inpatient mental health services the overall annual target has not been met however, the most recent data from quarter four has shown 95 percent of community clients and 98 percent of inpatient clients discharged having a transitional discharge plan upon exit from the service. This improvement is due to better data collection methods. During quarter four of 2018/19 the process of evaluating the quality of discharge plans both within the DHB and NGO services through file auditing has been implemented and completed. We are pleased to report that 99 percent of those files audited met an acceptable standard. This means for 2019/20 the annual result should exceed the 95 percent target. A commitment was also made to report on the use of transitional planning by the ethnicity of the client who has a completed plan. This is in line with the DHBs over-arching strategy to eliminate equity gaps for all services delivered to the DHBs population. This commitment has recently been achieved as challenges posed to collect data have been addressed and moving forward the ethnicity component will be identified.

Did you know?

In addition to the DHB provider arm,

36 DHB funded NGOs provided mental health and/or alcohol and drug services in the community in 2018/19

Did you know?

In 2018/19 Waikato DHB services made

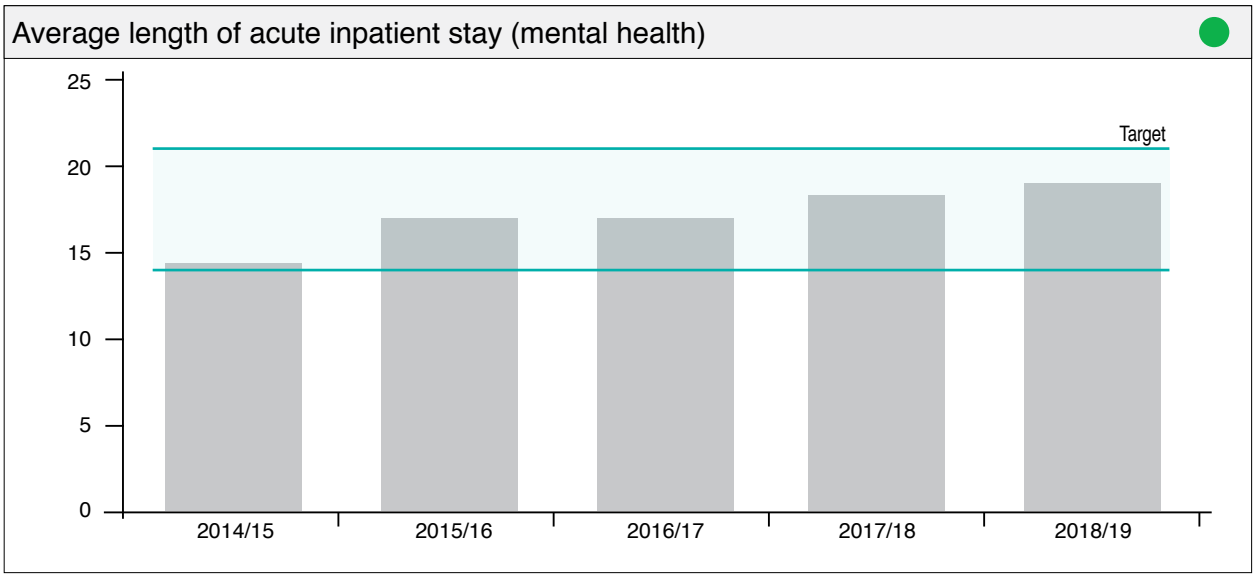
51,348

Mental Health community visits

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Average length of acute inpatient stay (mental health)	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 19.13 days Pacific 8.73 days Other 17.99 days Total 18.30 days	Between 14 and 21 days	Māori 20 days Pacific 18 days Other 18 days Total 19 days	● ● ● ●

Our performance:



The average length of stay across the acute adult inpatient wards has continued the pattern of the last few years and increased to 19 days over the last year. This is up slightly from 18.30 days for 2017/18. This remains largely reflective of the rising levels of acuity and complexity we continue to see in our Mental Health and Addictions services. As we have reported previously, there are a growing number of people whose needs are multiple and can range from availability of suitable housing to multiple co-existing physical and mental disorders. We do not discharge people to homelessness and we cannot discharge many of the people with complex presentations without adequate support arrangements in the community. As a result length of stay time can extend significantly. We currently have a number of people in our inpatient unit with over 30 days occupancy, some with more than 60 days and an increasing number with more than 90 days. We are working closely with the funder and cross sector organisations to transition identified individuals with very high length of inpatient stays to alternate community living arrangements.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Rates of post-discharge community care (mental health)	Māori 69% Pacific 73% Other 72% Total 87%	Māori 78.10% Pacific 75.60% Other 83.60% Total 82.20%	Between 90% and 100%	Māori 86% Pacific 69% Other 86% Total 85%	

Our performance:

During 2018/19 the Mental Health and Addictions service saw 85 percent of people within seven days of discharge from an inpatient admission. This is a slight increase on the 82.20 percent we were able to see within seven days the previous year. Throughout the year we were able to see over 90 percent of people discharged within seven days only during one month (April 2019). The service has undertaken an ongoing review process for all discharges from an inpatient setting and monitoring of follow up appointments within seven days for everybody. This process ensures that everyone is contacted and for every person not seen within seven days, a rationale is recorded. This exercise has helped us to identify some changes we can make to the follow up process, particularly in terms of improving discharge communications between inpatient and community settings. It has also offered us assurance that proactive efforts are made to follow up with everyone who has been recently discharged from hospital.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97%	**0-19 years** Māori 4.43% Pacific 3.16% Other 4.23% Total 4.25%	**0-19 years** Māori 4.73% Pacific 3.13% Other 4.23% Total 4.36%	**0-19 years** Māori 4.92% Pacific 3.39% Other 4.71% Total 4.73%	
	20-64 years Māori 7.12% Pacific 4.34% Other 3.60% Total 4.33%	**20-64 years** Māori 8.77% Pacific 4.02% Other 3.78% Total 4.80%	**20-64 years** Māori 8.77% Pacific 4.07% Other 3.78% Total 4.81%	**20-64 years** Māori 9.00% Pacific 4.14% Other 3.83% Total 4.89%	
	65+ years Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**65+ years** Māori 2.26% Pacific 1.05% Other 2.09% Total 2.09%	**65+ years** Māori 2.39% Pacific 1.69% Other 2.09% Total 2.11%	**65+ years** Māori 2.56% Pacific 2.15% Other 2.33% Total 2.35%	

Our performance:

Specialist Mental Health and Addictions services are funded for those people who are most severely affected by mental illness or addictions. The Waikato DHB has placed a focus on improving access that has resulted in meeting targets set for the 2018/19 year. These targets indicate a balanced percentage of access across age bands and ethnicity but there was one significant indicator of higher rates for Māori aged between 20-64 years accessing services.

Following on from the programme of work "Te Pae Tawhiti," the Waikato DHB has developed key strategic directions for Mental Health and Addictions that will enhance access rates through a focus of earlier and more accessible services. It is proposed to deliver locality based community services that are closer to home.

A review of the existing Infant, Child and Adolescent Mental Health services identified the Waikato DHB has a unique and innovative model that is strongly aligned with national and local strategic directions particularly in addressing the needs for Māori and those in rural communities. The inclusion of kaupapa Māori providers who are embedded in local communities and working in partnership with the DHB teams was identified as a huge strength. A focus on continuing to improve access rates will encompass the use of the CAPA model within the Infant, Child and Adolescent Mental Health services.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of aged residential care facilities utilising advance directives	100%	100%	100%	100%	●

Our performance:

An advanced 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. The Health and Disability Standards require that an advanced directive is on file for every long-term residential care facility and is used when indicated. Ensuring people in age residential care facilities have an advanced directive offers health providers an understanding of individual's wishes for their care and treatment.

Waikato DHB achieved 100 percent with all long-term residents of residential care having an advanced directive in place. The Advanced Care Plan model has been reviewed this year and a new service model is being implemented in 2019/20.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Number of new patients seen by the Waikato Hospital palliative care service	652	1247	1000	1244	●

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 stages of their illness when cure or long term control is no longer possible. The team work very closely with Hospice Waikato (third party provider) in a one service two provider model. The service has seen 1244 new patients during the year, (20 percent Māori and 80 percent 'Other'). The 2018/19 year has seen the development of joint clinics with Oncology and Renal which provides patients with a wider range of treatment options that can be less invasive.

The service has worked hard to develop registrars, recruit and retain the senior medical officer workforce and to support patients. Work has commenced, and will continue through 2019/20, on forming the next stage of the strategic leadership group and working groups for workforce prioritisation and service specification. This will help inform future models of care, access criteria, improved access to services for Māori and remuneration relative to services aligned with all stakeholders engaged with the process (patients, whānau, governance, clinicians, management and others as required).

Support services

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	94%	98%	95%	80%	●

Our performance:

We are disappointed that we have not met the target for the percentage of accepted referrals for elective coronary angiography will receive their procedure within three months. The increased number of complex acute procedures and the RDA strikes impacted our performance significantly.

We have a continued focus to ensure that we will achieve the target going forward and are looking for opportunities to increase capacity. We will be working with other Midland DHBs to support an increase in capacity. Staffing for a fourth cath lab has also been approved and implementation begun; it is expected this will have a positive impact on future results.

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	Māori 92% Pacific 100% Other 90% Total 90%	Māori 57% Pacific 52% Other 62% Total 79%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 65% Pacific 66% Other 68% Total 67%	● ● ● ●

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)	Māori 55% Pacific 53% Other 52% Total 48%	Māori 57% Pacific 55% Other 60% Total 60%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 75% Pacific 72% Other 79% Total 78%	● ● ● ●

Our performance:

We are disappointed that the targets for CT and MRI were not met this year. The international shortage of radiologists has contributed to our inability to recruit to our seven FTE vacancy. The shortage of radiologists and the increased referral rate of six percent mean that the targets are unachievable. CT scanning volumes are approximately 2200 patients per month and MRI are scanning approximately 1000-1200 patients per month.

Changes to care pathways mean that there has been an increase in referrals from services that have previously had low referral rates. Compared to 2017/18 there has been a large increase in the volume of referral for CT, the largest increase coming from general medicine where there has been a 56 percent increase followed by respiratory medicine with a 41 percent increase and urology, which increased by 29 percent.

We are currently meeting the target timeframe for inpatient and acute CT but we are losing ground due to the increased requests for follow up and outpatient CT. A recovery plan is in place to move our results closer to the targets in the future.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	78%	90%	90%	73%	●
Output measure	**Baseline 2014/15**	**Previous year 2017/18**	**Target 2018/19**	**Result 2018/19**	**Rating**
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	49%	60.9%	70%	57%	●
Output measure	**Baseline 2014/15**	**Previous year 2017/18**	**Target 2018/19**	**Result 2018/19**	**Rating**
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date	70%	71.9%	70%	65%	●

Our performance:

Quarter one to three had disappointing results reflected in the overall annual target not being achieved. Opportunities were identified and implemented to improve administrative and clinical systems and processes in the Endoscopy service. In quarter four we saw the hard work pay off with results improving drastically, and all three colonoscopy targets being met. The introduction of the nurse endoscopist and the clinical nurse specialist has been critical in increasing capacity and decreasing cancellations, and the introduction of "acute only" lists to support acute capacity and reduce elective cancellations has also been a big contributor to improved results.

Redesigning the waitlist systems and processes (supported by a large data clean-up) included offering patient choice bookings, booking lists to capacity, the introduction of "acute only" lists, and back-filling operators so that lists were not cancelled, all of which played a role in improving results. Increasing referral triaging capacity to eliminate 'bottle necks' occurring when patients are added to the waitlist has also supported the team's ability to meet the 42 day target in quarter four. The service is now in a better position going forward to successfully manage capacity and demand.

While sustaining compliance across the colonoscopy targets, the focus for 2019/20 is on continuous improvement and successful implementation of the national bowel screening programme. This will bring challenges and opportunities, and to ensure these are optimised we will implement governance and project management support for the programme. There will be a particular focus on Māori referral acceptance and reducing DNA rates. We will work towards opening and resourcing a fourth room to allow us to bring back the outsourcing of colonoscopies (1000 colonoscopies were outsourced in 2018/19).

Output measure	Baseline 2014/15	Previous year 2017/18	Target 2018/19	Result 2018/19	Rating
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	100%	100%	●

Our performance:

Laboratory tests are a medical procedure that involves testing a sample of blood, urine or other biological specimen. These laboratory tests can be requested by medical practitioners, lead maternity carers, and nurse practitioners as well as approved clinical nurse specialists and pharmacist prescribers.

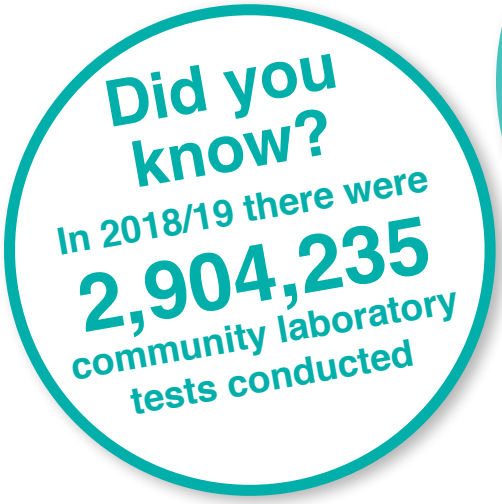
Pathlab is the main provider of community referred laboratory tests in the Waikato. Waikato Hospital Laboratory undertakes these tests on our southern localities including Te Kuiti, Tokoroa and Taumarunui.

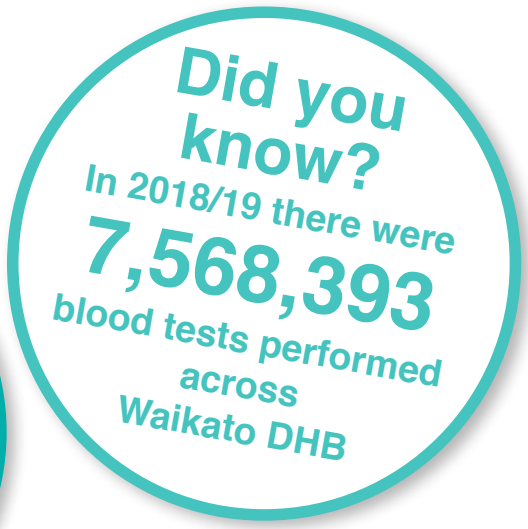
This measure is reported as Turnaround Times (the number of hours starting from the time a specimen is received in the laboratory until the time the result is authorised to be communicated to the referrer). Pathlab and Waikato Hospital Laboratory both report that 100 percent of results are communicated within 48 hours to the referrer for all patients who present for tests.

Our community laboratory services continue to exceed KPIs on turnaround times and service requirements. Clinicians and managers from both laboratories were actively engaged in the Waikato DHB Clinical Governance Group and actively support the DHB improving testing protocols for patient care and efficiency.

While we don't receive reports on whether the results are different for Māori and non-Māori both Pathlab and the Waikato Hospital Laboratory have undertaken actions to address inequity and access to laboratory services through their organisational Māori health plans. Activities include collection sites in low income rural communities; marae based services, training of Māori phlebotomists, and supply of consumables and effective engagement with Māori providers of primary health care.

Pathlab has completed the He Ritenga Audit process in 2018 which demonstrates an organisational commitment to improve services for Māori.





“I’ve been coming here for a long time and have seen a lot of changes, but the care has always been amazing. Everyone has always made me a priority.”

Savannah

South Waikato Primary Birthing Unit at Tokoroa Hospital opening ceremony

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 the three asset portfolios; property, equipment and information and communication technology, Waikato DHB has in place robust asset management processes and programmes with a key focus 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 appropropriate 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	2016/17 Net Book Value	2017/18 Net Book Value	2018/19 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.	$658 M	$639 M	$725 M
Equipment	Clinical equipment.	To facilitate the delivery of hospital services through the provision of fit for purpose clinical equipment.	$51 M	$52 M	$49M
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.	$27 M	$31 M	$28M

The 2018/19 asset performance indicators (APIs) 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 Result	2018/19 Target	2018/19 Result
Waikato campus buildings relative earthquake risk. -1	Condition	68%	68%	68%	> 77%	94%
Waikato campus building core services down time as a percentage of total operating hours, per annum.	Condition	0.67%	0.67%	0.52%	< 1%	0.78%
Waikato campus building core services net operating hours per annum. -2	Utilisation	100%	99%	99%	> 99%	99%
Waikato campus carparks as a percentage of total public car parking. -3	Functionality	5%	5%	5%	> 12.5%	13.3%
Waikato campus building energy efficiency savings as a percentage of targeted energy consumption. -4	Functionality	3%	7%	16%	> 7%	14%

Clinical portfolio performance

Asset performance indicators	Indicator class	2015/16 Result	2016/17 Result	2017/18 Result	2018/19 Target	2018/19 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%	100%
For Waikato Hospital Radiology department, actual CT scanned patients versus planned patient scans.	Utilisation	101%	101%	103%	> 90%	100%
For Waikato Hospital Radiology department CT scanners performing operationally to hospital requirements.	Functionality	N/A	100%	100%	>99%	100%
Linear Accelerators (Oncology department) planned operating hours versus hours utilised. -5	Utilisation	N/A	95%	92%	86%	85%
For Waikato Hospital, planned theatre usage versus actual usage. -6	Utilisation	75%	74%	76%	100%	73%
For Waikato Hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	104%	100%	100%	100%	98%
For Waikato Hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. -7	Utilisation	92%	92%	92%	>86%	88%
For Waikato DHB, elective surgery completed as a percentage of MOH elective surgery targets for last 12 months.	Utilisation	103%	102%	105%	100%	99%
For Waikato DHB, weighted average age of clinical Fixed Assets versus Suppliers weighted average life expectancy.	Condition / Functionality	N/A	N/A	89%	100%	178%

Information communication and technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2015/16 Result	2016/17 Result	2017/18 Result	2018/19 Target	2018/19 Result
Percentage of computer hardware used by staff less than five years old. -8	Condition	91%	97%	82%	> 90%	62%
The availability of Clinical ICT systems across Waikato campus as a percentage of total hours per annum.	Condition	99.96%	99.95%	99.80%	> 99.9%	99.78%
For Waikato DHB wide ICT systems, number of critical priority one faults, measured per annum. -9	Condition	N/A	N/A	9%	< 24	14
Waikato Hospital staff able to access clinical and non clinical system platforms remotely.	Utilisation	28%	17%	29%	> 30%	30%
Percentage of time ICT systems running at peak through core network switches.	Utilisation	N/A	N/A	18%	< 30%	19%
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 to 10 scale. -10	Functionality	88%	86%	92%	> 75%	91%
Percentage of ICT system incidents resolved within agreed department service levels.	Functionality	N/A	94%	93%	100%	93%

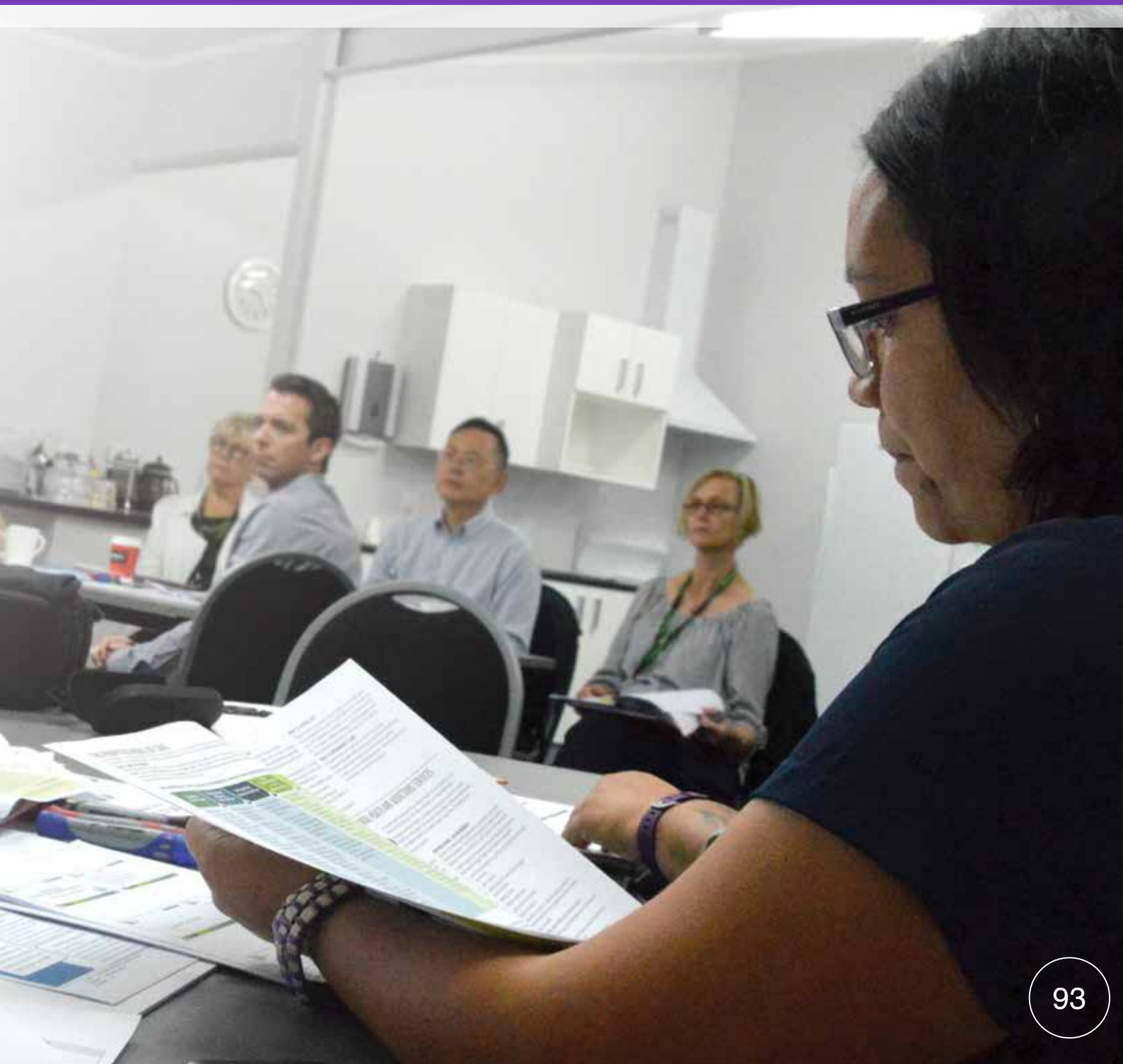
Addendum

1. Measuring earthquake risk against current building design and detail
2. Down time includes plant and equipment, generators, lifts and boilers
3. There are 152 carparks designated for disabled parking at the Waikato DHB
4. Measured as Kwh /m^2 per annum
5. Planned hours are the 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 / women's health but excludes Critical Care
8. Includes PCs / laptops / tablets
9. Priority one = Critical business impact, key service area's unable to work or there is an IT security breach
10. Six-monthly customer survey, target is 75 percent (7.5) or better.

“It’s not just the district nurses, it’s the whole hospital system and I just can’t say enough about it. It’s hard to put it into one single word but I am grateful, I truly am.”

Peter

Part five:
Financial statements



Statement of comprehensive revenue and expense for the year ended 30 June 2019

	Note	Group 2019 Budget $000	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Revenue						
Patient care revenue	2	1,479,452	1,500,647	1,422,904	1,500,647	1,422,904
Other revenue	3	18,308	20,341	18,244	19,648	17,608
Finance revenue	4	1,187	1,093	1,714	872	1,538
Total income		**1,498,947**	**1,522,081**	**1,442,862**	**1,521,167**	**1,442,050**
Expenses						
Personnel costs	5	643,358	688,995	573,756	688,995	573,756
Depreciation	6	45,103	46,545	46,399	46,545	46,399
Amortisation and impairment cost	7	6,830	8,371	5,319	8,371	5,319
Outsourced services		78,866	97,043	92,926	97,043	92,926
Clinical supplies		149,769	159,291	144,849	159,291	144,849
Infrastructure and non-clinical expenses		62,616	83,999	75,996	83,999	76,187
Other district health boards		62,103	63,538	61,130	63,538	61,130
Non-health board providers		457,108	447,910	433,665	447,910	433,665
Other operating expenses	8	14,365	11,669	8,804	11,652	8,788
Finance costs	9	192	415	116	415	116
Capital charge	10	34,708	34,137	37,124	34,137	37,124
Total expenses		**1,555,018**	**1,641,913**	**1,480,084**	**1,641,896**	**1,480,259**
Share of joint venture surplus/(deficit)	11	-	68	72	68	72
Surplus/(deficit)		**(56,071)**	**(119,764)**	**(37,150)**	**(120,661)**	**(38,137)**
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	90,351	-	90,351	-
Other comprehensive revenue and expense for the year		**-**	**90,351**	**-**	**90,351**	**-**
Total comprehensive revenue and expense for the year		**(56,071)**	**(29,413)**	**(37,150)**	**(30,310)**	**(38,137)**

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 2019

	Note	Group			Parent	
		2019 Budget $000	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Balance at 1 July		**582,389**	**582,389**	**622,676**	**582,063**	**622,394**
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(56,071)	(119,764)	(37,150)	(120,661)	(38,137)
Other comprehensive income/ (expense)		-	90,351	-	90,351	-
Total comprehensive revenue and expense for the year		**(56,071)**	**(29,413)**	**(37,150)**	**(30,310)**	**(38,137)**
Owner transactions						
Capital contribution		102,547	29,100	-	29,100	-
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	22	(237)	(478)	(943)	-	-
Balance at 30 June	**12**	**626,434**	**579,404**	**582,389**	**578,659**	**582,063**

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 2019

	Note	Group 2019 Budget $000	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Assets						
Current assets						
Cash and cash equivalents	13	8,022	8,756	7,855	-	-
Receivables	14	51,251	48,357	50,593	48,330	50,563
Prepayments	15	8,000	7,868	10,029	7,868	10,029
Inventories	16	11,601	12,218	11,452	12,218	11,452
Total current assets		**78,874**	**77,199**	**79,929**	**68,416**	**72,044**
Non-current assets						
Property, plant and equipment	6	763,711	773,940	691,371	773,940	691,371
Intangible assets	7	23,651	27,626	30,818	27,626	30,818
Investment in joint venture	11	375	443	375	443	375
Prepayment	15	-	4,608	-	4,608	-
Total non-current assets		787,737	806,617	722,564	806,617	722,564
Total assets		**866,611**	**883,816**	**802,493**	**875,033**	**794,608**
Liabilities						
Current liabilities						
Cash and cash equivalents	13	229	35,938	10,829	35,938	10,829
Borrowings	18	5,095	181	313	181	313
Employee entitlements	19	124,477	166,150	118,924	166,150	118,924
Trade and other payables under exchange transactions	20	68,377	65,778	54,252	65,763	54,238
Trade and other payables under non-exchange transactions	20	9,224	12,562	12,983	12,562	12,983
Provisions	21	692	987	680	987	680
Total current liabilities		**208,094**	**281,596**	**197,981**	**281,581**	**197,967**
Non-current liabilities						
Borrowings	18	9,983	185	366	185	366
Employee entitlements	19	13,972	14,117	13,738	14,117	13,738
Provisions	21	474	491	474	491	474
Restricted trust funds	22	7,654	8,023	7,545	-	-
Total non-current liabilities		32,083	22,816	22,123	14,793	14,578
Total liabilities		240,177	304,412	220,104	296,374	212,545
Net assets		**626,434**	**579,404**	**582,389**	**578,659**	**582,063**
Equity						
Crown equity (Contributed capital)	12	384,894	311,449	284,543	311,449	284,543
Revaluation reserve	12	261,187	351,539	261,188	351,539	261,188
Retained earnings (Accumulated deficit)		(20,023)	(84,329)	36,332	(84,329)	36,332
Trust funds	12	376	745	326	-	-
Total equity		**626,434**	**579,404**	**582,389**	**578,659**	**582,063**

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

Karen Poutasi
Commissioner
Waikato District Health Board
29 October 2019

Prof Margaret Wilson
Deputy Commissioner
Waikato District Health Board
29 October 2019

Statement of cash flows for the year ended 30 June 2019

	Note	Group			Parent	
		2019 Budget $000	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Cash flows from operating activities						
Operating receipts		1,497,849	1,522,179	1,439,182	1,521,486	1,438,355
Interest received		1,187	1,440	1,727	1,215	1,541
Payments to suppliers		(811,152)	(853,815)	(818,989)	(853,798)	(818,974)
Payments to employees		(638,470)	(641,390)	(558,499)	(641,390)	(558,497)
Interest paid		(825)	(415)	(116)	(415)	(116)
Payments for capital charge		(34,708)	(34,137)	(37,124)	(34,137)	(37,124)
Goods and services tax (net)		189	93	1,488	93	1,488
Net cash flows from operating activities	23	14,070	(6,045)	27,669	(6,946)	26,673
Cash flows from investing activities						
Purchase of property, plant and equipment		(101,716)	(39,577)	(28,905)	(39,577)	(28,905)
Purchase of intangible assets		(15,388)	(5,179)	(8,817)	(5,179)	(8,817)
Receipts from sale of property, plant and equipment		-	-	20	-	20
Net cash flows from investing activities		(117,104)	(44,756)	(37,702)	(44,756)	(37,702)
Cash flows from financing activities						
Capital contribution from the Crown		102,547	29,100	-	29,100	-
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		14,490	-	-	-	-
Repayment of borrowings		(1,042)	(313)	(324)	(313)	(324)
Net cash flows from financing activities		113,801	26,593	(2,518)	26,593	(2,518)
Net increase/(decrease) in cash and equivalents		10,767	(24,208)	(12,551)	(25,109)	(13,547)
Cash and cash equivalents at beginning of year		(2,974)	(2,974)	9,577	(10,829)	2,718
Cash and cash equivalents at end of year	13	7,793	(27,182)	(2,974)	(35,938)	(10,829)

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 DHB is a district health board established by the New Zealand Public Health and Disability Act 2000 and is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled and operates in New Zealand.

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. Its 20 percent 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 2019, and were authorised for issue by the commissioners on 29 October 2019.

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 principle has been adopted in the preparation of these financial statements. The Commissioner has received a letter of comfort, dated 21 October 2019 from the Ministers of Health and Finance which acknowledges that the Government is committed to provide support to maintain Waikato DHB financial viability. The letter of comfort is considered critical to the going concern assumption underlying the preparation of the financial statements, as the 2019/20 annual plan has yet to receive approval from the Minister of Health.

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). Remuneration and related parties are rounded to the nearest 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.

1. Statement of accounting policies (continued)

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Waikato DHB has not early adopted the amendment.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Waikato DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

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.

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.

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.

1. Statement of accounting policies (continued)

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.

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.

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

Critical judgements in applying accounting policies

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

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. Inter-district patient inflow revenue is recognised when services are provided.

2. Patient care revenue (continued)

Patient care revenue breakdown	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Non-exchange transactions				
Health and disability services (Crown appropriation revenue)[1]	1,255,171	1,176,808	1,255,171	1,176,808
Other MoH and government revenue	28,579	28,217	28,579	28,217
Patient co-payments	1,523	1,561	1,523	1,561
Exchange transactions				
Health and disability services (MoH)	31,620	37,486	31,620	37,486
ACC contract revenue	15,730	16,995	15,730	16,995
Revenue from other district health boards	138,809	135,688	138,809	135,688
Clinical Training Agency revenue	11,696	11,495	11,696	11,495
Other patient care related revenue	17,519	14,654	17,519	14,654
Total patient care revenue	1,500,647	1,422,904	1,500,647	1,422,904

1 - Performance against this appropriation is reported in the Statement of Performance on pages 45 to 87.

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 $1,206,301 (2018 - $1,150,497,000).

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.

3. Other revenue (continued)

Other revenue breakdown	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Non-exchange transactions				
Donations and bequests received	1,742	1,290	150	127
Grants received	-	-	899	527
Exchange transactions				
Rental revenue	1,380	1,266	1,380	1,266
Other revenue	17,219	15,688	17,219	15,688
Total other revenue	20,341	18,244	19,648	17,608

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 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Total finance revenue	1,093	1,714	872	1,538
Total finance revenue	1,093	1,714	872	1,538

5. Personnel costs

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

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 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Salaries and wages	622,139	541,880	622,139	541,880
Increase/(decrease) in liability for employee entitlements	47,605	15,167	47,605	15,167
Defined contribution plan employer contributions	19,251	16,709	19,251	16,709
Total personnel cost	688,995	573,756	688,995	573,756

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.

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	3-77 years	1.3-36%
Plant, equipment and vehicles	3-36 years	2.8-33.3%

6. Property, plant and equipment (continued)

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.

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.

6. Property, plant and equipment (continued)

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 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)
Revaluation	-	-	-	-	-
Balance at 30 June 2018	**44,476**	**602,877**	**231,858**	**13,119**	**892,330**
Balance at 1 July 2018	44,476	602,877	231,858	13,119	892,330
Additions	-	-	-	39,577	39,577
Transfers	-	6,018	15,611	(21,629)	-
Disposals	-	-	(20,588)	-	(20,588)
Disposal reversal	-	98	-	-	98
Revaluation	5,563	23,893	-	-	29,456
Balance at 30 June 2019	**50,039**	**632,886**	**226,881**	**31,067**	**940,873**
Accumulated depreciation and impairment losses					
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)
Revaluation	-	-	-	-	-
Balance at 30 June 2018	**-**	**30,977**	**169,982**	**-**	**200,959**
Balance at 1 July 2018	-	30,977	169,982	-	200,959
Depreciation charge and impairment losses for the year	-	29,918	16,627	-	46,545
Disposals	-	-	(19,676)	-	(19,676)
Revaluation	-	(60,895)	-	-	(60,895)
Balance at 30 June 2019	**-**	**-**	**166,933**	**-**	**166,933**
Carrying amounts					
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**
At 1 July 2018	44,476	571,900	61,876	13,119	691,371
At 30 June 2019	**50,039**	**632,886**	**59,948**	**31,067**	**773,940**

6. Property, plant and equipment (continued)

Parent Actual	Freehold land	Freehold buildings	Plant, equipment and vehicles	Work in progress	Total
Cost	$000	$000	$000	$000	$000
Balance at 1 July 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)
Revaluation	-	-	-	-	-
Balance at 30 June 2018	**44,476**	**602,877**	**231,858**	**13,119**	**892,330**
Balance at 1 July 2018	44,476	602,877	231,858	13,119	892,330
Additions	-	-	-	39,577	39,577
Transfers	-	6,018	15,611	(21,629)	-
Disposals	-	-	(20,588)	-	(20,588)
Disposal reversal	-	98	-	-	98
Revaluation	5,563	23,893	-	-	29,456
Balance at 30 June 2019	**50,039**	**632,886**	**226,881**	**31,067**	**940,873**
Accumulated depreciation and impairment losses					
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)
Revaluation	-	-	-	-	-
Balance at 30 June 2018	**-**	**30,977**	**169,982**	**-**	**200,959**
Balance at 1 July 2018	-	30,977	169,982	-	200,959
Depreciation charge and impairment losses for the year	-	29,918	16,627	-	46,545
Disposals	-	-	(19,676)	-	(19,676)
Revaluation	-	(60,895)	-	-	(60,895)
Balance at 30 June 2019	**-**	**-**	**166,933**	**-**	**166,933**
Carrying amounts					
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**
At 1 July 2018	44,476	571,900	61,876	13,119	691,371
At 30 June 2019	**50,039**	**632,886**	**59,948**	**31,067**	**773,940**

Valuation

The most recent valuation of land and buildings was carried out by P.D. Todd, an independent registered valuer and a member of the New Zealand Institute of Valuers. The valuation was carried out at 30 June 2019.

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.

6. Property, plant and equipment (continued)

Buildings

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

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Waikato 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 $0.3 million (2018: $0.5 million). Note 18 provides further information about finance leases.

Property, plant and equipment under construction

Buildings work in progress at 30 June 2019 is $12.7million (2018: $5.2million) and capital commitments is $3.4 million (2018: $3.4 million). Plant, equipment and vehicles work in progress at 30 June 2019 is $18.4 million (2018: $8.3million) and capital commitments is $6.6million (2018: $4.9 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 (FPIM Programme Asset) and the rights to the shared services is recognised as an intangible asset at the cost of the Waikato DHBs capital investment.

7. Intangible assets (continued)

Impairment of FPIM Programme Asset

Intangible assets include the FPIM Programme asset which is deemed to be a non-cash-generating asset. This is on the basis that there are no cash flows directly linked to the asset. Therefore, the applicable accounting standard is PBE IPSAS 21 Impairment of Non-Cash-Generating Assets. PBE IPSAS 21 requires an annual test for impairment by comparing the asset carrying value with its recoverable service amount.

The national FPIM Business Case approved by Cabinet 24 June 2019 materially changed from the FPIM Programme paused by the Cabinet decision of 28 June 2018 and the judgements that were assumed in assessing the national FPIM Programme carrying value at 30 June 2018. Key changes being:

- the Business Case has crystallised that only 10 DHBs are committing to a single system in the short to medium term;
- the Business Case conservatively reduced the benefits to only identifiable procurement spend. This impacts on Net Present Value calculations which formed part of the assessment of carrying value of the asset and the requirement for any impairment;
- NZ Health Partnerships now have visibility of a working system, which has been operational since July 2018 at four DHBs, on which user feedback is available in evaluating the broader initial scope and activities capitalised under Health Benefits Limited ownership prior to June 2014. It has considered how much of that work still holds value for the pared back system that was finally deployed.

NZ Health Partnerships tested the FPIM asset for impairment by determining the asset's value in use based on its depreciated replacement cost (DRC).

Based on the information provided by NZ Health Partnerships to Waikato DHB, an additional $3.0m impairment of the FPIM asset has been included in the Statement of Comprehensive Income for the year ended 30 June 2019

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	2-15 years	6.6-50%

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.

7. Intangible assets (continued)

Movements for intangible assets are as follows:

Group 2019 Actual	Internally generated	Other	Work in Progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2017	968	54,566	17,173	72,707
Additions	-	-	8,817	8,817
Transfers	532	3,720	(4,252)	-
Balance at 30 June 2018	**1,500**	**58,286**	**21,738**	**81,524**
Balance at 1 July 2018	1,500	58,286	21,738	81,524
Additions	-	-	5,179	5,179
Disposals	-	(6)	-	(6)
Transfers	1,189	12,014	(13,203)	-
Balance at 30 June 2019	**2,689**	**70,294**	**13,714**	**86,697**
Accumulated amortisation and impairment losses				
Balance at 1 July 2017	254	45,133	-	45,387
Amortisation and impairment charge for the year	29	5,290	-	5,319
Balance at 30 June 2018	**283**	**50,423**	**-**	**50,706**
Balance at 1 July 2018	283	50,423	-	50,706
Amortisation and impairment charge for the year	89	8,282	-	8,371
Disposals	-	(6)	-	(6)
Balance at 30 June 2019	**372**	**58,699**	**-**	**59,071**
Carrying amounts				
At 1 July 2017	714	9,433	17,173	27,320
At 30 June 2018	**1,217**	**7,863**	**21,738**	**30,818**
At 1 July 2018	1,217	7,863	21,738	30,818
At 30 June 2019	**2,317**	**11,595**	**13,714**	**27,626**

7. Intangible assets (continued)

Parent 2019 Actual	Internally generated	Other	Work in Progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2017	968	54,566	17,173	72,707
Additions	-	-	8,817	8,817
Transfers	532	3,720	(4,252)	-
Balance at 30 June 2018	**1,500**	**58,286**	**21,738**	**81,524**
Balance at 1 July 2018	1,500	58,286	21,738	81,524
Additions	-	-	5,179	5,179
Transfers	1,189	12,014	(13,203)	-
Disposals	-	(6)	-	(6)
Balance at 30 June 2019	**2,689**	**70,294**	**13,174**	**86,697**
Accumulated amortisation and impairment losses				
Balance at 1 July 2017	254	45,133	-	45,387
Amortisation and impairment charge for the year	29	5,290	-	5,319
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Balance at 1 July 2018	283	50,423	-	50,706
Amortisation and impairment charge for the year	89	8,282	-	8,371
Disposals	-	(6)	-	(6)
Balance at 30 June 2019	**372**	**58,699**	**-**	**59,071**
Carrying amounts				
At 1 July 2017	714	9,433	17,173	27,320
At 30 June 2018	**1,217**	**7,863**	**21,738**	**30,818**
At 1 July 2018	1,217	7,863	21,738	30,818
At 30 June 2019	**2,317**	**11,595**	**13,714**	**27,626**

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	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Breakdown of other expenses	$000	$000	$000	$000
Allowance for credit losses on receivables	761	190	761	190
Audit fees for the audit of the financial statements	246	238	229	222
Audit fees for the audit of the financial statements – 2016/17	-	86	-	86
Audit related fees for assurance and internal audits	15	27	15	27
Board members' remuneration and expenses	302	330	302	330
Koha and donations	164	20	164	20
Operating lease expenses	9,367	7,803	9,367	7,803
Loss on disposal of property, plant and equipment	814	110	814	110
Total other operating expenses	**11,669**	**8,804**	**11,652**	**8,788**

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	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Interest and financing expenses	415	116	415	116
Total finance cost	**415**	**116**	**415**	**116**

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	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Capital charge	34,137	37,124	34,137	37,124
Total capital charge	**34,137**	**37,124**	**34,137**	**37,124**

Waikato DHB pays a capital charge to the Crown every six months. This charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the period ended 30 June 2019 was 6% (2018:6%).

11. 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 2019	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b) Carrying amount of investment

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Opening Balance	375	303	375	303
Share of joint venture surplus/(deficit)	68	72	68	72
Closing Balance	**443**	**375**	**443**	**375**

11. Investments in joint venture (continued)

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

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Current assets	1,488	1,435	1,488	1,435
Non-current assets	3,817	2,774	3,817	2,774
Current liabilities	(1,303)	(1,331)	(1,303)	(1,331)
Non-current liabilities	(3,559)	(2,503)	(3,559)	(2,503)
Net assets	**443**	**375**	**443**	**375**
Revenue	3,478	3,077	3,478	3,077
Expenses	(3,410)	(3,005)	(3,410)	(3,005)
Share of surplus/(deficit) of joint venture	**68**	**72**	**68**	**72**

12. 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 Reconciliation of movement in equity	Trust Funds $000	Crown Equity $000	Revaluation Reserve $000	Retained Earnings $000	Total Equity $000
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**
Balance at 1 July 2018	326	284,543	261,188	36,332	582,389
Total comprehensive revenue/(expense)	897	-	90,351	(120,661)	(29,413)
Contributed capital - deficit support funding	-	29,100	-	-	29,100
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(478)	-	-	-	(478)
Other movement		-	-	-	-
Balance at 30 June 2019	**745**	**311,449**	**351,539**	**(84,329)**	**579,404**

12. 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 29.

Parent Reconciliation of movement in equity	Crown Equity $000	Revaluation Reserve $000	Retained Earnings $000	Total Equity $000
Balance at 1 July 2017	286,737	261,188	74,469	622,394
Total comprehensive revenue/(expense)	-	-	(38,137)	(38,137)
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**
Balance at 1 July 2018	284,543	261,188	36,332	582,063
Total comprehensive revenue/(expense)	-	90,351	(120,661)	(30,310)
Contributed capital - Deficit support funding	29,100	-	-	29,100
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	-	-	-	-
Balance at 30 June 2019	**311,449**	**351,539**	**(84,329)**	**578,659**

13. 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.

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

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	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Cash at bank/(overdraft) and cash on hand	58	(1,311)	58	(1,311)
Advance to/(from) New Zealand Health Partnerships Limited	(35,996)	(9,518)	(35,996)	(9,518)
Trust funds	8,756	7,855	-	-
Total cash and cash equivalents	**(27,182)**	**(2,974)**	**(35,938)**	**(10,829)**

14. Receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. Bad debts are written off during the period in which they are identified. The simplified expected credit loss model of recognising lifetime expected credit losses for receivables has been applied.

In measuring expected credit losses, receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the type of receivable and days past due. The expected loss rates are based on the payment profile of transactions over a period of 24 months before 30 June 2019 and the corresponding historical credit losses experienced within this period.

Receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the length of time the balance remains outstanding.

Previous accounting policy for the impairment of receivables:

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was only recognised when there was objective evidence that the amount would not be fully collected.

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Ministry of Health trade receivables	3,508	4,242	3,508	4,242
Other trade receivables	8,216	6,805	8,216	6,775
Less: Allowance for credit losses	(1,234)	(1,133)	(1,234)	(1,133)
Total trade receivables	**10,490**	**9,914**	**10,490**	**9,884**
Ministry of Health accrued revenue	19,287	17,683	19,287	17,683
Other accrued revenue	18,580	22,996	18,553	22,996
Total receivables	**48,357**	**50,593**	**48,330**	**50,563**
Total receivables comprises:				
Receivables from non-exchange transactions	18,786	9,466	18,786	9,466
Receivables from exchange transactions	29,571	41,127	29,544	41,097

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 are based on the payment profile of invoices issued over the past 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward looking macroeconomic factors that might affect the recoverability of receivables.

There have been no changes during the reporting in the estimation techniques or significant assumptions used in measuring the loss allowance.

The allowance for credit losses at 30 June 2019 was determined as follows:

Group	Receivables days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	TOTAL
30 June 2019					
Expected Credit Loss Rate	0.26%	27.23%	14.11%	56.94%	
Gross Carrying Amount ($000)	47,163	437	333	1,658	49,591
Lifetime expected credit loss ($000)	124	119	47	944	1,234
1 July 2018					
Expected Credit Loss Rate	-	4.78%	1.11%	57.73%	
Gross Carrying Amount ($000)	44,316	2,195	3,502	1,713	51,726
Lifetime expected credit loss ($000)	-	105	39	989	1,133

14. Receivables (continued)

Parent	Receivables days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	TOTAL
30 June 2019					
Expected Credit Loss Rate	0.26%	27.23%	14.11%	56.94%	
Gross Carrying Amount ($000)	47,136	437	333	1,658	49,564
Lifetime expected credit loss ($000)	124	119	47	944	1,234
1 July 2018					
Expected Credit Loss Rate	-	4.78%	1.11%	57.73%	
Gross Carrying Amount ($000)	44,286	2,195	3,502	1,713	51,696
Lifetime expected credit loss ($000)	-	105	39	989	1,133

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

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Allowance for credit losses as at 1 July under PBE IPSAS 29	1,133	1,050	1,133	1,050
PBE IFRS 9 expected credit loss adjustment – through opening accumulated surplus/deficit	-	-	-	-
Opening allowance for credit losses at 1 July	1,133	1,050	1,133	1,050
Increase in loss allowance made during the year	699	190	699	190
Receivables written off during the year	(660)	(174)	(660)	(174)
Receivables recovered during the year	62	67	62	67
Balance at 30 June	**1,234**	**1,133**	**1,234**	**1,133**

15. Prepayments

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Current portion				
Prepayments	7,868	10,029	7,868	10,029
Total prepayments	**7,868**	**10,029**	**7,868**	**10,029**
Non-current portion				
Prepayments	4,608	-	4,608	-
Total prepayments	**4,608**	**-**	**4,608**	**-**

16. 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	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Pharmaceuticals	1,100	1,159	1,100	1,159
Surgical and medical supplies	7,249	9,613	7,249	9,613
Other supplies	3,869	680	3,869	680
Total inventories	12,218	11,452	12,218	11,452

The amount of inventories recognised as an expense due to change in stock value during the year was $55,752 (2018: $104,543), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $377,419 for 2019 (2018: $161,329). 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 2019 was $Nil (2018: $Nil). No inventories are pledged as security for liabilities.

17. 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 (2018: $Nil). The foreign currency principal amounts were $ Nil (2018: USD Nil).

18. Borrowings

Accounting policy

Borrowings are initially recognised at the amount borrowed plus transaction costs. After initial recognition all borrowings are measured at amortised cost using the effective interest method.

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

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	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Current portion	$000	$000	$000	$000
Loan from Energy Efficiency and Conservation Authority	61	93	61	93
Finance leases	120	220	120	220
	181	**313**	**181**	**313**
Non-current portion				
Loan from Energy Efficiency and Conservation Authority	15	76	15	76
Finance leases	170	290	170	290
	185	**366**	**185**	**366**
Analysis of finance leases				
Minimum lease payments payable:				
No later than one year	120	220	120	220
Later than one year and not later than five years	170	290	170	290
Later than five years	-	-	-	-
Total minimum lease payments	**290**	**510**	**290**	**510**
Future finance charges	(8)	(32)	(8)	(32)
Present value of minimum lease payments	**282**	**478**	**282**	**478**
Present value of minimum lease payments payable:				
No later than one year	112	217	112	217
Later than one year and not later than five years	170	261	170	261
Later than five years	-	-	-	-
Total present value of minimum lease payments	**282**	**478**	**282**	**478**

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 $282,000 (2018: $478,000). Fair value has been determined by using a discount rate of 1.12% (2018:2.07%).

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.

19. 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	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Current portion	$000	$000	$000	$000
Liability for long service leave	3,248	2,852	3,248	2,852
Liability for retirement gratuities	3,366	3,308	3,366	3,308
Liability for annual leave	115,498	71,676	115,498	71,676
Liability for sick leave	1,434	1,440	1,434	1,440
Liability for continuing medical education leave and expenses	10,983	10,337	10,983	10,337
PAYE payable	10,668	5,538	10,668	5,538
Salary and wages accrual	20,953	23,773	20,953	23,773
	166,150	**118,924**	**166,150**	**118,924**
Non-current portion				
Liability for long service leave	1,395	1,802	1,395	1,802
Liability for sabbatical leave	4,586	4,118	4,586	4,118
Liability for retirement gratuities	8,136	7,818	8,136	7,818
	14,117	**13,738**	**14,117**	**13,738**

19. Employee entitlements (continued)

Key assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advise from an independent actuary. Two discount rates for retirement and long service leave are used, 1.4% and 1.2%, respectively. (2018: 2.6% and 1.9% respectively) and a salary inflation factor of 3.0% (2018:3.0%) 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.

Holidays Act 2003

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 DHBs and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, Waikato DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

20. Trade and other payables

Accounting policy

Short term payables are recorded at their face value.

	Group		Parent	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Payables under exchange transactions	$000	$000	$000	$000
Creditors	65,397	53,727	65,382	53,713
Revenue received in advance	381	525	381	525
Total payables under exchange transactions	**65,778**	**54,252**	**65,763**	**54,238**
Payables under non-exchange transactions				
ACC levy payable	679	910	679	910
GST payable	9,128	9,035	9,128	9,035
Accrual – non exchange expenses	2,755	3,038	2,755	3,038
Total payables under non-exchange transactions	**12,562**	**12,983**	**12,562**	**12,983**
Total payables	**78,340**	**67,235**	**78,325**	**67,221**

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

21. Provisions

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, it is probable that an outflow of future economic benefits will be required to setlle the obligation 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	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	933	680	933	680
Motor vehicle repairs on disposal	54	-	54	-
	987	**680**	**987**	**680**

21. Provisions (continued)

	Group		Parent	
	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Non-current liabilities	$000	$000	$000	$000
Motor vehicle repairs on disposal	491	474	491	474
	491	**474**	**491**	**474**

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 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**
Balance at 1 July 2018	680	474	1,154
Additional provisions made/released	1,250	299	1,549
Amounts used	(997)	(228)	(1,225)
Balance at 30 June 2019	**933**	**545**	**1,478**

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 2019. 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 11.6% (2018:15%) 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 1.72% per annum (2018:1.7%); and
- a discount factor of 1.35% for 30 June 2019 (2018:2.3%).

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.

22. Restricted trust funds

Movements are as follows:	Group 2019 Actual $000 Waikato Health Trust	Group 2018 Actual $000 Waikato Health Trust
Balance at 1 July	7,545	6,603
Transfer from accumulated funds	478	942
Balance at 30 June	**8,023**	**7,545**

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 29.

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

	Note	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Net surplus/(deficit)		(119,764)	(37,150)	(120,661)	(38,137)
Add/(less) non-cash items:					
Depreciation	6	46,545	46,399	46,545	46,399
Amortisation and impairment cost	7	8,371	5,319	8,371	5,319
Bad and doubtful debts	14	699	190	699	190
Share of joint venture (surplus)/deficit	11	(68)	(72)	(68)	(72)
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	3,8	814	110	814	110
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	16	(766)	(446)	(766)	(446)
(Increase)/decrease in gross receivables	14	1,538	1,006	1,534	997
(Increase)/decrease in prepayments	15	(2,447)	6,116	(2,447)	6,116
Increase/(decrease) in employee entitlements	19	47,605	15,167	47,605	15,167
Increase/(decrease) in trade and other payables	20	11,104	(9,010)	11,104	(9,010)
Increase/(decrease) in other provisions	21	324	40	324	40
Net cash flows from operating activities		**(6,045)**	**27,669**	**(6,946)**	**26,673**

24. Capital commitments and operating leases

Capital commitments	Group 2019 Actual $000	Group 2018 Actual $000	Parent 2019 Actual $000	Parent 2018 Actual $000
Buildings	3,378	3,418	3,378	3,418
Plant, equipment and vehicles	6,655	4,893	6,655	4,893
Intangible assets	2,767	2,780	2,767	2,780
Total capital commitments	**12,800**	**11,091**	**12,800**	**11,091**

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

24. Capital commitments and operating leases (continued)

Non-cancellable operating lease commitments

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

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Not later than one year	8,567	8,523	8,567	8,523
Later than one year and not later than five years	30,945	25,202	30,945	25,202
Later than five years	20,446	6,933	20,446	6,933
	59,958	**40,658**	**59,958**	**40,658**

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.

25. Contingencies

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Contingent liabilities				
Personal grievances	325	140	325	140
	325	**140**	**325**	**140**

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, have considered and continue 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.

In the 2018 financial year, Waikato DHB was unable to determine the impact of the interpretation of compliance with the Holidays Act and did not recognise a provision.

In the current year, Waikato DHB has recognised a provision at balance date based on a reasonable estimate of the potential liability.

Contingent assets

Waikato DHB has no contingent assets at 30 June 2019 (2018:$Nil).

26. 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.

	2019 Actual $000	2018 Actual $000
Balance at 1 July	32	25
Receipts	94	74
Payments	(81)	(67)
Balance at 30 June	**45**	**32**

27. Financial instruments

Early adoption of PBE IFRS 9

In January 2017 the External Reporting Board issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early adoption permitted. Waikato DHB has elected to early adopt PBE IFRS 9 Financial Instruments (2014) from 1 July 2018 without restatement, in accordance with the transition requirements and guidance from Treasury. The date of initial application is 1 July 2018. This standard sets out the new requirements for the classification and measurement of financial assets, impairment provisioning and hedge accounting for financial instruments.

The following table explains the original measurement categories under PBE IPSAS 29 and the new measurement categories under PBE IFRS 9 for each class of financial assets as at 1 July 2018 for Waikato DHB Group.

		Classification		Carrying amount	
Transition statement	Note	IPSAS 29	PBE IFRS 9	IPSAS 29	PBE IFRS 9
Financial assets				$000	$000
Cash and cash equivalents	13	Loans and Receivables	Amortised cost	7,855	7,855
Trade and other receivables - exchange transactions	14	Loans and Receivables	Amortised cost	41,127	41,127
Net financial assets impacted by transition				**48,982**	**48,982**

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Group		Parent	
Financial instrument categories	2019 Actual	2018 Actual	2019 Actual	2018 Actual
Financial assets measured at amortised cost	$000	$000	$000	$000
Cash and cash equivalents	8,756	7,855	-	-
Receivables – credit impaired	48,357	50,593	48,330	50,563
Total financial assets measured at amortised cost	**57,113**	**58,448**	**48,330**	**50,563**
Fair value through surplus or deficit				
Derivative financial instrument	-	-	-	-
Total derivative financial instrument	**-**	**-**	**-**	**-**
Financial liabilities measured at amortised cost				
Cash and cash equivalents	35,938	10,829	35,938	10,829
Trade and other payables (excluding income in advance)	77,959	67,235	77,944	67,221
Borrowings – loans	366	679	366	679
Total other financial liabilities	**114,263**	**78,743**	**114,248**	**78,729**

Financial assets are measured on an amortised cost basis. The transition to PBE IFRS 9 required application of the expected credit risk model. In prior year, financial assets were based on an incurred credit loss model. The impact of the transition for Waikato DHB Group was zero.

27. Financial instruments (continued)

Financial instrument risks

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.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Waikato DHB, causing it to incur a loss. Waikato DHB places its cash balances with high-quality financial institutions via a national DHB shared banking arrangement facilitated by New Zealand Health Partnerships Limited.

Concentrations of credit risk from trade receivables are limited due to ACC and Ministry of Health being the largest single debtors (7% and 47% respectively, at 30 June 2019). 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. No collateral or other credit enhancements are held for financial assets that give rise to credit risk.

Cash and cash equivalents (note 13) and receivables (note 14) are subject to the expected credit loss model. The notes for these items provide relevant information on impairment.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings or to historical information about counterparty default rates.

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Counterparties with credit ratings				
Cash and cash equivalents				
AA	58	48	58	48
AA-	8,756	6,496	-	(1,359)
Total cash and cash equivalents	**8,814**	**6,544**	**58**	**(1,311)**
Counterparties without credit ratings				
New Zealand Health Partnership Limited	(35,996)	(9,518)	(35,996)	(9,518)
Receivables				
Counterparty with no defaults in the past	47,933	50,332	47,906	50,302
Counterparty with defaults in the past	424	261	424	261
Total receivables – credit impaired	**48,357**	**50,593**	**48,330**	**50,563**

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 loan facilities.

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 2019 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
Loans from Energy Efficiency and Conservation Authority	76	76	30	31	15	-	-
Finance Leases	290	290	60	60	170	-	-
Trade and other payables	77,959	77,959	77,959	-	-	-	-
	78,325	**78,325**	**78,049**	**91**	**185**	**-**	**-**

	Parent 2019 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
Loans from Energy Efficiency and Conservation Authority	76	76	30	31	15	-	-
Finance Leases	290	290	60	60	170	-	-
Trade and other payables	77,944	77,944	77,944	-	-	-	-
	78,310	**78,310**	**78,034**	**91**	**185**	**-**	**-**

27. Financial instruments (continued)

	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
Loans from Energy Efficiency and Conservation Authority	169	169	47	47	75	-	-
Finance Leases	510	510	110	110	290	-	-
Trade and other payables	67,236	67,236	67,236	-	-	-	-
	67,915	**67,915**	**67,393**	**157**	**365**	**-**	**-**

	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
Loans from Energy Efficiency and Conservation Authority	169	169	47	47	75	-	-
Finance Leases	510	510	110	110	290	-	-
Trade and other payables	67,221	67,221	67,221	-	-	-	-
	67,900	**67,900**	**67,378**	**157**	**365**	**-**	**-**

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.

Fair value interest rate sensitivity analysis

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market interest rates.

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 2019, it is estimated that a general increase of one percentage point in interest rates would decrease the group surplus by approximately $47,146 (2018: $30,000) with an equivalent impact on net value of the financial instrument.

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 (2018: $ 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.

28. 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.

29. 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 $1.33 billion (2018:$1.24 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2019 was $22.8 million (2018:$21.9 million). Waikato DHB incurred a capital charge of $34.1 million (2018:$37.1 million) to the Government during the year.

Identity of related parties

Waikato DHB has a related party relationship with the Waikato Health Trust, HealthShare Limited, New Zealand Health Partnership Limited and with its Board members. Transactions with the Waikato Health Trust, HealthShare Limited and New Zealand Health Partnership 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 2019 of $15.7 million (2018:$17.0 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 2019 was $138.8 million (2018:$135.7 million). Expenditure to other DHBs for their care of patients from Waikato DHBs district for the year ended 30 June 2019 was $63.5 million (2018:$61.1 million).

Collective, but not individually significant, transactions with government-related entities

In conducting its activities, Waikato DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies is based on the standard terms and conditions that apply to all tax and levy payers. Waikato DHB is exempt from paying income tax.

Waikato DHB also purchased goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended the 30 June 2019 totalled $19.0 million (2018 $17.2 million). These purchases included the purchase of electricity from Genesis and Merdian 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 2019, HealthShare Limited had total assets of $26.525 million (2018:$21.044 million) and total liabilities of $24.309 million (2018:$19.168 million). During the year Waikato DHB received $1,823,000 (2018: $1,030,000) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $7,150,000 (2018:$6,019,000) for services provided.

As at 30 June 2019 Waikato DHB owed HealthShare Limited $691,000 (2018: $54,000) and HealthShare Limited owed Waikato DHB $684,000 (2018: $874,000).

The Group's investment in HealthShare Limited has been accounted for using the equity method.

29. Related parties (continued)

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 2019 are Andrew McCurdie, Lydia Aydon and Prof Margaret Wilson. 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 $0.899 million (2018:$0.527 million). There was $Nil owing to Waikato DHB at 30 June 2019 (2018:$Nil).

NZ Health Partnerships Limited

NZ Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2018:6,948,005) shares being 10.17% (2018:10.17%). Waikato DHB does not have a controlling interest in New Zealand Health Partnership Limited.

30. 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 follows:

Compensations

There were no loans to board members during the year ended 30 June 2019 (2018:$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 2019 (2018:$Nil).

Remuneration

Key management includes the commissioners, Board and executive management including the chief executive. Key management compensation for the period was as follows:

	2019 Actual	2018 Actual
Commissioner	$	$
Dr Karen Poutasi	30,138	-
Deputy Commissioners		
Andrew Connolly	6,000	-
Chad Paraone	6,000	-
Prof Margaret Wilson	4,565	-
	46,703	

Board members (to 8 May 2019)	2019 Actual $000	2018 Actual $000
Salaries and other short-term benefits	278	310
Contributions to superannuation schemes	-	-
Members	11	11
Executive management team		
Salaries and other short-term benefits	4,282	4,758
Contributions to superannuation schemes	138	174
Full-time equivalent members	13.6	17

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.

30. Key management personnel remuneration (continued)

Board members	No. of meetings eligible to attend 2019	No. of meetings actually attended* 2019	Remuneration 2019 Actual	2018 Actual
			$	$
Sally Webb (chair person)	20	15	46,938	46,321
Margaret Wilson (deputy chair)	9	7	22,123	-
Sally Christie	21	18	23,199	26,438
Crystal Beavis	17	16	23,699	27,000
Phillippa Mahood	14	14	22,949	26,250
Mary Anne Gill	14	20	22,699	26,250
Martin Gallagher	16	19	23,449	27,083
Sharon Mariu	17	13	23,386	27,353
Clyde Wade	24	21	24,011	27,520
Dave Macpherson	23	21	23,449	26,750
Tania Hodges	21	18	22,449	26,000
Bob Simcock	-	-	-	22,875
			278,351	**309,840**

* No. of meetings actually attended does not include committee meetings Board members voluntarily attended.

Non-Board members who attended committee meetings	No. of meetings eligible to attend 2019	No. of meetings actually attended* 2019	Remuneration 2019 Actual	2018 Actual
John McIntosh	4	3	750	1,000
Te Pora Thompson-Evans	11	10	2,500	2,000
David Slone	4	4	1,000	500
Paul Malpass	2	2	500	-
Christine Rankin	3	2	500	250
Judy Small	4	3	750	-
Fungai Mhlanga	3	1	250	500
Kahu McClintock	3	2	500	750
Ron Scott	3	2	500	250
Mark Arundel	4	3	750	750
Rob Vigor-Brown	4	-	-	750
Glen Tupuhi	7	3	750	1,000
Arama Chase	4	2	500	-
Mere Balzer	7	6	1,500	250
Tureiti Moxon	7	3	1,750	-
Janise Eketone	-	-	-	500
Anna Rolleston	-	-	-	500
			12,500	**9,000**

31. Termination payments to employees

During the year the Board made payments to 36 employees (2018:27) in respect of the termination of employment with Waikato DHB.

	2019 Actual $000	2018 Actual $000
Amount paid	1,043	1,301

32. Waikids early childhood centre – Waikato Hospital

	Group		Parent	
	2019 Actual $000	2018 Actual $000	2019 Actual $000	2018 Actual $000
Summary of transactions relating to Waikids:				
Subsidy funding – Ministry of Education	202	219	202	219
Equity funding – Ministry of Education	32	26	32	26
Other income	12	-	12	-
Personnel costs	(218)	(197)	(218)	(197)
Minor equipment purchases	(19)	(15)	(19)	(15)
Administration costs	(9)	(2)	(9)	(2)
Surplus/(Deficit) for the year	-	31	-	31
Accumulated surplus attributed to Waikato Early Childhood Centre				
Balance at 1 July	200	169	200	169
Surplus for year	-	31	-	31
Balance at 30 June	200	200	200	200

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.

Waikato DHB contributed to personnel costs to the extent of the work done in relation to inpatient care. $251,500 of the personnel costs are offset from the total of $470,000.

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 group deficit of $119.8 million against a budgeted deficit of $56.1 million. An unbudgeted increase in revaluation movement of $90.4 million brought the total comprehensive deficit for the year to $29.4 million

The total comprehensive result for the year is a variance of $26.7 million favourable to budget.

Explanations of major variances are:

Variances in comprehensive revenue and expenses

Waikato DHB recorded a $26.7 million favourable variance to budget. This includes:

- revenue is $23.1 million favourable mainly due to additional funding for extra health services delivered together with reimbursement of specific costs incurred (offset in expenses)
- personnel costs are $45.6 million unfavourable mainly due to the impact of the interpretation of the Holidays Act Memorandum of Understanding
- outsourced services and personnel are $18.2 million unfavourable mainly due to higher outsourcing to cover vacancies (offset in personnel) and cost of contractors to cover external projects (offset in revenue)
- infrastructure and non-clinical expenses are $21.4 million unfavourable mainly due to unachieved central high risk savings targets held in this area.
- other expenses are $1.6 million unfavourable due to variances against a wide range of costs
- other comprehensive revenue is $90.4 million favourable to budget due to the unplanned revaluation of land and buildings at year end resulting in an increase in the land and buildings revaluation reserve.

35. Explanation of financial variances from budget (continued)

Variances in statement of changes in equity

Total equity is $47.0 million unfavourable to budget. This includes:

- Crown equity is $73.4 million unfavourable to budget mainly due to lower than budgeted equity contribution received
- revaluation reserve is $90.4 million favourable due to unbudgeted increase in land and buildings values
- retained earnings is $64.3 million unfavourable due to deficit result as described above
- group trust funds are $0.4 million favourable mainly due to donations received exceeding grants compared to that budgeted.

Variances in financial position

Current assets are $1.7 million lower than budgeted due to the timing of transactions.

Non current assets are $18.9 million higher than budget mainly due to the impact of the revaluation of land and buildings $90.4 million offset by lower than planned capital spend $70.4 million.

Current liabilities are $73.5m higher than budget. This includes a lower cash balance due mainly to the unfavourable deficit result and lower than budgeted equity contribution and employee entitlements are higher than budget mainly due to the impact of the interpretation of the Holidays Act Memorandum of Understanding.

Non current liabilities are $9.3 million lower than budget due to the deferment of planned finance leases.

Variances in cash flows

- Net cash flows from operating activities are $20.1 million lower than budget due mainly to unfavourable deficit for the year as described above.
- Net cash outflows from investing activities are $72.3 million lower than budgeted due to deferment of planned capital spend.
- Net cash inflows from financing activities are $87.2 million lower than budgeted due to deferment of planned finance leases and lower than budgeted equity contribution received.

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 on 24 October 2018 by the Board.

In the current year, the statement of performance expectations relating to the year ended 30 June 2020 was approved by the commissioner on 27 June 2019 so the Waikato DHB is no longer in breach of the Act.

Part six: Audit report

Whaea Betty harvests harakeke for wahakura (safe sleep device) wānanga

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 2019

The Auditor-General is the auditor of Waikato District Health Board Group (the Group). The Auditor-General has appointed me, B H Halford, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 94 to 133, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on page 31 and 46 to 87.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the *Basis for our qualified opinion* section of our report:

- the financial statements of the Group on pages 94 to 133:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on page 31 and 46 to 87:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2019, 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 29 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Group being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Commissioners and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 19 on page 121, the Group has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Group has estimated a provision as at 30 June 2019 of $34.844 million to remediate these issues. However, until further work is undertaken by the Group, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Group is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 98 that outline the financial difficulties being experienced by the Group. The Group has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Group with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

Responsibilities of the Commissioners for the financial statements and the performance information

The Commissioners are 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 Commissioners are responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Commissioners are responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. The Commissioners are 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 Commissioners' 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 Commissioners.
- 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 Commissioners 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 Commissioners 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 Commissioners are responsible for the other information. The other information comprises the information included on pages 2 to 30, 32 to 45 and 88 to 93, 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

> When one of the surgeries didn't go as planned, Dr Kukkady was open and honest with us. He took the time to talk to me, making sure that as a parent, my input in Maanas's care was appreciated.
>
> He would say 'you know him best so you tell me how he is feeling today'. It is so important to feel heard, especially when you have a special needs child who can't talk.

Maanas's mother

Waikato Hospital staff stand together for campaign against violence and abuse toward staff

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
ARC	Aged Residential Care
ASH	Ambulatory Sensitive Hospital Admissions • Hospital admissions that are considered as avoidable
CCM	Certified Care Manager Nurse
CHF	Community Health Forum
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CPHAC	Community and Public Health Advisory Committee
CT	Computed Tomography
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
DAP	District Annual Plan
DHB	District Health Board
DMFT	Decayed Missing and Filled teeth
DNA	Did Not Attend • When a patient does not attend their scheduled appointment without notification
DSAC	Disability Services Advisory Committee
DSS	Disability Support Sservice
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
HR	Human Resources
HSP	(Waikato) Health System Plan, Te Korowai Waiora
HWAC	Health Waikato Advisory Committee
iHub	Hauora ihub • A welcoming place for health and wellbeing information, advice, and some opportunistic health services. Located on level one of the Meade Clinical Centre, Waikato Hospital
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

Acronym	Meaning
LMC	Lead Maternity Carer
LOS	Length of Stay
MCC	Meade Clinical Centre (Waikato Hospital)
MDS-HC	Minimum Dataset Homecare Assessment Tool
MHAS	Mental Health and Addictions Service
MHN	Midland Health Network
MOH	Ministry of Health
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MWOK	Manawanui Whai Ora Kaitiaki (RN and kaiawhina linked to GP to support complex diabetic patients)
NASC	Needs Assessment and Service Coordination
NES	National Enrolment Service
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
NIR	National Immunisation Register
NRT	Nicotine Replacement Therapy
NZPHD	New Zealand Public Health and Disability Act 2000
OPR	Older Persons and Rehabilitation
OARS	Outpatient Appointment Reminder System
PHN	Public Health Nurse
PHO	Primary Health Organisation
RN	Registered Nurse
RSP	Regional Service Plan
SLA	Service Level Agreement
SLAT	Service Level Alliance Team
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
START	• Support Transfer and Rehabilitation Team
TLA	• Territorial Local Authority
TPO	• Te Puna Oranga (Waikato DHB Māori Health)

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