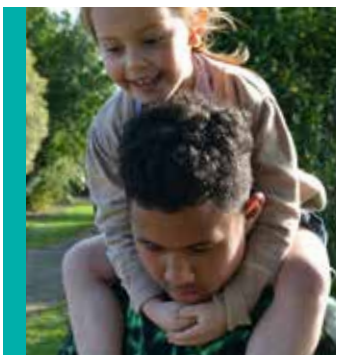
Waikato District Health Board

2019/20 ANNUAL REPORT

For the year ended 30 June 2020

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

Waikato District Health Board



Statement of responsibility for the year ended 30 June 2020

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 2019/20 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 2019/20 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 (Annual Plan, Statement of Performance Expectations and Annual Report) are available on our website at: www.waikatodhb.health.nz/key-publications-and-policies

The commissioner team and the management of Waikato DHB accept responsibility for the preparation of the financial statements, the statement of performance, including the performance information for an appropriation under section 19A of the Public Finance Act 1989, and for the judgements made in them.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting.

In our opinion these financial statements and the performance information fairly reflects the financial position and operations of Waikato DHB for the year ended 30 June 2020.

Signed by:

Dame Karen Poutasi
Commissioner
Waikato District Health Board
16 December 2020

Prof. Margaret Wilson
Deputy Commissioner
Waikato District Health Board
16 December 2020

Mihi

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

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

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

'Tūturu whakamaua kia tina!'

'Tina!'

'Haumi e; hui e!'

'Taiki e!'

A brief explanation of the mihi

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

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

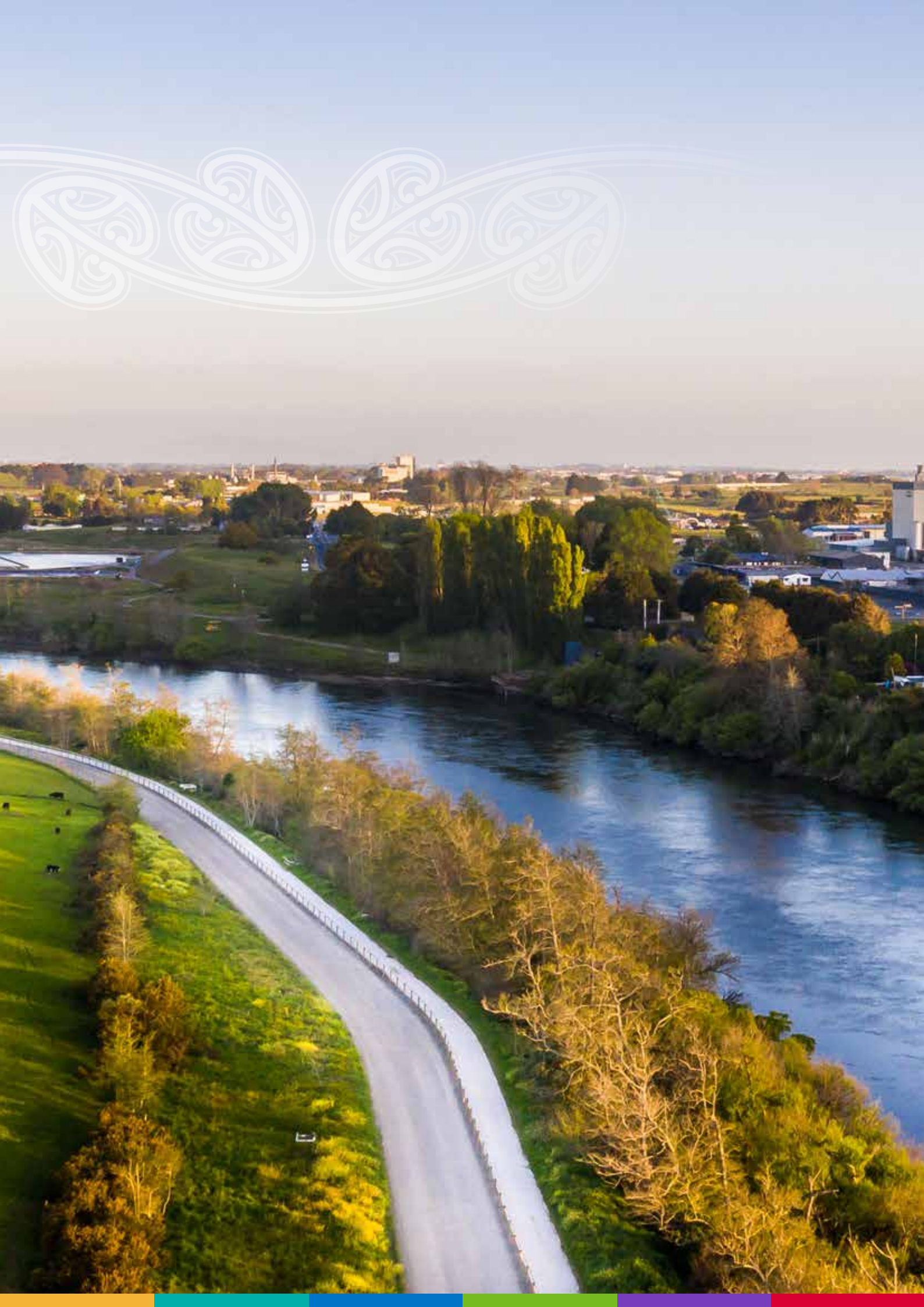
Confirms that what follows is the Waikato DHB annual report for public scrutiny, thus confirming an old saying, which translates, in this case, as:

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

'It shall be done!'

'Gather it together; weave everything together!'

'It is accomplished!'



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

Dame Karen Poutasi
Commissioner

Dr Kevin Snee
Chief Executive

Paimārire.
He honore, he kororia ki te Atua
He Maungarongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Tae noa ki te Kiingi Tuheitia me te whare Arikinui tonu
Nā te Atua e tiaki e manaaki ki a rātou hei manaaki
E huri ki ngā mate huhua o te wā ara o koutou o tātau hoki
Haere rātou ki tua o te ārai haere, haere, haere atu rā
Nō reira!
E Rau rangatira ma e mihi mahana tēnei ki a koutou
Kaua wareware ko te nuinga mō tātou ko ā tātou iwi, e panaia te waka ki mua e mahia te mahi e hapai ana a tātou iwi ahakoa ngā piki me ngā heke ahakoa te huarahi tāpokopoko.
Tēnā koutou, tēnā koutou, tēnā tātou katoa.

Waikato DHB has maintained its focus on equity, access, locality development, primary care partnerships, quality of care and financial responsibility. To achieve this was notable during what has been an unprecedented year for the healthcare sector. The Whakaari/White Island eruption and COVID-19 pandemic each required a response from us which combined the substantial efforts of many individuals with extensive coordination and collaboration between iwi, communities, healthcare providers and government.

Across both events we have been hugely proud of our healthcare workers as they have demonstrated their expertise and dedication to ensuring our communities have the support and care they need. As it is expected this pandemic will have an ongoing impact on our operations and community, it is important we maintain a sustainable approach which takes into account the additional demand on healthcare workers, while retaining our ability to scale our response as required. We have been grateful for the support of our community and the way Waikato residents have closely followed the guidance of health experts in our response to the pandemic. We are also grateful for the close working relationships between government agencies in a united response.

It is difficult to measure the comprehensive financial impact of the pandemic on the DHB to date. There are direct and ongoing costs which can be clearly measured such as the redeployment of staff and resources to combat the virus through activities such as testing. There are also indirect costs which are harder to measure but nonetheless are of importance.

We ended the year by confirming a considerable achievement, delivering the planned deficit of $72.4 million. While this remains a significant deficit, it also marks a strong improvement from the previous year and the reversing of a trend which had seen growing deficits over successive years. This shows the organisation has developed its understanding of its operations to support accurate budget setting, alongside the discipline and capability to deliver on our strategic objectives necessary to achieve this result while maintaining services. The DHB will continue its drive on a return to a sustainable model in out-years.

Work continues to boost the DHB's capability in delivering to our objectives and a significant development this year was the creation of new executive leadership roles.

The executive was reduced to just 10 members with a simplified structure offering greater clarity of roles, accountability and alignment between teams.

As described in its Health System Plan, Te Korowai Waiora, the DHB is committed to radically improving Māori health and achieving equitable health outcomes for everyone in our Waikato community. The recent appointment of our executive director Māori Equity and Health Improvement and commitment to increasing the DHB's Māori workforce are critical steps to building a partnership model to drive equity.

Te Korowai Waiora, adopted in August 2019, sets a 10-year pathway to create a healthcare system which works for our communities and improves health outcomes, particularly for Māori. Key to this is a locality approach to strengthen access, address service gaps, and enhance primary and community care services. We have held numerous community forums to facilitate engagement on local health issues and to hear from communities on their experience of COVID-19.

The pandemic provided opportunities to rapidly build on our partnerships with iwi and Māori organisations. We worked together to deploy testing and assessment centres which also offered vaccine and health check services, targeting areas which have historically been underserved. This resulted in testing equity across most districts and record rates of immunisation for kaumātua and tamariki. We are committed to growing and expanding our partnerships across the spectrum of healthcare planning and delivery. This includes all underserved populations notably Māori, Pacific peoples and rural populations.

Mental Health and Addictions services continue to face high demand and we welcomed the Government's $100 million funding approval for a new acute mental health facility for Waikato. It is an opportunity to create a purpose-built facility with design informed by service users, whānau and a range of service providers. We are also working to enhance our community mental health and acute alternative facilities to reduce demand for hospital-level care, and to improve access and outcomes for service users who benefit from treatment options in the community. $4.5 million was committed to the provision of additional mental health services over the year.

The COVID-19 pandemic will continue to create challenges and we remain grateful to our staff, partners and Waikato residents for how they have responded together as a community.

The DHB has set ambitious targets for the coming year to improve healthcare services in the Waikato and continue on our path to a sustainable operating model. As we set our sights on achieving those goals our priority remains the support and care of our people.

Dame Karen Poutasi

Commissioner
Waikato DHB

Date: 16 December 2020

Dr. Kevin Snee

Chief Executive
Waikato DHB

Date: 16 December 2020

Commissioner interests

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.

As of 8 May 2019 our Board was replaced by a commissioner appointed by the Minister of Health. The commissioner is responsible to the Minister of Health and will remain until the next local election in 2022.

The commissioner appointed three deputy commissioners as per s31 (3) of the New Zealand Public Health and Disability Act 2000

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

Agendas and minutes of commissioner meetings are not publically available.

Dame Karen Poutasi

Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Deputy Chair, Network for Learning
- Daughter, Consultant Hardy Group
- Son, Health Manager, Worksafe

Mr Andrew Connolly

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Chair, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Board member, Health Quality and Safety Commission
- Southern Partnership Group
- Employee, Counties Manukau DHB
- Member, Health Workforce Advisory Board
- Crown Monitor, Southern DHB
- Member, Planned Care Advisory Group, Ministry of Health

Mr Chad Paraone

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Independent Chair, Bay of Plenty Alliance Leadership Team
- Independent Chair, Team Rotorua Alliance Leadership Team
- Independent Chair, Integrated Community Pharmacy Services Agreement National Review
- Strategic Advisor (Māori) to CEO, Accident Compensation Corporation
- Māori Health Director, Precision Driven Health
- Board member, Sport Auckland
- Committee of Management Member and Chair, Parengarenga A Incorporation
- Director/Shareholder, Finora Management Services Ltd

Prof. Margaret Wilson

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Chair, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Member, Waikato Health Trust
- Co-chair, Waikato Plan Leadership Group

> Experiencing two exceptional midwives helped me physically, emotionally and mentally, they were wonderful and I felt loved and respected for my family and my son.

Kay, obstetric patient, June 2020

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 2020. 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 2019/20.

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 2019/20 year, we received approximately $1.4 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 2019/20 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 healthcare 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 29 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 Te Manawa Taki 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:

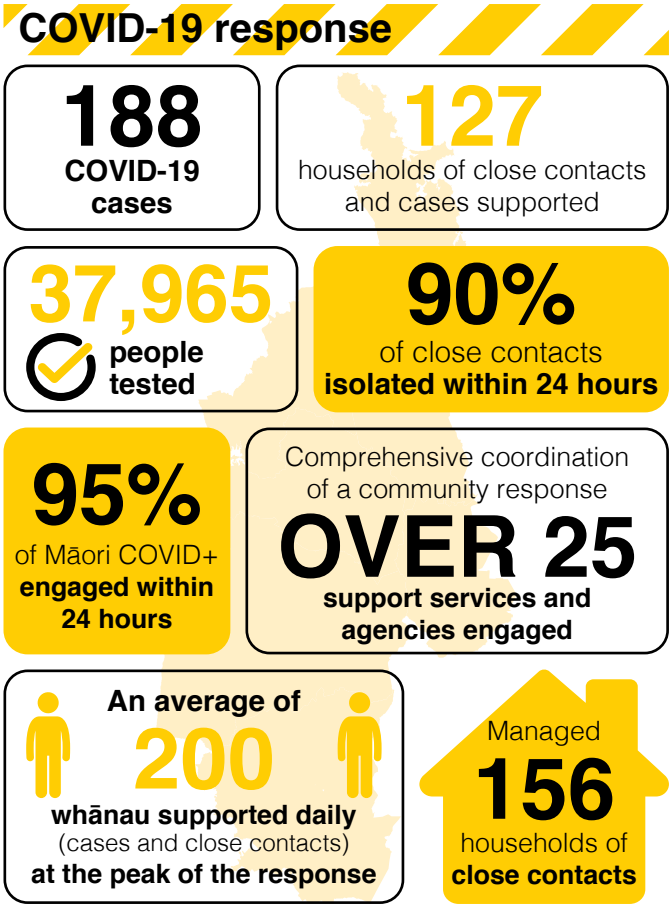
- emergency department providing 24-hour care for people with serious illness or injury
- x-ray and laboratory services for seriously ill patients (24 hours a day, seven days a week) and for planned hospital visits Monday to Friday
- inpatient unit, maternity unit, maternity centre, day unit
- outpatient clinics for a wide range of services including orthopaedics, medicine, surgery, paediatrics and women's health.

COVID-19 response

Through the major events of the Whakaari/ White Island eruption and the COVID-19 pandemic we saw the individual commitment and ability of so many healthcare workers backed by the support of our iwi and community.

The COVID-19 pandemic was an unprecedented event which required a national response and confirmed for us the importance of a focus on our localities and access. It will almost certainly remain a dynamic situation in the future, with our response requiring regular review and flexibility. Lockdown requirements led to many elective procedures being deferred and ensuring all those affected can receive timely treatment is a vital piece of work for 2020/21. The response also brought positive developments in how we work with our community and partners to ensure a unified and inclusive approach. Initiatives to improve equity of access accelerated such as Telehealth and mobile services to provide testing and vaccinations to rural areas.

Snapshot of activity during the first wave of the COVID-19 pandemic



The partnership approach was evident in the COVID-19 pandemic response, a Māori liaison officer and Pacific people's liaison officer were key to providing culturally appropriate care and support, working with local iwi and providers to ensure we worked as one team to deliver mobile assessment and testing services coupled with health and welfare checks and vaccine services. Another key partner has been Civil Defence, an electronic dashboard was set up within 24 hours of the first confirmed case. This was vital to sharing up-to-date information across the DHB and Civil Defence.

Also central to the COVID-19 response has been the Waikato DHB Public Health unit who not only completed contact tracing but offered support to providers by advising how to operate safely and helping organisations manage when outbreaks or clusters were detected.

During the first COVID-19 wave (18 March to 22 April 2020) the Waikato Public Health team notified the 188 confirmed cases of their result, along with members of their household and close contacts. 'Daily checks' were then made to these people which resulted in an average of 200 daily calls being made to check on every symptom and reassure whānau who were often very scared. These calls on average take an hour, especially when there are multiple people to talk to in each household. This contact was vital and over time the daily checks became more familiar, with some people saying it became part of their family bubble.

Our vision

Waikato DHB published its strategy with the vision of "Healthy people. Excellent care."
This encompasses our aspiration, that people will stay healthy and live healthy lives in their community. However, if care is required it will be easy to get to, be consistently good and user friendly.

This vision identified the need for transformative innovation causing significant change. It calls for a move away from thinking about hospitals as the most important part of the health system to thinking about care that meets the needs of people, provided closer to where people live. To achieve Waikato DHB's vision, health and social care must be well connected, coordinated and cohesive.

Our strategic imperatives and priorities

The strategy describes the organisation as part of a wider health and social system, outlining six key strategic imperatives. 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 our focus. 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.

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

WAIKATO Health System Plan Te Korowai Waiora

A plan to improve the health and wellbeing of people of the Waikato

The Waikato Health System Plan, Te Korowai Waiora, was adopted in August 2019 and sets out a 10-year direction to help us improve our health services to better the health and wellbeing of the people of the Waikato.

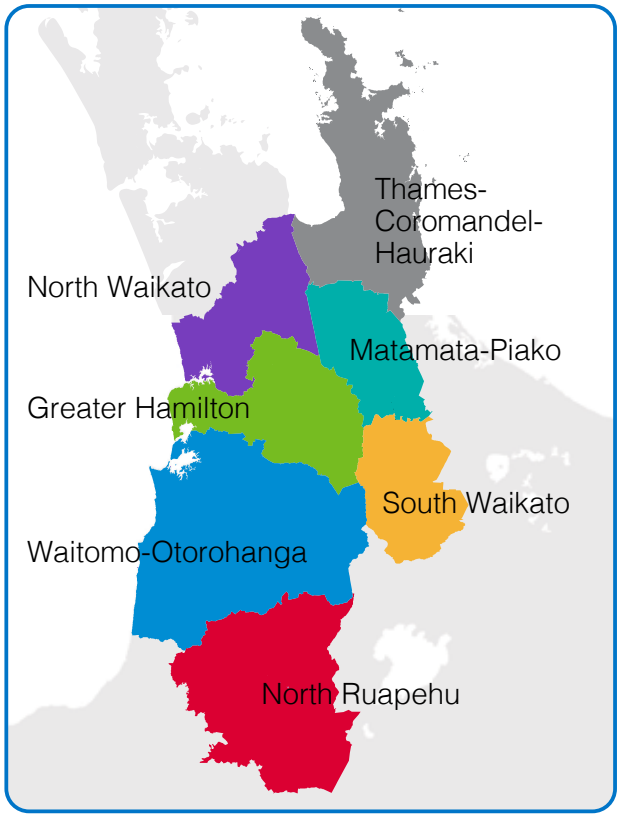
Te Korowai Waiora puts people at its heart. It describes a vision where every person and whānau in the Waikato has the opportunity to reach their full health potential. It identifies key actions the Waikato health system can take to work as one cohesive, integrated and coordinated health sector and involve the community and whānau/families in its planning and delivery. Te Korowai Waiora translates the Waikato DHB vision of Healthy people. Excellent care into a set of seven goals that all our activity will align to.

Te Korowai Waiora		
Seven goals		Examples of 2019/20 achievements
goal 1	Partner with Māori in the planning and delivery of health services	The appointment of the executive director Māori Equity and Health Improvement is a crucial step, as is the commitment to increase the DHB's Māori workforce under the He Korowai Oranga – Māori Health Action Plan. The partnership approach was evident in the COVID-19 pandemic response as the DHB worked with iwi and Māori organisations to deliver mobile assessment and testing services coupled with health and welfare checks and vaccine services. That this approach allowed us to achieve testing equity across the majority of districts and significantly higher immunisation rates for kaumātua and tamariki than ever before is a testament to the value of partnership.
goal 2	Empower whānau to achieve wellbeing	Ki te Taumata o Pae Ora, the Waikato DHB Māori Health Strategy was refreshed, adopting the Hauora WAI2575 Report Treaty Principles of partnership, active protection, equity and options. The move to adopt the Hauora Report te Tiriti principles is a critical indicator of our pathway forward. Waikato DHB has been working to improve the quality of our ethnicity data collection and reporting. Nearly all measures are now monitored by ethnicity. This enables the reconfiguring of services to ensure we deliver high quality health care meeting the needs of Māori and other groups where inequity has been proven.
goal 3	Support community aspirations to address the determinants of health	Participating in the 'Vibrant Safe Waitomo' joint leadership programme. Waikato DHB has been actively engaged with the 'Waikato Plan' and is supporting the key agreed priorities of mental health and wellbeing, housing, and the establishment of Waikato Wellbeing targets and goals.
goal 4	Improve access to services	Through COVID-19 some initiatives to improve equity of access were accelerated, such as Telehealth and mobile services to provide testing and vaccinations to rural areas. The mobile immunisation outreach service will be enhanced and expanded in 2020/21. Our Waikato DHB Consumer Council and the newly formed Clinical Equity Leadership Group have started, and will continue to work on the Telehealth Programme and co-develop and implement the DHB's Digital strategy.

goal 5	Enhance the capacity and capability of primary and community health care	The Waikato Primary and Community Health Care Alliance was re-established and began regular meetings, the Alliance will oversee a work programme to enhance and broaden the use of the primary care workforce. The Community Based Attachment Programme (CBA, Health Workforce NZ) started with 10 resident medical officers (RMOs) providing GP training that will enhance capability, capacity and supports the shared care approach.
goal 6	Strengthen intermediate care	The Whānau Pai Collaborative was developed by Māori, Pacific, PHOs and other NGO services will provide a Māori for all approach that seeks to provide earlier and more responsive primary mental health and addiction supports and outcomes for whānau. Implementation starts in Q1 2020/21.
goal 7	Enhance the connectedness and sustainability of specialist care	2019/20 is a turning point for the DHB, reversing the trend of increasing deficits and beginning on a new path towards surplus, investment and sustainability. A strengthened financial position underpins all DHB activity and has a positive impact on our daily operations as well as our ability to plan and prepare for the future.

The locality approach

Te Korowai Waiora recognises the locality approach as a key enabler of system transformation. Understanding locality needs will inform new models of care and ensure we are delivering the right service, at the right time, by the right people. The locality approach ensures services are designed and delivered in a way that focuses on closing the equity gap for Māori, Pacific and other populations that experience inequities. Having services delivered locally to where people live will improve access, in addition, the use of technologies such as telemedicine will improve efficiency.



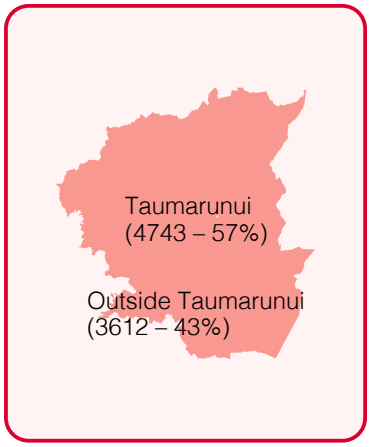
In early 2020, profiles were developed for each locality that outline the demographic profile, service utilisation and health outcomes (see pages 18-25).

Locality development has four key objectives:

1. To ensure equity of access to health and wellbeing services
2. To ensure the appropriate service mix in each locality with respect to what is provided locally and what can be accessed through district-wide services, minimising the requirement for travel where possible
3. To introduce or strengthen health system enablers to ensure the provision of health services into local communities is sustainable. These include rural workforce development, telemedicine and transport.
4. To support communities in the development of their own capacity with respect to community activity that supports good health and wellbeing.

We are planning to fund a locality project manager in each high need rural locality, to be employed by iwi or an NGO. The purpose of this role is to enable local capacity, with local relationships, to work with the DHB in the coordination and implementation of service changes. This will include addressing the service gaps and implementing locally developed responses.

North Ruapehu – a snapshot



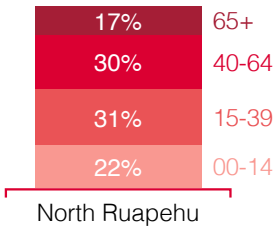
People

2% of Waikato DHB population live in North Ruapehu

8355 people live in North Ruapehu

-11.5% is the population change in the next 10 years

North Ruapehu has a slightly older population than the rest of the Waikato



High deprivation (living in dep 9 and 10)

59% of North Ruapehu

72% of Māori living in high deprivation

43% of North Ruapehu identify as Māori

2% of North Ruapehu identify as Pacific

Health and wellbeing

North Ruapehu's mortality rate is **1.1** times greater than the rest of the Waikato DHB

Cause of death

84% of North Ruapehu residents are enrolled in a Waikato DHB general practice

(85% Māori and 84% non-Māori)

78% of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are **3.57** mental health admissions a year in North Ruapehu, slightly higher than the rest of Waikato DHB at 3.35

2% of mental health admissions are from North Ruapehu

Location of death of 65+ year olds in North Ruapehu

40% Home	54% Hospital	6% Rest home	0.5% Hospice
33%	33%	31%	3% Waikato

Hospitalisations per capita for North Ruapehu residents is nearly **1.4** times the rate of the Waikato DHB, and Māori are hospitalised **1.3** times more than non-Māori

ED presentations per capita of North Ruapehu residents is **2** times the rate of the Waikato DHB and Māori present at **1.1** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (543)
2. General surgery (102)
3. Orthopaedic surgery (74)

Outpatient appointments at Waikato Hospital

1. Plastic surgery (416)
2. Oncology (359)
3. Opthalmology (341)

Outpatient **DNA rates** at Waikato Hospital

1. Diabetology (42%)
2. General medicine (25%)
3. Neurosurgery (20%)

Mothers smoking at first registration with LMC

Māori	Pacific	All
53%	53%	39%

Fully immunised at 1 year old

Māori	Pacific	All
84%	100%	84%

Laboratory tests per person per annum

4.9
6.6 Waikato

Pharmaceutical items per person per annum

9.7
9.7 Waikato

65+ year olds needing **complex home and community support services**

7.2% North Ruapehu

5.6% Waikato

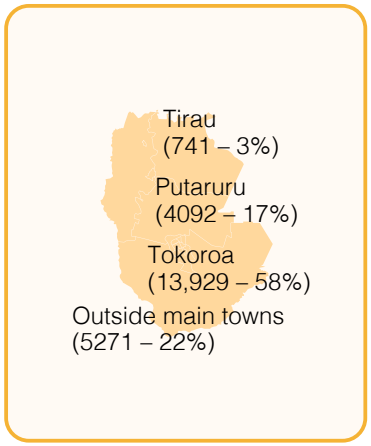
Workforce
GP FTEs per 100,000 population

39 North Ruapehu

59 Waikato

67 New Zealand

South Waikato – a snapshot



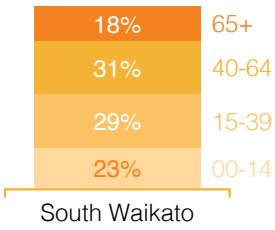
People

6% of Waikato DHB population live in South Waikato

24,033 people live in South Waikato

-2.8% is the population change in the next 10 years

South Waikato has a slightly older population than the rest of the Waikato



High deprivation (living in dep 9 and 10)

64% of South Waikato

78% of Māori living in high deprivation

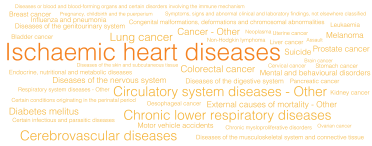
34% (8101) of South Waikato identify as Māori

13% (3129) of South Waikato identify as Pacific

Health and wellbeing

South Waikato's mortality rate is **1.4** times greater than the rest of the Waikato DHB

Cause of death

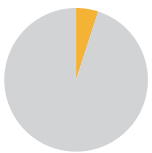


93% of South Waikato residents are enrolled in a Waikato DHB general practice

(95% Māori and 91% non-Māori)

80% of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are **3.07** mental health admissions a year in South Waikato, slightly lower than the rest of Waikato DHB at 3.35



5% of mental health admissions are from South Waikato

Location of death of 65+ year olds in South Waikato

52% Home **33%**

38% Hospital **33%**

9% Rest home **31%**

1% Hospice **3%** Waikato

Hospitalisations per capita for South Waikato residents is nearly **1.4** times the rate of the Waikato DHB, and Māori are hospitalised **2** times more than non-Māori

ED presentations per capita of South Waikato residents is **2** times the rate of the Waikato DHB, and Māori present at **1.6** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (1028)
2. General surgery (370)
3. Paediatric medicine (203)

Outpatient appointments at Waikato Hospital

1. Ophthalmology (1320)
2. Plastic surgery (955)
3. Allied Health + other (900)

Outpatient **DNA rates** at Waikato Hospital

1. Paediatric surgery (25%)
2. Gastroenterology (16%)
3. Geriatric rehabilitation (16%)

Mothers smoking at first registration with LMC

Māori	Pacific	All
32%	26%	24%

Fully immunised at 1 year old

Māori	Pacific	All
88%	92%	90%

Laboratory tests per person per annum

5.8 **6.6** Waikato

Pharmaceutical items per person per annum

10.4 **9.7** Waikato

65+ year olds needing **complex home and community support services**

7.5% South Waikato

5.6% Waikato

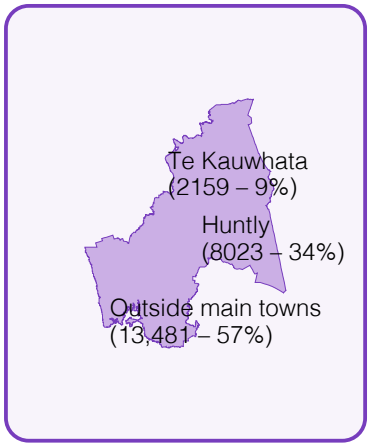
Workforce GP FTEs per 100,000 population

40 South Waikato

59 Waikato

67 New Zealand

North Waikato – a snapshot



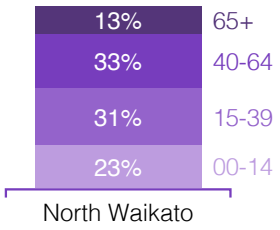
People

6%
of Waikato DHB population
live in North Waikato

23,663
people
live in North Waikato

+9.9%
is the population change in the
next 10 years

North Waikato has a slightly younger population
than the rest of the Waikato



High deprivation (living in dep 9 and 10)

36%
of North Waikato

56%
of Māori living in high deprivation

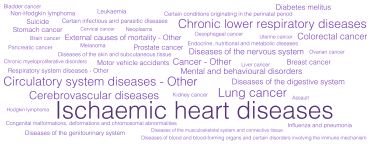
32%
of North Waikato identify as
Māori

5%
of North Waikato identify as
Pacific

Health and wellbeing

North Waikato's
mortality rate is
1.1 times greater
than the rest of the Waikato DHB

Cause of death

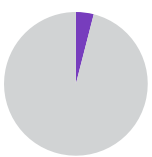


81%
of North Waikato residents are enrolled in a Waikato DHB general practice
(87% Māori and 78% non-Māori)

79%
of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are

2.66 mental health admissions
a year in North Waikato, lower than the rest of Waikato DHB at 3.35



4% of mental health admissions
are from North Waikato

Location of death of 65+ year olds in North Waikato

31% Home
33%

27% Hospital
33%

39% Rest home
31%

3% Hospice
3% Waikato

Hospitalisations
per capita for North Waikato residents is nearly **1.2** times the rate of the Waikato DHB, and Māori are hospitalised **1.7** times more than non-Māori

ED presentations
per capita of North Waikato residents is **0.7** times the rate of the Waikato DHB, and Māori present at **1.5** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (510)
2. General surgery (328)
3. Paediatric medicine (251)

Outpatient appointments
at Waikato Hospital

1. Allied Health + other (1738)
2. Orthopaedic surgery (1338)
3. Opthalmology (1332)

Outpatient **DNA rates**
at Waikato Hospital

1. Paediatric surgery (28%)
2. General medicine (25%)
3. Pain management (22%)

Mothers smoking at first registration with LMC

Māori **35%** All **22%**

Fully immunised at 1 year old

Māori **90%** Pacific **100%** All **91%**

Laboratory tests per person per annum

6.9
6.6 Waikato

Pharmaceutical items per person per annum

10.2
9.7 Waikato

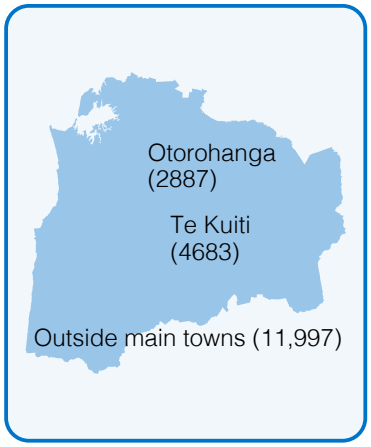
65+ year olds needing **complex home and community support services**

4.7%
North Waikato
5.6% Waikato

Workforce
GP FTEs per 100,000 population

42
North Waikato
59 Waikato
67 New Zealand

Waitomo-Otorohanga – a snapshot



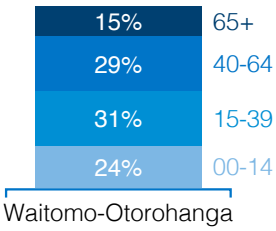
People

5%
of Waikato DHB population
live in Waitomo-Otorohanga

19,567
people
live in Waitomo-Otorohanga

-2.1%
is the population change in the
next 10 years

Waitomo-Otorohanga has a slightly younger population
than the rest of the Waikato



High deprivation (living in dep 9 and 10)

41%
of Waitomo-Otorohanga

56%
of Māori living in high deprivation

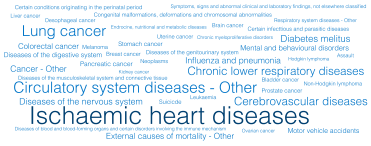
36%
of Waitomo-Otorohanga identify as
Māori

3%
of Waitomo-Otorohanga identify as
Pacific

Health and wellbeing

Waitomo-Otorohanga's
mortality rate is
1.2 times greater
than the rest of the Waikato DHB

Cause of death



93%
of Waitomo-Otorohanga residents are enrolled in a Waikato DHB general practice
(87% Māori and 78% non-Māori)

For every 1000 people, there are

3.27 mental health admissions
a year in Waitomo-Otorohanga, lower than the rest of Waikato DHB at 3.35

5% of mental health admissions
are from Waitomo-Otorohanga

Location of death of 65+ year olds in Waitomo-Otorohanga

38% Home
33%

35% Hospital
33%

24% Rest home
31%

3% Hospice
3% Waikato

Hospitalisations per capita for Waitomo-Otorohanga residents is nearly **1.0** times the rate of the Waikato DHB, and Māori are hospitalised **1.5** times more than non-Māori

ED presentations per capita of Waitomo-Otorohanga residents is **0.8** times the rate of the Waikato DHB, and Māori present at **1.5** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (678)
2. General surgery (210)
3. Orthopaedic surgery (166)

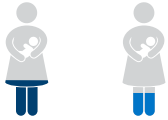
Outpatient appointments
at Waikato Hospital

1. Orthopaedic surgery (978)
2. Opthalmology (895)
3. Allied Health (865)

Outpatient **DNA rates**
at Waikato Hospital

1. Dental surgery (24%)
2. Paediatric surgery (20%)
3. Pain management (19%)

Mothers smoking at first registration with LMC



Māori **33%** | All **19%**

Fully immunised at 1 year old

Māori **84%** | Pacific **92%** | All **85%**

Laboratory tests per person per annum

5.7
6.6 Waikato

Pharmaceutical items per person per annum

9.2
9.7 Waikato

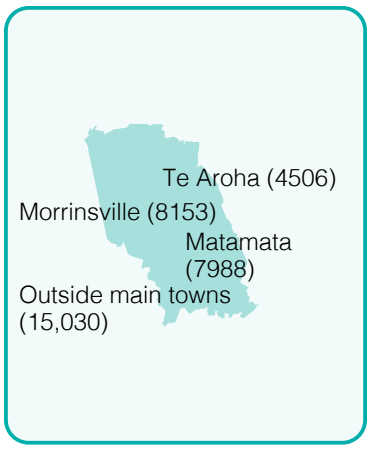
65+ year olds needing **complex home and community support services**

5.3%
Waitomo-Otorohanga
5.6% Waikato

Workforce
GP FTEs per 100,000 population

48
Waitomo-Otorohanga
59 Waikato
67 New Zealand

Matamata-Piako – a snapshot



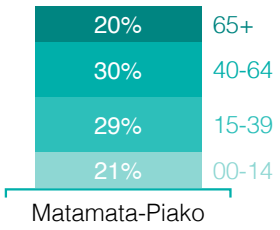
People

8% of Waikato DHB population live in Matamata-Piako

35,677 people live in Matamata-Piako

+4.4% is the population change in the next 10 years

Matamata-Piako has an older population than the rest of the Waikato



High deprivation (living in dep 9 and 10)

11% of Matamata-Piako

22% of Māori living in high deprivation

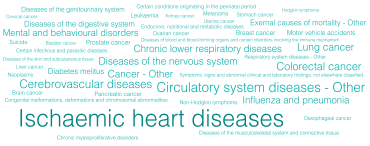
17% of Matamata-Piako identify as Māori

2% of Matamata-Piako identify as Pacific

Health and wellbeing

Matamata-Piako's mortality rate is **0.8** times greater than the rest of the Waikato DHB

Cause of death

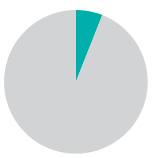


94% of Matamata-Piako residents are enrolled in a Waikato DHB general practice

(84% Māori and 96% non-Māori)

76% of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are **2.34** mental health admissions a year in Matamata-Piako, lower than the rest of Waikato DHB at 3.35



6% of mental health admissions are from Matamata-Piako

Location of death of 65+ year olds in Matamata-Piako

32% Home	43% Hospital	23% Rest home	2% Hospice
33%	33%	31%	3% Waikato

Hospitalisations per capita for Matamata-Piako residents is nearly **0.9** times the rate of the Waikato DHB, and Māori are hospitalised **1.3** times more than non-Māori

ED presentations per capita of Matamata-Piako residents is **0.6** times the rate of the Waikato DHB, and Māori present at **1.2** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (886)
2. General surgery (428)
2. Paediatric medicine (310)

Outpatient appointments at Waikato Hospital

1. Allied Health (2427)
2. Orthopaedic surgery (2087)
3. Opthalmology (2029)

Outpatient **DNA rates** at Waikato Hospital

1. Paediatric surgery (24%)
2. Pain management (21%)
3. Neurosurgery (12%)

Mothers smoking at first registration with LMC

Māori	Pacific	All
28%	6%	16%

Fully immunised at 1 year old

Māori	Pacific	All
90%	100%	91%

Laboratory tests per person per annum

6.3
6.6 Waikato

Pharmaceutical items per person per annum

8.9
9.7 Waikato

65+ year olds needing **complex home and community support services**

6.1% Matamata-Piako

5.6% Waikato

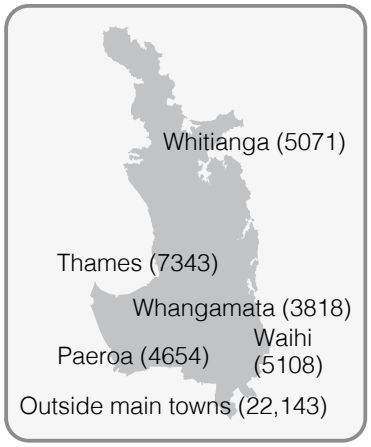
Workforce
GP FTEs per 100,000 population

53 Matamata-Piako

59 Waikato

67 New Zealand

Thames-Coromandel-Hauraki – a snapshot



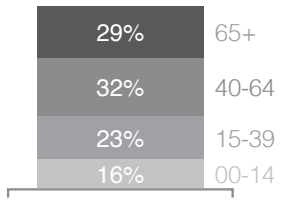
People

11% of Waikato DHB population live in Thames-Coromandel-Hauraki

48,137 people live in Thames-Coromandel-Hauraki

+0.9% is the population change in the next 10 years

Thames-Coromandel-Hauraki has a much older population than the rest of the Waikato



High deprivation (living in dep 9 and 10)

30% of Thames-Coromandel-Hauraki

42% of Māori living in high deprivation

20% of Thames-Coromandel-Hauraki identify as Māori

2% of Thames-Coromandel-Hauraki identify as Pacific

Health and wellbeing

Thames-Coromandel-Hauraki's mortality rate is **1.1** times greater than the rest of the Waikato DHB

Cause of death

95% of Thames-Coromandel-Hauraki residents are enrolled in a Waikato DHB general practice

(86% Māori and 97% non-Māori)

82% of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are **2.67** mental health admissions a year in Thames-Coromandel-Hauraki, lower than the rest of Waikato DHB at 3.35

9% of mental health admissions are from Thames-Coromandel-Hauraki

Location of death of 65+ year olds in Thames-Coromandel-Hauraki

32% Home	29% Hospital	38% Rest home	1% Hospice
33%	33%	31%	3% Waikato

Hospitalisations per capita for Thames-Coromandel-Hauraki residents is nearly **0.9** times the rate of the Waikato DHB, and Māori are hospitalised **1.2** times more than non-Māori

ED presentations per capita of Thames-Coromandel-Hauraki residents is **1.0** times the rate of the Waikato DHB, and Māori present at **1.0** times the rate of non-Māori

Top 3 specialties (volumes)

Hospitalisations

1. General medicine (1180)
2. General surgery (604)
3. Orthopaedic surgery (364)

Outpatient appointments at Waikato Hospital

1. Opthalmology (2682)
2. Oncology (1679)
3. Orthopaedic surgery (1621)

Outpatient **DNA rates** at Waikato Hospital

1. Paediatric surgery (31%)
2. Dermatology (15%)
3. Dental surgery (14%)

Mothers smoking at first registration with LMC

Māori	Pacific	All
28%	17%	15%

Fully immunised at 1 year old

Māori	Pacific	All
90%	88%	86%

Laboratory tests per person per annum

6.4
6.6 Waikato

Pharmaceutical items per person per annum

11.2
9.7 Waikato

65+ year olds needing **complex home and community support services**

5% Thames-Coromandel-Hauraki

5.6% Waikato

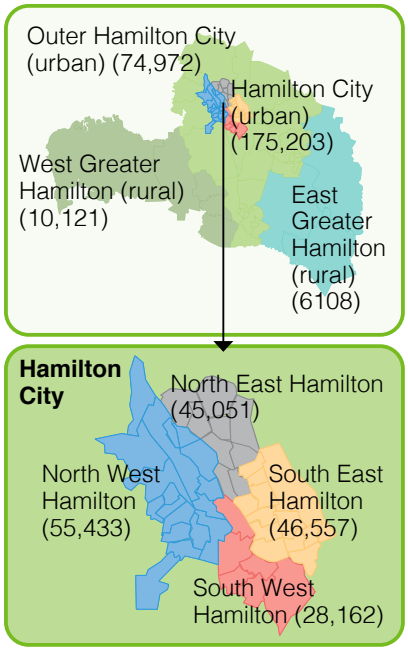
Workforce
GP FTEs per 100,000 population

72 Thames-Coromandel-Hauraki

59 Waikato

67 New Zealand

Greater Hamilton – a snapshot



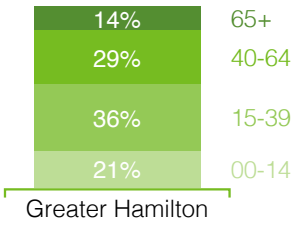
People

63% of Waikato DHB population live in Greater Hamilton

266,404 people live in Greater Hamilton

+13.4% is the population change in the next 10 years

Greater Hamilton has a slightly younger population than the rest of the Waikato



High deprivation (living in dep 9 and 10)

19% of Greater Hamilton

21% of Māori living in high deprivation

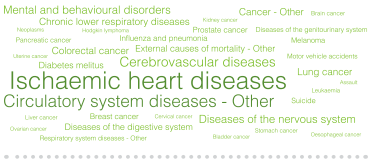
21% of Greater Hamilton identify as Māori

5% of Greater Hamilton identify as Pacific

Health and wellbeing

Greater Hamilton's mortality rate is **0.9** times greater than the rest of the Waikato DHB

Cause of death



Mothers smoking at first registration with LMC

Māori	Pacific	All
27%	5%	12%

Fully immunised at 8 months old

Māori	Pacific	All
82%	87%	88%

65+ year olds needing **complex home and community support services**

5.5% Greater Hamilton

5.6% Waikato

Location of death of 65+ year olds in Greater Hamilton

30% Home	31% Hospital	35% Rest home	4% Hospice
33%	33%	31%	3% Waikato

92% of Greater Hamilton residents are enrolled in a Waikato DHB general practice

(84% Māori and 96% non-Māori)

75% of enrolled patients visit a general practice once or more in a year

For every 1000 people, there are **4.09** mental health admissions a year in Greater Hamilton, higher than the rest of Waikato DHB at 3.35

70% of mental health admissions are from Greater Hamilton

Laboratory tests per person per annum

7.0

6.6 Waikato

Pharmaceutical items per person per annum

9.4

9.7 Waikato

Workforce

GP FTEs per 100,000 population

58 Greater Hamilton

59 Waikato

67 New Zealand

ED presentations per capita of Greater Hamilton residents is **0.9** times the rate of the Waikato DHB, and Māori present at **1.6** times the rate of non-Māori

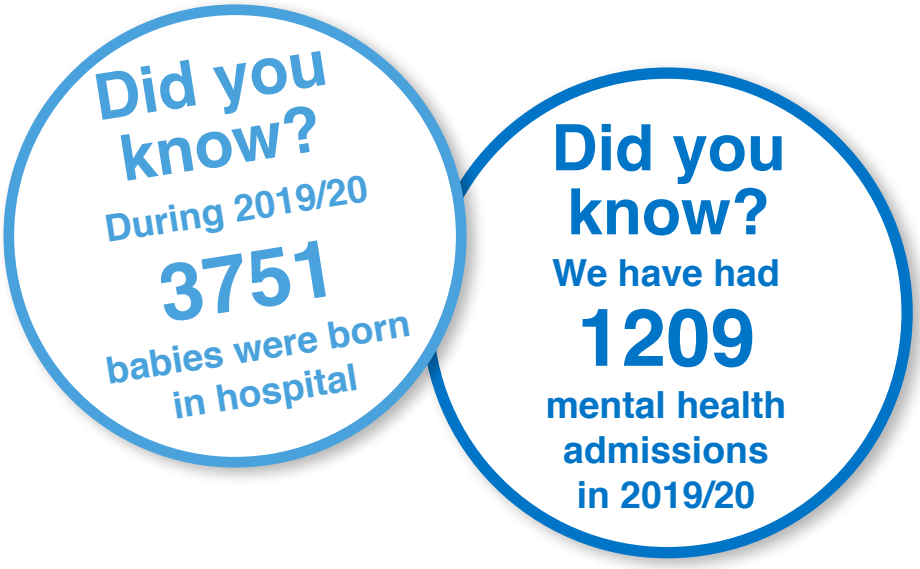
Hospitalisations per capita for Greater Hamilton residents is the same as the rate of the Waikato DHB, and Māori are hospitalised **1.2** times more than non-Māori

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.



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.

Te Manawa Taki vision	He kapa kī tahi – a singular pursuit of Māori health equity					
Regional strategic outcomes	To improve the health of the Te Manawa Taki 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 Te Manawa Taki 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 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.

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.

Transition from Regional Service Plan to a Regional Equity Plan

Legislation requires the DHBs to collaborate regionally and for each of the four regions of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Te Manawa Taki DHBs (formally referred to as the Midland DHBs) shared services agency, is tasked with developing on our behalf, the Midland RSP, to be replaced by Te Manawa Taki, Regional Equity Plan.

The equity priorities of previous RSPs and the 2019 Memorandum of Understanding between the Te Manawa Taki DHBs Regional Governance Group and Te Manawa Taki Iwi Relationship Board are the foundations of this plan. The vision of Te Manawa Taki is *He kapa kī tahi – a singular pursuit of Māori health equity*.

The Te Manawa Taki Chief Executive (CE) Group oversees regional collaboration. The five DHBs of Te Manawa Taki – Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki and Waikato – have a history of cooperating on issues of regional importance and on new programmes of change. Regional clinical networks and forums, executive forums, and workforce are linked to Te Manawa Taki CE Group through a DHB CE lead (as sponsor) and through regular reporting to the Te Manawa Taki CE Group.

About **Te Manawa Taki**

21%

Te Manawa Taki covers an area of 56,728km², or 21 percent of New Zealand's land mass.

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

5 DHBs

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

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

985,285 people (2020/21 population projections), including 265,360 Māori (27 percent) and 43 local iwi groups.

Te Manawa Taki iwi

Bay of Plenty DHB

Ngai Te Rangi, Ngāti Ranginui, Te Whānau ā Te Ēhutu, Ngāti Rangitihi, Te Whānau ā Apanui, Ngāti Awa, Tūhoe, Ngāti Mākino, Ngāti Whakaue ki Maketū, Ngāti Manawa, Ngāti Whare, Waitahā, Tapuika, Whakatōhea, Ngāti Pūkenga, Ngai Tai, Ngāti Whakahemo, Tūwharetoa ki Kawerau

Lakes DHB

Te Arawa, Ngāti Tūwharetoa, Ngāti Kahungunu ki Wairarapa

Hauora Tairāwhiti DHB

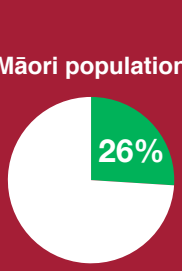
Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu, Ngā Ariki Kaiputahi, Te Aitanga-a-Hauiti

Taranaki DHB

Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngāruahine, Ngāti Ruanui, Ngā Rauru Kiitahi

Waikato DHB

Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Waikato, Tūwharetoa,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 reports on a large number of Performance Priorities, Crown Funding Agreements, and annual plan progress updates. 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.

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

Te Manawa Taki vision	He kapa kī tahi – a singular pursuit of Māori health equity					
Regional strategic outcomes	To improve the health of the Te Manawa Taki 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

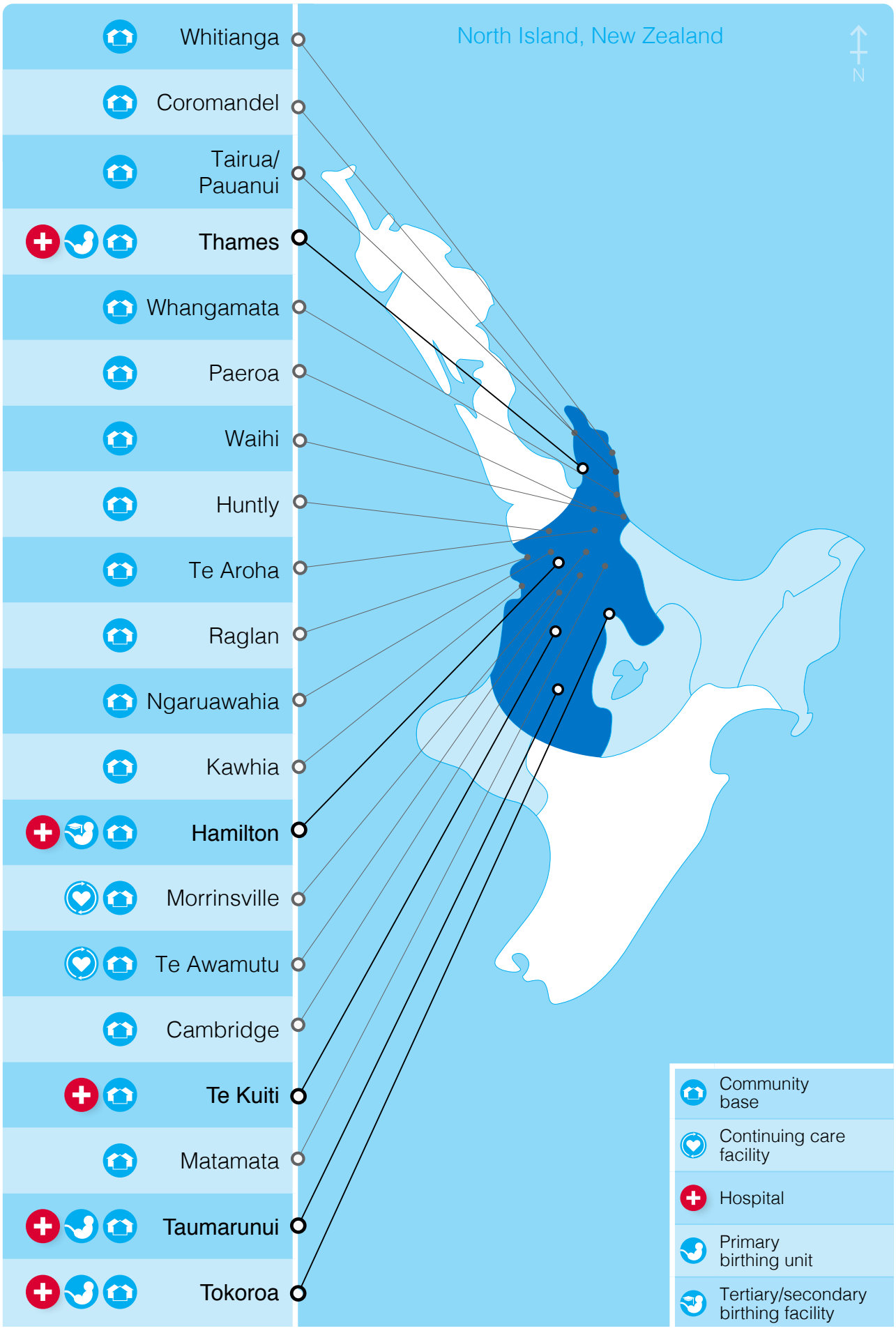
Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood 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 month olds will have their primary course of immunisation on time	Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours

Stewardship

Stewardship	Workforce	Organisational performance management	Clinical integration / collaboration / partnerships	Information

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

Waikato DHB profile



Location and population at a glance

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

10 territorial local authorities within our boundary

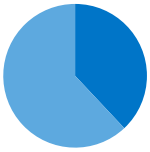
Our population in 2019/20 is 425,836

59% Urban

41% Rural

105,101

Total population living in high deprivation (dep 9 and 10)



39,733 38% **Māori**

65,368 62% **non-Māori**

51% Female

49% Male

High deprivation as a percentage of total locality population

64%	South Waikato
59%	North Ruapehu
41%	Waitomo-Otorohanga
36%	North Waikato
30%	Thames-Coromandel -Hauraki
19%	Greater Hamilton
11%	Matamata-Piako

16.6% of our population is aged 65 years or over

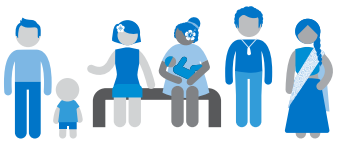
23% **Māori population** compared to national average of 16%

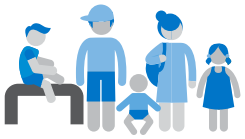
Our ethnicity population make up

23% Māori

74% Other

3% Pacific





27.4% of our population are under 20 years

Population growth in the next 10 years

+9% Total

+19% Māori

+37% 65 or older

Overall population statistics hide significant variations within the large geographical area we cover. Documents such as locality profiles and health needs analysis provide an in-depth analysis of our population, 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

Over 16 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.

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 30 June 2020 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 30 June 2020, Waikato DHB had 8012 employees with 6694 full-time equivalents.

8012 Total employees

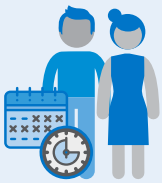
Employee diversity

46.9% NZ European
9% Māori
1.7% Pacific
42.4% Other

Employee age range

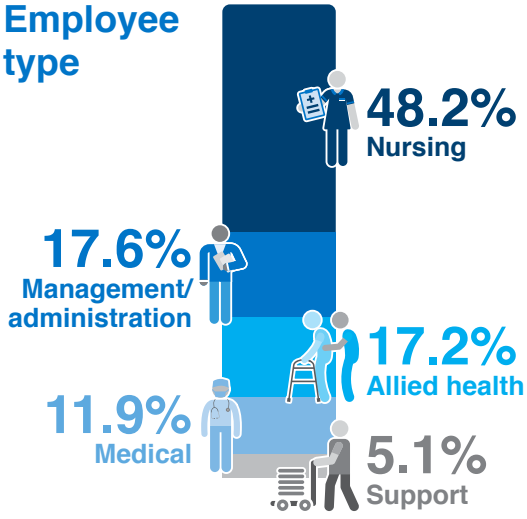
6.4% <25
25.8% 25-34
20.4% 35-44
21.6% 45-54
20.6% 55-64
5.2% 65 and over

Employment status



48.6% Full-time
47.3% Part-time
4.1% Casual

Employee type



48.2% Nursing
17.6% Management/ administration
17.2% Allied health
11.9% Medical
5.1% Support

Employee diversity

New Zealand European is 46.9 percent of the workforce and Māori is 9 percent.

Ethnic group	Headcount	Percent
NZ European	3758	46.9%
Asian	2033	25.4%
Other European	1159	14.5%
Māori	725	9.0%
Pacific	139	1.7%
Other ethnicity	88	1.1%
African	54	0.7%
Middle Eastern	40	0.5%
Latin American	16	0.2%
Total	8012	100.0%

Age range

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

Age range	Total	Percent
<25	510	6.4%
25-34	2068	25.8%
35-44	1636	20.4%
45-54	1727	21.6%
55-64	1653	20.6%
65 and over	418	5.2%
Total	8012	100.0%

Employment status

The majority of our employees are full-time (48.6 percent) and 47.3 percent are part-time. 4.1 percent are casual employees.

Status	Headcount	Percent
Full-time	3892	48.6%
Part-time	3789	47.3%
Casual	331	4.1%
Total	8012	100.0%

Employee type

Type	Headcount	Percent
Senior Medical Officer (SMO)	463	5.8%
Resident Medical Officer (RMO)	485	6.1%
Nursing	3863	48.2%
Allied health	1377	17.2%
Support	412	5.1%
Management/administration	1412	17.6%
Total	8012	100.0%

Employee exiting information

The table below shows the number of terminations for the past 12 months and the reasons for leaving recorded in the system (1 July 2019 to 30 June 2020, source: PeopleSoft). The top five reasons for why people left over 2019/20 are similar to the reasons stated for 2018/19.

The top five reasons people left the Waikato DHB for 2019/20 are:

- end of employment agreement
- relocation
- personal reasons
- career progression; and
- family reasons.

Reason for leaving	Total
End temporary employment	454
Relocation	213
Personal reasons	210
Career progression	115
Family reasons	108
Retirement	92
Dissatisfied with work conditions	52
Health reasons	52
Changed status to casual	39
Travel	30
Further study	19
Elimination of position	16
Reason unknown	12
Career change	11
Offer declined	9
Resigned from parental leave	8
Mutual consent	3
Death	3
Dissatisfied with compensation policies	2
Moved to HealthShare	2
Dissatisfied with pay	1
Dissatisfied with hours	1
Externally paid	1
Failure to return from leave	1
Total	1454

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.

Healthy People. Excellent Care is the vision of Waikato DHB. This will be achieved through the implementation of the 10 year Waikato Health System Plan, Te Korowai Waiora completed in August 2019. Te Korowai Waiora describes a future health system that will improve health outcomes particularly for Māori and enable the people of the Waikato the opportunity to achieve their full health potential.

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

We strive to:

- build a workforce that is representative of our community, with a specific focus on increasing our Māori workforce
- 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 the values of the organisation are demonstrated at all levels
- provide a healthy and safe workplace
- build the capability for all our employees enhancing their career development.

Leadership, accountability and culture

We believe a high performing organisation is built on a values based culture. The development of a Strategic Direction for Our People, Te Rautaki Mā Tātou Ki Mua puts our people at the centre of everything we do, built on four pou (pillars).

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.

The focus is to ensure that we understand the development needs of our people and provide appropriate learning through multiple channels that work for all our employees.

He iwi ahurea
OUR CULTURE

Build an inclusive, supportive and safe place to work.

This pou prioritises the need to ensure that our values are understood and demonstrated at all times ensuring that our people feel safe in every way.

Āhei mā tātou
ENABLE US

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

The focus within this pou is to ensure that we 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 Public Service Commission's framework for Leadership and Talent Development.

Waikato DHB has an evolving self-service model, starting with myHR (for employee information) and myPeople (for people leader information) intranet pages and work will be undertaken in the next 12 months to simplify and streamline Human Resources (HR) business practices further.

Recruitment, selection and induction

The DHB has a centralised recruitment function that ensures robust recruitment processes are consistently managed across the DHB. 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. Our recruitment processes comply fully with safety checking regulations.

The Taleo applicant management system ensures consistent candidate care and the DHB has a particular focus on increasing Māori and Pacific uptake into health careers. There will be continued focus in the coming year with the development of both a Māori and Pacific Workforce development action plans. The DHB has committed to ensuring that all Māori applicants who meet the essential criteria of positions are shortlisted for interview.

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 within the top five in terms of candidate applications received compared to all other DHBs nationwide.

Orientation and onboarding are being continuously improved and will be a focus for the next 12 months. Te Hono Whakataki, Our First Meeting was launched last year and this warmly welcomes new employees to Waikato DHB, with an expo showing what we offer to care for our people.

Puna Waiora has been 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.

Employee development, promotion and exit

Waikato DHB has a fair and equitable performance appraisal system in place which has recently been refreshed and will be rolled out over the coming 18 months. Whilst the process is well documented and available to all staff the system does enable strength-based conversations to occur on a more regular basis, where the staff member is able to identify personal development needs and document career aspirations.

The health workforce is a diverse, highly qualified and often highly specialised workforce. The training and development needs reflect this diversity. The DHB is committed to supporting all staff to access the appropriate training in accordance with their needs. This is in multiple forms including face-to-face, assessments and online learning through our online learning system, Ko Awatea. This blended approach provides the DHB greater ability to provide training opportunities which are more effective and efficient for our clinical and non-clinical staff.

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 are completed, however inconsistently and therefore in the next 12 months, they will be refreshed to ensure we gather more useful feedback for the organisation.

Flexibility and work design

The DHB gives consideration to flexible work practices to accommodate staff wherever practical. Guidelines to assist managers to respond to requests for flexible work arrangements are available on the DHB's intranet.

The DHB's Human Resource service also works closely with managers and our union partners as required to implement change in work practice that meets the needs of staff and assists the organisation to achieve its service and financial performance objectives.

Remuneration, recognition and conditions

Waikato DHB recognises the valuable contribution our employees make to patient care through recognition programmes and/or awards, including long service awards. The DHB has a number of communication mediums which are delivered to all staff and key local health sector leaders which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through our intranet, and within the regular chief executive update. Further opportunities to embed a broader recognition strategy are currently being developed.

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 meetings with its union partners where views are exchanged and information shared.

Employee remuneration

Remuneration	2020 Actual	2019 Actual
Employee remuneration over $100,000 ($10,000 bands)		
100,000 - 110,000	365	260
110,001 - 120,000	216	146
120,001 - 130,000	116	109
130,001 - 140,000	94	73
140,001 - 150,000	74	47
150,001 - 160,000	47	36
160,001 - 170,000	38	35
170,001 - 180,000	28	32
180,001 - 190,000	27	26
190,001 - 200,000	18	35
200,001 - 210,000	19	23
210,001 - 220,000	18	13
220,001 - 230,000	28	10
230,001 - 240,000	28	26
240,001 - 250,000	31	19
250,001 - 260,000	23	23
260,001 - 270,000	17	22
270,001 - 280,000	19	19
280,001 - 290,000	15	25
290,001 - 300,000	24	19
300,001 - 310,000	23	18
310,001 - 320,000	21	21
320,001 - 330,000	16	17
330,001 - 340,000	12	16
340,001 - 350,000	9	19

Remuneration	2020 Actual	2019 Actual
Employee remuneration over $100,000 ($10,000 bands)		
350,001 - 360,000	17	6
360,001 - 370,000	10	9
370,001 - 380,000	10	7
380,001 - 390,000	8	5
390,001 - 400,000	2	3
400,001 - 410,000	6	5
410,001 - 420,000	4	3
420,001 - 430,000	3	1
430,001 - 440,000	2	3
440,001 - 450,000	3	3
450,001 - 460,000	3	1
460,001 - 470,000	1	-
470,001 - 480,000	2	4
480,001 - 490,000	2	1
490,001 - 500,000	1	1
500,001 - 510,000	2	-
520,001 - 530,000	-	1
530,001 - 540,000	1	1
560,001 - 570,000	1	-
580,001 - 590,000	-	1
620,001 - 630,000	1	-
670,001 - 680,000	-	1
690,001 - 700,000	1	-
860,001 - 870,000	1	-
1,230,001 - 1,240,000	1	-
Total	1408	1145

Between the 2019 and 2020 fiscal years the number of employees earning over $100,000 increased by 263, of which 94 percent related to clinical staff classifications.

Harassment and bullying prevention

The Speaking Up For Safety programme was introduced last year and 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. To date over 60 percent of our workforce have attended the training. This programme along with other initiatives over the next 12 months will ensure that we begin to truly embed and demonstrate the values and behaviours of the DHB.

Safe and healthy environment

The DHB is continuing to make changes to our policies and procedures to reflect the Health and Safety legislation.

The DHB promotes and provides opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Health and Safety representatives. The Governance of the DHB is committed to ensuring that health and safety is embedded across the organisation and have prioritised the development of a new Health and Safety strategy for the coming year. The organisation has also undertaken an assessment through Safe365 online tool to identify any gaps in relation to the health and safety requirements and will continue to build the capability of all and develop a culture whereby health and safety is embedded in everything we do.

Waikato DHB maintains its ACC partnership programme which recognises that appropriate systems support a safe environment and are implemented throughout the organisation.

A Wellbeing Practice lead has recently been appointed to the DHB and will be developing a wellbeing framework and programme of work to be implemented over the coming 12 months.

Systems are utilised by Waikato DHB to ensure 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.

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.

Governance and accountabilities

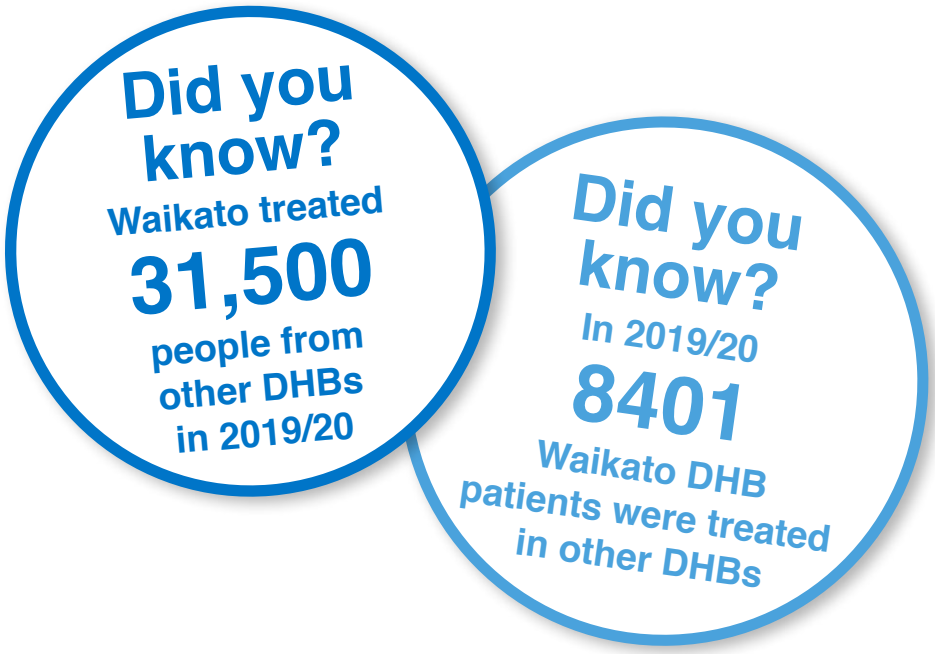
Waikato DHB has three statutory committees; Community Public Health Advisory Committee, the Disability Support Advisory Committee and the Hospitals Advisory Committee, which are made up of commissioner representation, members of Iwi Māori Council and members from the community.

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, Raukawa, and Whanganui iwi.

Ministerial directions

Directions issued by a Minister during the 2019/20 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, Information communication and technology (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
- In accordance with DHBs' responsibilities under section 23 of the New Zealand Public Health and Disability Act 2000 to plan and coordinate at local, regional, and national levels for the most effective and efficient delivery of health services, all DHBs must act consistently with the following national-level plans and policies:
  a) The Government response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and
  b) the national Health Emergency Plan (Ministry of Health 2015).



Some highlights from the year

New Zealand's first radiation therapy linear machine

This year it was Yellow Room's turn to get a makeover and a new, upgraded treatment machine to keep Waikato's radiation oncology services at the highest level possible. The addition of large photographs, ambient LED lighting in colours of a patient's choice, and a beautiful "sky ceiling" transform the environment into something much more pleasant than the previous concrete bunker.

This new radiation therapy linear machine from Varian Medical Systems has HyperArc technology that is the first of its kind in New Zealand and one of the first in a public health site in Australasia. It allows not only faster, highly accurate, targeted radiation delivery but also dramatically speeds up the treatment planning stage.

It can also deliver the rate of radiation from the machine up to four times faster thanks to a "flattening free filter", reducing the time a patient spends on the treatment couch.

The Yellow Room's new Varian machine sits under the beautiful new sky ceiling. The ceiling was made possible through funding from Dry July Trust.

Waikato DHB Women's Health service in Thames

Recently undergoing significant transformation, which included regaining full medical training accreditation back in early 2019, the Women's Health service has gone from strength to strength and now have a fully recruited senior medical officer team, as well as nine obstetrics and gynaecology trainees and sub-speciality fellows.

This has now put them in a position to branch out into rural areas, starting by offering non-complex gynaecological surgery at Thames Hospital. Specialists from Waikato Hospital will travel to Thames Hospital every fortnight to provide gynaecological surgeries to women.

This exciting development will be the start of more services being offered in the rural areas which we hope will improve equity and access for the many women who do not reside in Hamilton.

L-R: Some of the team behind the new Thames surgical services; specialist Dr Karena de Souza who delivered the first surgical list at Thames, Rebecca MacRae service manager, and clinical unit leader Dr Narena Dudley.

Global champion for hepatitis C

Under Jo de Lisle's guidance, the five Te Manawa Taki DHBs – Waikato, Bay Of Plenty, Tairāwhiti, Lakes and Taranaki – contribute to the Midland Region Community Hepatitis C Service, provided by Waikato Hospital, and spread that service far and wide across Waikato and other Te Manawa Taki DHB districts.

De Lisle's approach has been to provide a community "One-stop-Hep C-shop" which means tailoring a testing and treatment programme for each community by collaborating and developing new partnerships with other community services. This grassroots approach might lead her team to bring mobile fibroscan machines to communities with no medical facilities, set-up testing clinics in a probation office lobby, and promote testing incentives such as a small grocery package relevant to the community. This point-of-care, pop-up shop approach has expanded hepatitis C treatment access widely, from people living without a home to rural communities.

The Coalition for Global Hepatitis Elimination has selected Jo de Lisle as one of only six 2020 Elimination Champions worldwide for her contributions to advancing hepatitis C elimination in the Midland region and within New Zealand. Other chosen champions coming from Canada, Burundi, Mexico, Uganda and China.

Elimination Champion Jo de Lisle

The Elimination Champion initiative was launched in 2019 and aims to recognise the remarkable contributions of individuals to improved political commitment, policies, and programmes that expand access to interventions and accelerate progress toward hepatitis elimination, particularly in areas with limited resources.

A new acute mental health facility announced

The Government has approved funding for a new acute mental health facility for Waikato which will provide better care and support to people with mental health and addiction issues.

Prime Minister Jacinda Ardern and Health Minister Dr David Clark announced the $100 million project to replace the aging Henry Rongomau Bennett Centre during a visit to Hamilton.

It is the perfect opportunity to co-design user and whānau-centred healthy spaces and their healing effect on people. A new purpose-built facility will provide a modern environment with patient and whānau-centred spaces. The design will continue to be informed by people with lived experience of mental health and addiction issues, their whānau, iwi and community providers, as well as staff and other health and social services.

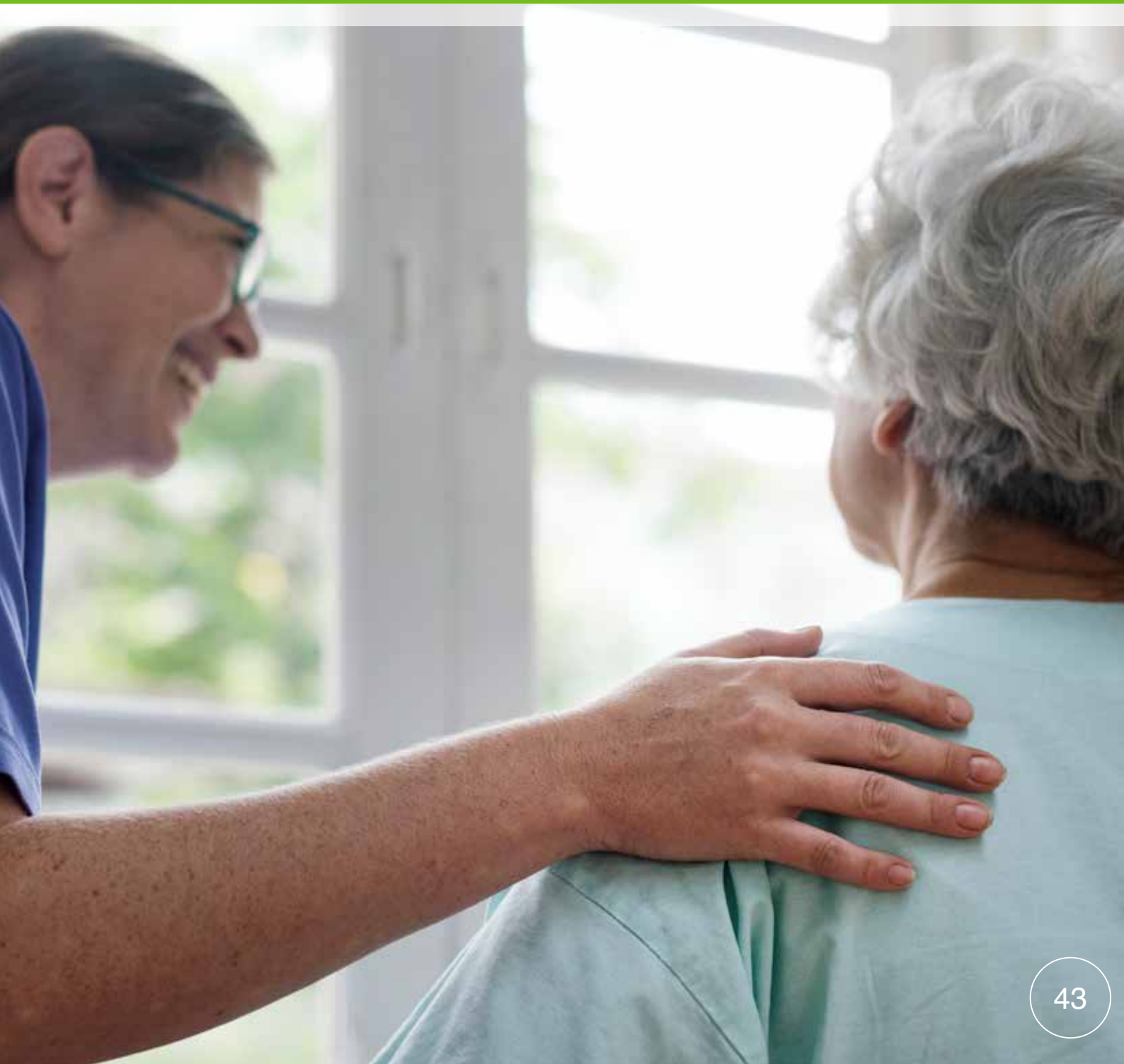
Planning and design work continues alongside the business case development. The indicative business case is expected to be complete early 2020, followed by the detailed business case in early 2021. Funding is subject to approval of the final business case. Grounds works are expected to start in 2022, with the facility due to open in 2023.

Prime Minister Jacinda Ardern and David Clark (previous Minister of Health) talking with the Waikato DHB commissioner Dame Karen Poutasi.

> The staff are to be congratulated in their exceptional care; at all times I felt supported and listened to, which made me feel safe and confident. It has been a pleasure to observe a team of nurses and support staff working in harmony.

Debs, orthopaedic patient on Ward M6, May 2020

Part two: Quality and patient safety



The Waikato DHB approach sees quality as an "embedded" responsibility of services

Risk management and quality improvement should be considered as an integrated approach when determining strategic and operational planning in every area and service of healthcare delivery, clinical and non-clinical. Continuous improvement and risk management should be data driven and reflective of the issues that are most significant to the organisation, not only the process of data and information collection itself.

Quality and Patient Safety aims to bring together empowered frontline teams and a meaningful role for patients and whānau so that improvement activity is aligned to what they most need and value; alongside regulatory compliance, accreditation and data systems that drive improvement.

Current priorities and achievements

Patient safety

Focus on risk

The focus has been to support, guide and influence leaders to identify, manage and own risks that they are faced with.

- The risk matrix was updated to assist with risk ratings, to ensure risks are rated correctly to ensure there is consistent risk ratings.
- 'Risk Assessment and Escalation Form' was created to assist risk owners with writing concise risk statements and identify controls and actions to mitigate risks. This process also ensures risk owners are not siloed, it identifies how the risk impacts on the organisation.
- Risk training was developed and trialled within some services in the DHB.

Patient safety

Deteriorating patient programme – year four of five

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 has been in use for two years. Quality and Safety Marker data shows that overall the process is effective in recognising clinical deterioration. Ongoing focus is needed to support timely escalation. One addition to the adult chart was to use increasing scores as a prompt to consider screening the patient for Sepsis and aligns with the Sepsis Ready programme.

The **Maternal Early Warning Score** chart has completed its development phase and is being rolled out across the DHB. Any woman presenting to the hospital, who is pregnant or within six weeks of having given birth, will have this chart used. The parameters are designed specifically around the vital signs changes that are relevant to pregnancy and provide a significant safety net to recognising clinical deterioration early.

Sepsis Ready programme

Formally introduced across the DHB in late 2018, the Sepsis Ready programme has shown initial improvement in the recognition and management of patients presenting to Emergency Department (ED) with sepsis or developing sepsis whilst an inpatient.

- Sepsis Ready significantly increased Sepsis Six bundle compliance
- Sepsis Ready has reduced in-hospital mortality in the post intervention period
- The sepsis recognition and management tools have significantly improved the proportion of patients receiving fluid resuscitation in the first hour after presentation and time to first medical review.
- Intensive Care Unit (ICU) length of stay for sepsis appears to be reducing. This is a reflection of similar programmes internationally.
- Despite the increase in sepsis presentations, the 28 day mortality rate appears to be falling.
- 'Sepsis Ready' is increasingly seen as an integral part of the DHB's antimicrobial stewardship programme.

The next steps are in place to recruit a sepsis clinical nurse specialist. Maintaining a focus on sepsis recognition and management is vital to ensuring ongoing success, sustainability and growth. With a strong clinical focus, the role will align closely with the Infectious Diseases service and Infection Prevention and Control. It will include increased support to patients and their family/whānau as well as a follow-up component, where evidence shows that many patients suffer from long-term adverse effects of Post Sepsis Syndrome.

Choosing Wisely – year two of three

Choosing Wisely is a global initiative that has been implemented in a number of countries, including USA, Canada, the UK, Australia and some of Europe. The campaign aims to promote a culture where low value and inappropriate clinical interventions are avoided, and patients and health professionals have well-informed conversations around their treatment options, leading to better decisions and outcomes.

- Waikato DHB is the first DHB in New Zealand to employ a full-time coordinator to implement Choosing Wisely. The DHB-wide programme works with clinicians and consumers to embed the Choosing Wisely initiative; with a initial focus on reducing low-value care.
- Incorporation of consumer representation in the Choosing Wisely governance group and feedback from the DHB Consumer Council in the development of our Choosing Wisely framework, ensures our envisioned progression of Choosing Wisely is embedded in the lived reality of patient and whānau experiences.
- A framework has been developed to establish clear measures for success. Key aspects to implementing Choosing Wisely in the DHB included exploring the culture of high value care amongst health professionals, working with a Qlik Sense designer to provide local laboratory and patient data for real-time use by wards and services and embedding equity into the metrics.

Patient experience

Kōrero mai – Talk to me – Year one of two and part of the deteriorating patient programme

Kōrero mai
Talk to me

Patients and whānau often say 'something just doesn't feel right' and they are often correct, recognising subtle signs of patient deterioration in hospital, even when vital signs are normal.

Failure to respond adequately to concerns raised by patients, families/whānau is commonly highlighted in Health and Disability Commissioner reports relating to adverse events associated with clinical deterioration.

Kōrero Mai is a communication process that enables family/whānau to escalate their concerns through a series of steps. It is anticipated that most concerns will be managed at the ward level though the final step is to call a phone number and activate an independent review.

The escalation process is being developed with a group of consumers, using co-design principles. The consumer's lived experiences are invaluable to shaping both the process and supporting materials.

A pilot phase is starting in October 2020 and will run for four months. Following review, it is anticipated the process will be rolled out across the DHB including rural facilities.
The service will be available 24/7.

Improving communication with trauma patients and their whānau

MIDLAND TRAUMA SYSTEM

Trauma (physical injury) is a life changing event for patients and their whānau. It can happen to all ages and ethnicities and can permanently alter the lives and relationships of those involved. The Waikato trauma service coordinates complex care within the hospital and helps patients and whānau through what is commonly the worst time of their lives.

The Midland Trauma System and Quality and Patient Safety have been collecting patient and whānau experience of major trauma patients to identify where improvements in quality of care can be made.

Research has shown that patient experience is positively associated with better health outcomes, better use of health resources, better adherence to medications and treatments and better use of preventative services and is now considered one of the central pillars of quality of healthcare alongside patient safety and clinical effectiveness.

Patients and whānau are talking to us about their experience at Waikato Hospital and sharing what was important during their inpatient stay and what matters to them. From this, we have developed a patient and whānau insights journey board which provides an overview of what went well and how we can improve.

Many patients and whānau have shared inspirational stories of recovery and positive experiences of care. Opportunities for improvement include patient transitions from one clinical area to another, e.g. from Critical Care to wards.

Patients and their whānau wish to be more involved and better informed of the decision to transfer patients. Some patients and whānau experienced fear and anxiety due to the different levels of care provided. They need reassurance that they/their loved one would be looked after and not be forgotten.

Whānau are often the patient's advocate and it was not uncommon for them to feel left out of decision making and unable to advocate in the whānau's best interests. We are working with all stakeholders to improve the experience of our patients and whānau in this area. We are appreciative of the generosity of time and openness of our patients and whānau who have been so willing to share their experiences with us.

Consumer engagement

Listening to our patients

Supporting the **Consumer Council** as they work through their priority plan: Their priorities align with Te Korowai Waiora, equity for Māori, those living in rural areas, and those living with disability.

Examples include:

- facilitating engagement with a disability rōpū to determine how and what data is required to understand disability in the Waikato
- utilising Consumer Council input and support for the transport plan, including to secure a new bus for Taumarunui patients
- involving local members of the Consumer Council in the development of localities plans
- Consumer Council representation on working groups including Kōrero Mai
- involving Consumer Council members in recruitment for executive positions
- expanding the voice of the consumer by offering multiple platforms for engagement, such as the Friends of the DHB Facebook group

Co-design work

Co-design is being embedded as a way of making change at the DHB. Patients, their whānau, and members of the community are being engaged more regularly and earlier in quality improvement initiatives.

Examples include:

- the roll out of Telehealth
- supporting Trauma patients transition between services
- embedding the role of the Key Support Person
- prevention and management of pressure injuries

Health Quality and Safety Commission – Quality Safety Markers for consumer engagement

Waikato DHB has been a pilot site for the development of Quality Safety Markers for consumer engagement. The Consumer Engagement Team, alongside a member of the Consumer Council, have provided a local lens for the markers matrix, and have added a Te Tiriti layer to recognise the need to use the matrix as a mechanism to drive equity. The Quality Safety Markers help evaluate the success of the programme and determine whether the desired changes in practice and reductions in harm have occurred.

PATIENT EXPERIENCE

ROWENNA CALDER

WARD M6 – ORTHOPAEDICS, HIGH DEPENDENCY UNIT (HDU) AND INTENSIVE CARE UNIT (ICU) PATIENT

> Nurses, Sam, Fiona H and Sarah were amazing. I got to know them all really well – they make such a huge difference!

I have scoliosis – a spinal deformity, and was admitted to Waikato Hospital for spinal fusion surgery. I spent a total of three months in hospital and ended up needing two surgeries to straighten my spine. Because the curve in my spine was quite bad, I had to be put in halo traction for seven weeks before the surgery. This involved having pins put in my skull and weight added gradually to stretch out my spine. Towards the end, I had 30 kilos of weight added! It looked horrific, but it wasn't that bad really!

After the first surgery I had to lay flat for three weeks to wait for the swelling to go down and to help me to regain movement. I spent this time on Ward M6 and nurses, Sam, Fiona H and Sarah were amazing, I couldn't fault them at all.

I am so grateful to the nurses who took so much care when moving me as my spine was unstable. My family all told me how it was such a relief to leave me in their care as they were that good.

I remember Fiona stayed with me when I had a chest drain put in. She also stayed a lot of that night with me between helping other patients and was quite often sitting in my room to make sure everything was ok.

The nurses worked so hard – they were incredible.

I bounced between Ward M6, HDU and ICU. I don't remember a whole lot about my time in ICU, but my family have told me that they were lovely! One thing that stands out for me is the extra care I received in HDU. They would wash and brush my hair and put it in braids which was nice because I felt like a bit of a mess! It was important for me to be able to start to feel like myself again.

I appreciated that they arranged for me to return to Ward M6 following my second surgery, as they knew me and the care that I needed. It was a relief to know I was returning to a safe, familiar environment.

It has been a long journey, but I got through it with daily visits from friends and family and got to know some of the nurses on Ward M6 really well – they make such a huge difference! I liked that they would often stop in for a chat before their shift to see how I was. I appreciated how much they cared, and their kindness and empathy.

Today, I'm back at work full time and everything is pretty normal, though I still have some weakness and loss of sensation, but it's been pretty good.

I've been quite lucky really!

PATIENT EXPERIENCE

MARISSE KOHU
WARD M6 – ORTHOPAEDICS PATIENT

"Waikato Hospital staff on Ward M6 have my seal of approval 100%! They are one of a kind."

PATIENT EXPERIENCE

MATUA RANGI MANIHERA AND HIS WIFE WHAEA LINDA-ANN
WARD OPR 2 (OLDER PERSONS AND REHABILITATION) PATIENT

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

Quality improvement around the organisation

Making a difference for our patients and consumers

Antimicrobial stewardship

Antimicrobials are a vital part of our health system. The consistent misuse and overuse of antimicrobials has contributed to the emergence and spread of antimicrobial resistance. This has huge implications, where common infections could become untreatable, and medical procedures impossible due to the risk of infection. Around 40 percent of all patients admitted to the Waikato DHB hospitals are prescribed at least one antimicrobial, of which one in four have been assessed as prescribed inappropriately. To improve antimicrobial prescribing, an Antimicrobial Steering Group was formed, involving various specialties and clinical roles with the aim of identifying service specific and DHB-wide initiatives.

The focus on antibiotics and related therapies includes:

- an annual point prevalence survey reviewing all antimicrobials prescribed at a point in time and assessing quality of prescribing and documentation, along with the appropriateness of therapy
- switching from IV to oral antibiotics to reduce prolonged unnecessary IV therapy
- the development and availability of resources including Microguide® and Script® (paediatric specific) for prescribing antimicrobials, including calculators which are mobile device friendly
- overall improved guidance for clinicians
- education on adequate documentation to support rational prescribing.

Improving equity

The message from audits, research and related activity is to ensure Māori are represented in the data to adequately address equity. Moving away from the focus of ethnicity data as a demographic descriptor, work has been done to encourage researchers and auditors to commence their planning by first identifying the impact of the activity under focus for Māori, ensuring the use of that data is done respectfully and that findings do not contribute to 'deficit' framing. We now cite Te Mana Raraunga: Māori Data Sovereignty as the guide to ensuring we are representing Māori correctly and looking to how findings inform our service provision to meet the needs for Māori.

Where possible, particularly in research, representative numbers may mean oversampling Māori with the condition of interest, or using equal explanatory power, a method where the intervention effect might be different by ethnicity and therefore sufficient numbers are required to explore that effect. This may also be true in translational research were conditions within a clinical trial show efficacy of a drug, while the true effectiveness (how well it works in the real world outside the 'trial' environment – usually male, age in 30s and European) may be less effective. Promoting clinical trials to Māori contributes to early intervention and access to new medications or devices as well as personal oversight for the condition of interest. Ensuring the acceptability of the processes of clinical trials research is being developed between DHB clinical trials unit and Te Puna Oranga (Māori Health).

While Māori health gains are the most vital of all, improving equity and access for disabled and rural populations are also a key priority. Work is being done to identify how best disability can be measured and how this in turn can help the organisation respond. In addition, work is ongoing into new ways of working to support how rural populations can access services in a timely manner.

Priorities for 2020/21

Risk focus

To embed processes in the organisation that consider risk to be an integral part of the decision making process. To have risk management roles and responsibilities documented and communicated in all areas, and that risk training is undertaken on a regular basis. Ongoing improvement by ensuring regular formal reviews of risk management practices are in place to identify improvements.

Kōrero mai – Talk to me

Year two of two. Implementing the process across the organisation.

Sepsis Ready

Continue to grow the programme across the organisation and into the community through the employment of a sepsis nurse specialist.

Choosing Wisely

Year three of three. Complete the Qlik Sense reports which combine lab/rad data with patient information as part of the recharge, conduct quality improvement in ED addressing unnecessary intravenous cannula insertion; and a focus on the need for routine group and screen testing.

Listening to our patients and community

Ongoing work to improve the partnership between providers and consumers.

> The service was amazing; she felt well supported and the procedure was explained well to put her at ease to the point where she opted out of sedation. The nurses were great and friendly and the surgeon was amazing. It has put her at ease for future treatment that might be required, and she is extremely grateful.

"D", mother of colonoscopy patient, June 2020

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.

Performance disclosure

2019/20 has been a year of challenges and we are exceptionally proud of the way Waikato DHB staff responded to the measles outbreak, Whakaari/White Island volcanic eruption and COVID-19 pandemic.

On 11 March 2020, the World Health Organisation declared the outbreak of COVID-19 a pandemic and two weeks later the New Zealand Government declared a State of National Emergency. New Zealand was in lockdown at alert level four for the period 26 March to 27 April and remained in lockdown at alert level three, thereafter, until 13 May.

During the COVID-19 lockdown our frontline essential service staff showed a commitment and dedication that ensured our population had access to testing and health services throughout the level four lockdown, others completed their role from home and contributed to ensuring the business as usual operations such as payments to providers continued seamlessly allowing focus to remain on the delivery of care to our population.

Needless to say much of the Waikato DHB's work and focus in early 2020 was dominated by the COVID-19 emergency response. In the early days of the response thousands of staff were set up with the capability to work from home. Community Based Assessment Centres were set up to relieve pressure on our primary care partners and ensure COVID-19 testing capacity could meet demand across the Waikato district. At its peak the Waikato Hospital laboratory processed 828 COVID-19 swabs in a 24-hour period, at 30 June 2020 the total number was 28,994. Personal protective equipment was distributed to aged residential care and community health care providers, Waikato Hospital elective and outpatient activity was restricted in anticipation of possible COVID-19 demands.

Workforce capacity was impacted as 'vulnerable' staff[1] were required to stay home and many remaining staff were re-deployed from their usual job to help 'stand up' and support the emergency response. COVID-19 contact tracing, Community Based Assessment Centres and Managed Isolation Facilities occupied the public health nurse workforce limiting capacity to focus on previously planned initiatives.

These actions were essential but have inevitably impacted on our performance for the year with activity during alert level four lower than had been planned. The coming pages show how we performed against the commitments we made in our 2019/20 Annual Plan across all areas of service delivery. In 2019/20 we have met or exceeded 26 of 62 non-financial performance targets, comprehensively outlined in pages 57-94. Results should be seen in recognition that many of the targets are aspirational, and the impact COVID-19 has had on service delivery.

[1] 'Vulnerable' includes staff aged 70+, who have a pre-existing condition, who are pregnant, immunocompromised, or have a family member who is vulnerable.

Our performance measures that were directly impacted by COVID-19 are listed below with more details included in each of their performance story in the following pages:

- Percentage of eligible 12 year olds have received HPV dose two (page 63)
- Percentage of eligible population who have had their B4 School Check completed (page 74)
- Percentage of patients waiting longer than four months for their first specialist assessment (page 85)
- Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks (page 88)
- Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (page 93).

Looking forward

The COVID-19 response is moving to business as usual with capability to step up as required allowing the organisation's focus to resume on implementation of Te Korowai Waiora and our locality approach (see pages 16-17). This work will help to re-orientate the way we deliver services and will ultimately improve our performance. With eliminating health inequities being a top priority of Te Korowai Waiora we will have a continued focus on establishing partnerships with iwi in order to bring a more collaborative approach to healthcare and ensure as a sector we are working together toward the common goal of improving health equity and outcomes.

COVID-19 propelled progress in the virtual care space and this momentum will continue in 2020/21. Virtual care will help to increase capacity, supporting delivery of the right professionals, treating people at the right time, in the right place according to service users' needs and health preferences. All of which will contribute to improved service delivery and performance.

Lastly, the realignment of the Executive Leadership Team is now complete and will drive performance and accountability in the coming year.

Our impacts

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

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

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

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

Our outputs

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 2019/20 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 and 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 2019/20. Output class allocations are based on specific costing system rules to separate and assign costs resulting in total revenue and total expenses that will be different to the statement of comprehensive revenue and expense.

Output class reporting is a different way of slicing information. The output class financial reporting for 2019/20 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 2020

	Group 2020 ACTUAL	Group 2020 BUDGET	Group 2019 ACTUAL
Revenue			
Prevention	28,833	26,753	25,636
Early detection and management	335,216	320,335	305,097
Intensive assessment and treatment	1,127,575	1,111,631	1,069,584
Rehabilitation and support	131,319	132,032	121,764
Total revenue	1,622,943	1,590,751	1,522,081
Expenditure			
Prevention	27,553	25,891	24,640
Early detection and management	331,556	319,343	304,266
Intensive assessment and treatment	1,190,784	1,172,365	1,173,569
Rehabilitation and support	145,425	145,577	139,438
Total expenses	1,695,318	1,663,176	1,641,913
Share of joint venture surplus/(deficit)	(14)	-	68
Surplus/(deficit)	(72,389)	(72,425)	(119,764)

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	Babies who live in smokefree homes at six weeks
		Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking
		Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
		Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer (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 olds have received HPV dose two
		Seasonal influenza immunisation rates in the eligible population (65 years and over)
	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 (by December 2019)
		The number of people participating in Green Prescription programmes
		Percentage of Kura Kaupapa Māori primary schools participating in Project Energize
		Percentage of total primary schools participating in Project Energize

Why does this matter?

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

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

Māori are underrepresented in preventative primary care and overrepresented in acute services. It is essential that this changes to ensure that Māori experience the best health outcomes possible.

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

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

● We achieved the target	● We almost met the target (within 10 percent)	● We have not met the target

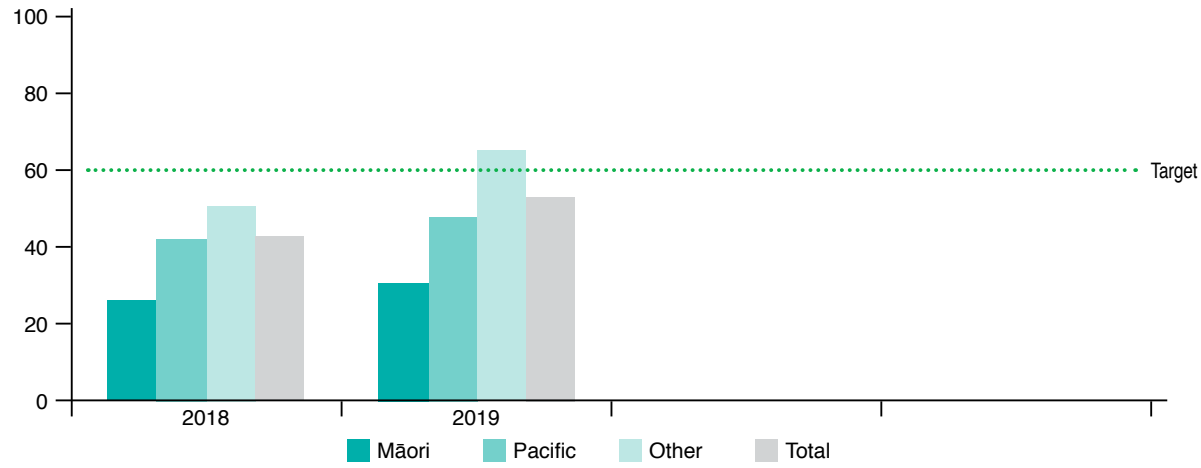
People are supported to take greater responsibility for their health

Fewer people smoke

Impact measure	Baseline 2018	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
		New measure 2019/20			
Babies who live in smokefree homes at six weeks	Māori 26% Pacific 42% Other 51% Total 43%	Māori N/A Pacific N/A Other N/A Total N/A	Māori 60% Pacific 60% Other 60% Total 60%	Māori 31% Pacific 48% Other 65% Total 53%	

Our performance

Percentage of babies who live in smokefree homes at six weeks 



The data for this measure is based on the 2019 calendar year.

Achieving the babies living in smokefree homes target is crucial in achieving the Smokefree Aotearoa 2025 target and to ensuring our tamariki have the best possible start to life.

Although improvements have been made year on year, it is disappointing that there remains a high number of babies experiencing avoidable harm that can lead to poorer health outcomes.

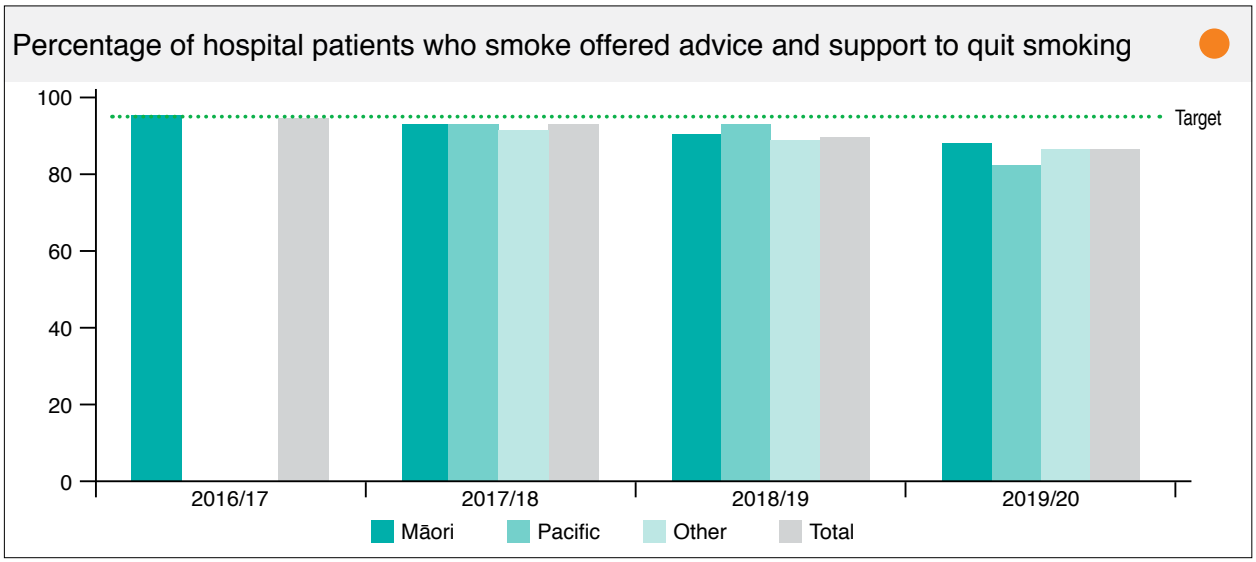
The focus for 2020/21 is to engage LMCs, general practice and other health care professionals in maternity care to increase the referral rate of pregnant women to smoking cessation services. Areas of particular focus are where there is high maternal smoking prevalence, including Huntly, Ngaruawahia, Te Kuiti, Taumaranui, Tokoroa, and parts of Hamilton.

Did you know?
During 2019/20 there were
5182
births in Waikato DHB funded facilities

Did you know?
38,217
smokers were offered advice and support to quit 2019/20

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 90% Pacific 92% Other 88% Total 89%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 87% Pacific 82% Other 86% Total 86%	

Our performance



Smokefree hospitals target has not been met.

The hospital smoking cessation target has not been met and results have deteriorated compared to last year.

When looking at the monthly results the trend for Māori is positive with the number of referrals for Māori and pregnant wāhine increasing each month.

To help improve our result we have a network of smokefree champion nurses on wards supported by constant active coordination that enables them to sustain their leadership role and knowledge of Nicotine Replacement Therapy (NRT) products, dosage and how to refer.

Business managers are required to show evidence of access to services and equity for Māori in all areas. This has meant increased smokefree activity and leadership by medical staff in their specialty areas resulting in monthly smokefree tables for doctors by specialty groups, intention to add smoke status to inpatient interactive Patient Flow Manager (showing 'smoker – needs intervention'), increased regular prescribing of NRT, earlier referrals in the pre-hospital surgical admission journey and smoking cessation interventions updated in resident medical officer orientation handbooks.

Waikato DHB uses mainly paper medical records and clinical coders report inconsistencies in documentation and conflicting information. There is renewed interest in using electronic Clinical Work Station to record smoking status and interventions giving coders just one place to look. This will be investigated in 2020/21.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 81% Pacific 75% Other 85% Total 83%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 77% Pacific 74% Other 80% Total 79%	

Our performance

We are disappointed to see that the result for this target has deteriorated from last year.

During 2019/20 there has been a focus on supporting Māori to be smokefree through the use of Tobacco Control Funding from the Ministry of Health. A smokefree coordinator has recently been recruited to work with Māori communities and providers offer DHB smoking cessation services, engage with health providers, community organisations and other sectors to support the achievement of Smokefree Aotearoa, and to liaise closely with the clinical smokefree coordinator based at Waikato Hospital.

In addition, two kaitiaki have been appointed and report to Te Puna Oranga. These roles will support Māori patients and their whānau to become and stay smokefree.

We expect the new roles, combined with the ongoing funding of the smoking cessation and clinical education programme through community pharmacies in the Waikato to improve results in 2020/21.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 87% Pacific N/A Other N/A Total 81%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 67% Pacific N/A Other N/A Total 65%	

Our performance

Please note: Due to COVID-19 this data was not collected by the Ministry during Q3 therefore, the result is based on Q1, Q2 and Q4 data only.

We are disappointed to have not met the target. The significant change in this year's result is attributable to data collection methods. 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 Lead Maternity Carers 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.

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 out if they choose to do so. 'Once and For All' continue to offer incentives for pregnant women who remain smokefree at the end of the programme which encourages the women and partners to accept a referral.

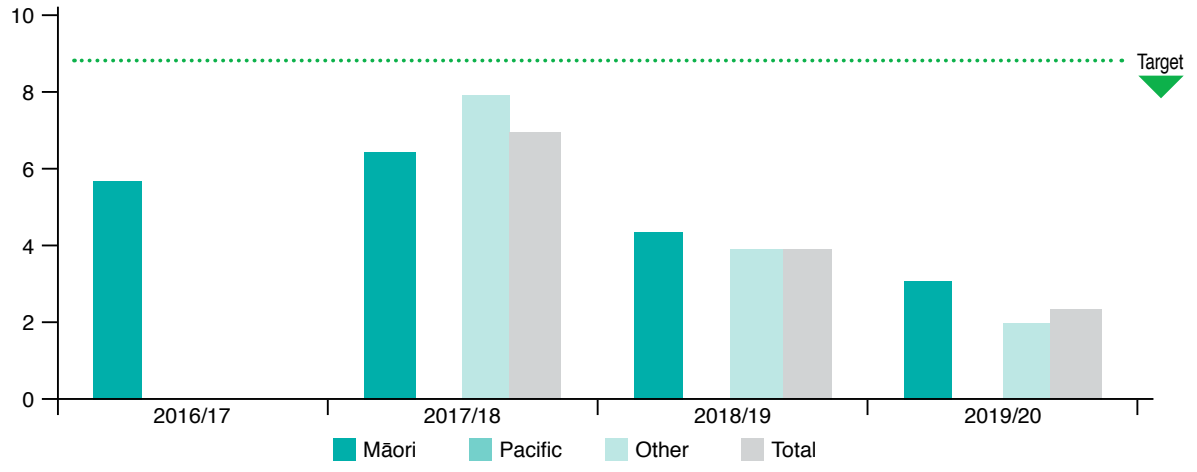
Children who have a parent who smokes are seven times more likely to become smokers compared to those without a parent that smokes. These children are also at greater risk of SUDI, premature births, low birth weight and serious respiratory infections. Due to this association, we have provided stop smoking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

Reduction in vaccine preventable diseases

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 4.3 Pacific 0.0 Other 3.9 Total 3.9	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori 3.1 Pacific 0.0 Other 2.0 Total 2.3	● ● ● ●

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 2019/20. 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 fatal consequences particularly for the young, elderly and immune compromised in our community.

Did you know?
In 2019/20 there were **4935** immunisations for 8 month olds

Did you know?
In 2019/20 there were **5025** immunisations for 2 year olds

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 81% Pacific 88% Other 92% Total 88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 82% Pacific 91% Other 92% Total 88%	

Our performance

Although we have not met the immunisation target for eight month old tamariki, the rates have increased from last year. The rates may have been higher if the COVID-19 lockdown had not impacted on parents' perception of attending medical centres for vaccinations.

We will continue to work with sector partners improve access and reduce barriers to 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 at risk in our community who are unable to be vaccinated themselves due to age or having medically compromised immune systems.

We will continue to work in partnership with general practice and iwi to investigate alternative approaches to immunise hard to reach children. Currently this is mainly through outreach services and some opportunistic immunisation places like Hauora ihub.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of two year olds are fully immunised and coverage is maintained	Māori 91% Pacific 95% Other 91% Total 90%	Māori 83% Pacific 91% Other 90% Total 88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 85% Pacific 94% Other 92% Total 89%	

Our performance

Although improvements have been made across all ethnicities for this target, 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 at risk as early as possible to reduce 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.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of eligible children fully immunised at five years of age	Māori 73% Pacific 78% Other 76% Total 73%	Māori 82% Pacific 85% Other 87% Total 85%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 83% Pacific 89% Other 89% Total 87%	

Our performance

Although results are below the target of 95 percent and the equity gap remains, it is pleasing to see an increase across all ethnicities, particularly with the disruption to health services caused by the COVID-19 response.

We will continue to work hard with all partners to improve immunisation rates at each milestone (eight months, two years, and five years) and provide children with a better start and healthier future.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of eligible 12 year olds have received HPV dose two	Māori 70% Pacific 106% Other 62% Total 66%	Māori 72% Pacific 79% Other 53% Total 62%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 62% Pacific 53% Other 53% Total 56%	

Our performance

In the 2018/19 Annual Report it was stated it would be beneficial to report on Human Papillomavirus (HPV) 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. Therefore the 2019/20 result is the 2019 calendar year.

The HPV vaccination evaluation studies have clearly shown a decline in HPV infection and the school based HPV vaccination programme delivered by the Public Health service continues to be an excellent option to achieve the greatest coverage. The specific timeframe for delivery of the vaccination programme does create some challenges as schools face increasing demands and commitments on their time. It has also been noted that the anti-vax promoters aim their programme nationally for the beginning of the year at the time when public health nurses are gaining consent for immunisation from parents.

This year the COVID-19 outbreak occurred at the time the annual school vaccination programme was being delivered, however round one HPV was able to be completed once schools returned and just before the July school holidays.

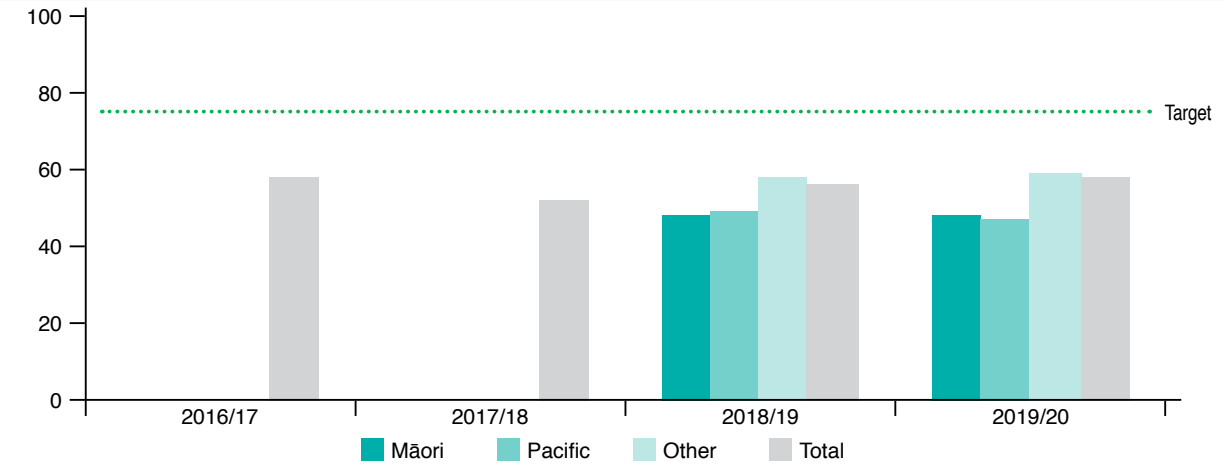
Early 2020 service records indicate 68 percent consent for the eligible population group for this immunisation, which shows consent numbers are increasing. Giving the vaccination in Year 7 may be a solution to gain more consents as it can separate out the sexual connotation for parents and caregivers. There are three small schools in the Waikato area who do not participate in the HPV programme and they are actively encouraged to reconsider this each year.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Seasonal influenza immunisation rates in the eligible population (65 years and over)	Māori 46% Pacific 49% Other 53% Total 52%	Māori 48% Pacific 49% Other 58% Total 56%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 48% Pacific 47% Other 59% Total 58%	●

Our performance

Percentage of eligible population older than 65 years 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. The data for this measure is from the six month period from 1 March to 30 September as this is the 2019 influenza season.

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 2019 influenza season our results are slightly better than for the 2018 influenza season. During the COVID-19 outbreak our Māori and Pacific providers (alongside Waikato DHB's Te Puna Oranga) operated mobile clinics that offered immunisations to our most at risk whānau. We will continue to work with our Māori NGOs, PHOs, pharmacy partners and age related residential care services to increase uptake.

Did you know?

39,707

influenza vaccinations were given to people 65 years of age and older in 2019/20

Improving health behaviours

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 (by December 2019)	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

Waikato has consistently achieved a 100 percent referral rate across all ethnicities.

Waikato's referral decline rate was 26 percent at the end of May 2020 which was lower than the national decline rate of 28 percent. Waikato's referral decline rate is consistent across populations with a decline rate of 26 percent for Māori and 'Other' populations, and 25 percent for Pacific.

New Zealand has the second highest rate of child obesity in the world (UNICEF, 2019), with an estimated 31 percent of children aged between two to 14 years in the overweight and obese range (Ministry of Health, 2019). 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. During 2019/20, 22 percent of Waikato children at their B4 School Check at age four were identified as overweight or obese. Māori and Pacific children were more likely to be identified as overweight or obese than other population groups with 31 percent of Māori and 37 percent of Pacific children overweight or obese compared to 18 percent of other populations.

In 2018 Waikato DHB implemented an Active Families programme suitable for younger children who are identified as having an unhealthy weight. The programme is called Whaanau Kori Tamariki Ora – Active Families, Healthy Kids (WKTO) and focuses on supporting whānau to make healthy changes including food options, ideas to keep kids moving and active, reducing screen time and improving sleep. The programme has a deliverable target of 75 percent of referrals being for Māori and Pacific whānau or children living in high socioeconomic deprivation areas (quintile five). This deliverable target has consistently been met. 79 percent of new referrals during 2019/20 quarter four were for the target population.

A key component of the WKTO programme is Waikato's BeSmarter resource to support practitioners in having a conversation with whānau regarding the health of their child. In 2019/20 Waikato and MidCentral DHB collaborated to create a bicultural version of BeSmarter called Tinana Ora. Tinana Ora is Māori for physical wellbeing and it covers the same nine key messages and recommendations as BeSmarter, except in the Tinana Ora format.

In 2019/20 an evaluation of the programme was completed. The evaluation showed the programme was accessible to the target population with the majority of referrals being from the target population and no difference in engagement rate for the target population compared to other referrals received. Whānau were supported from across the Waikato district with half of referrals being outside of Hamilton city and over half of the referrals were for the target age group of four to six years. The evaluation results show the programme has been successful in supporting whānau to make healthy changes across the Waikato DHB region. Positive changes in individual BMI scores were found. There was statistically significant difference in BMI z-score over the six month programme ($p<0.001$) and 58 percent of children reduced or maintained their BMI.

Whānau on the programme made many changes to support the on-going health of their children with 85 percent of participants indicating a higher frequency of the 'healthier' BeSmarter basics at the end of the programme. Following the successful outcomes determined in the evaluation, we will be looking for further support to continue this programme during 2020/21.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
The number of people participating in Green Prescription programmes	5802	4997	6700	3196	●

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 worked closely with Sport Waikato to redesign how Green Prescriptions are delivered. From October 2019 Sport Waikato provided three levels of Green Prescription based on client needs and their support requirements. This allows longer engagement with the service, but for fewer patients.

The previous short intervention was not always 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.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	100%	100%	100%	100%	●
Output Measure	**Baseline 2014/15**	**Previous year 2018/19**	**Target 2019/20**	**Result 2019/20**	**Rating**
Percentage of total primary schools participating in Project Energize	100%	100%	100%	98%	●

Our performance

We continue to have high 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 235 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	Children and adolescents have better oral health	An improvement in childhood oral health
		Mean decayed missing and filled teeth score of Year 8 children
		Percentage of children (0-4) enrolled in DHB funded dental services
		Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination
		Percentage of adolescent utilisation of DHB-funded dental services
	Long-term conditions are detected early and managed well	Percent of the eligible population who have had their cardiovascular risk assessed in the last five years
		Percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past five years
		Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months
		Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram every two years
	Fewer people are admitted to hospital for avoidable conditions	Ambulatory sensitive hospitalisation rate per 100,000 for 0-4 year olds
		Ambulatory sensitive hospitalisation rate per 100,000 for 45-64 year olds
		Percentage of eligible population who have had their B4 School Check completed
		Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to age related residential care
		Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days
		Percentage of people enrolled with a PHO
		Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

Why does this matter?

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

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

We achieved the target	We almost met the target (within 10 percent)	We have not met the target

People stay well in their homes and communities

Children and adolescents have better oral health

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Mean decayed missing and filled teeth (DMFT) score of Year 8 children	Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.88 Pacific 1.05 Other 0.40 Total 0.56	Māori 0.65 Pacific 0.65 Other 0.65 Total 0.65	Māori 0.84 Pacific 0.60 Other 0.44 Total 0.57	

Our performance

The above results are based on the 2019 calendar year and represent the measure of the mean number of decayed, missing and filled permanent teeth for 12-13 year olds. The cohort of Pacific children is statistically too small (approximately 200 children) for meaningful results.

There is a small overall increase in the mean DMFT for Year 8 children in 2019 compared to 2018. Although small, it is pleasing to note a reduction in the number of children who identify as Māori having decayed, missing or filled teeth.

The service will continue to work on reducing the DMFT measure in 2020 by:

- engaging with parents and inviting them to assessment appointments with their children. This compares to previous generations of children who were taken from class with no parental involvement. Parental health literacy in the home environment is critical to good oral health. Parents can engage by participating in the 'text and remind' system and attend their child's community oral health appointment
- an annual fluoride varnish application programme for all children, with increasing applications per year for those in high need areas, where resource permits. The programme is reviewed annually with the intention of increasing the number of children receiving fluoride varnish and the frequency of application.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of children (0-4) enrolled in DHB-funded dental services	Māori 72% Pacific 72% Other 72% Total 72%	Māori 85% Pacific 76% Other 98% Total 92%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%	Māori 82% Pacific 48% Other 88% Total 84%	

Our performance

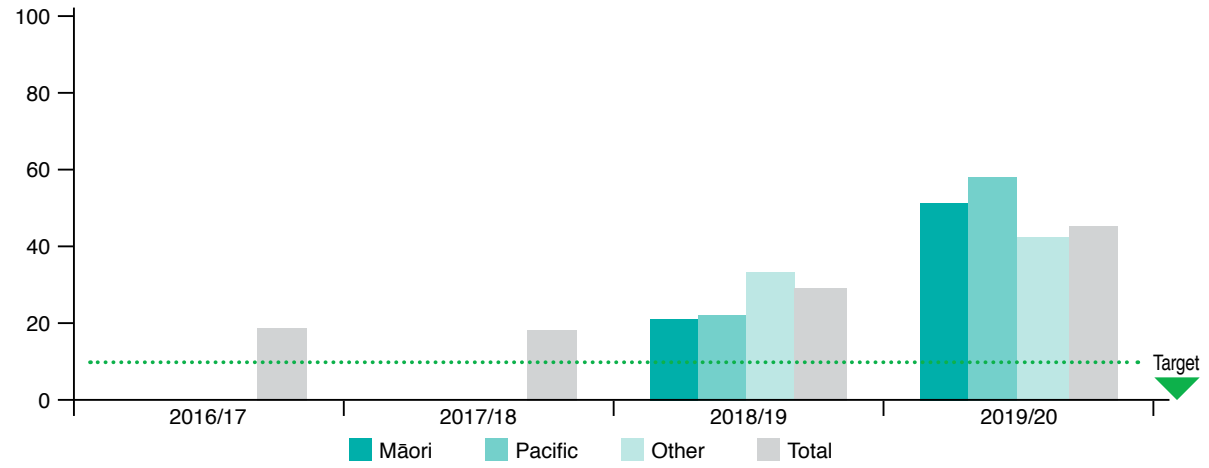
The above results are based on the 2019 calendar year and represent the number of children (0-4) enrolled in the DHB-funded dental service. The cohort of Pacific children is statistically too small (approximately 200 children) for meaningful results.

The service did not achieve its set targets against these measures in 2019 with a disappointing small decrease in Māori enrolments. There is an overall decrease of eight percent in enrolments against calendar year 2018.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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%	Māori 21% Pacific 22% Other 33% Total 29%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori 51% Pacific 58% Other 42% Total 45%	

Our performance

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



The above results are based on the 2019 calendar year and represent the number of children aged 12 and under who are overdue for their scheduled dental examination. The cohort of Pacific children is statistically too small (approximately 200 children) for meaningful results. It is disappointing to see the results have deteriorated further in 2019 against results in 2018 and the trend is continuing into the 2020 calendar year with arrears towards 50 percent in May 2020.

The new service structure implemented in late 2018 has had a follow-on effect on service productivity with approximately five full time clinical staff removed from the service to undertake leadership and administration roles. Increasing difficulty recruiting to vacancies has also contributed to the reduction in clinical capacity for the service. In addition, the number of appointments which are 'failed to attend' remains high at approximately 30 percent of all appointments scheduled for pre-schoolers.

The service has a focus on arrears reduction:

- Developing and implementing an arrears management plan
- Complete analysis of actual against budgeted FTE to determine variance and identify optimal staffing levels required and complete work required for recruitment
- Identify and implement a plan to improve recruitment for long-term, hard-to-fill clinical vacancies through consideration of base location and using staff travelling to high needs, hard-to-fill areas as required
- Review the appointment booking set up to ensure appointment booking is prioritised based on recall status
- Continued support for undergraduates to gain work experience at Waikato DHB in an effort to attract them back as graduate staff
- Establish a weekly review of productivity to track progress and capacity demand
- Set recalls to reduce appointments offered to nine months or less and prioritise most at risk and high needs population groups
- Develop strategy with pre-school coordinator to provide oral health education to family and whānau of pre-schoolers enrolled under nine months to reduce time spent by clinical staff on education
- Improve Titanium reporting tools to support and assist staff to direct their activity and productivity towards achieving targets through greater understanding of, and access to, available data.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of adolescent utilisation of DHB-funded dental services	Māori 45% Pacific 53% Other 80% Total 70%	Māori 47% Pacific 53% Other 79% Total 67%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 46% Pacific 55% Other 77% Total 65%	● ● ● ●

Our performance

This result is based on data from the 2019 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 national New Zealand average.

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 lifelong 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.

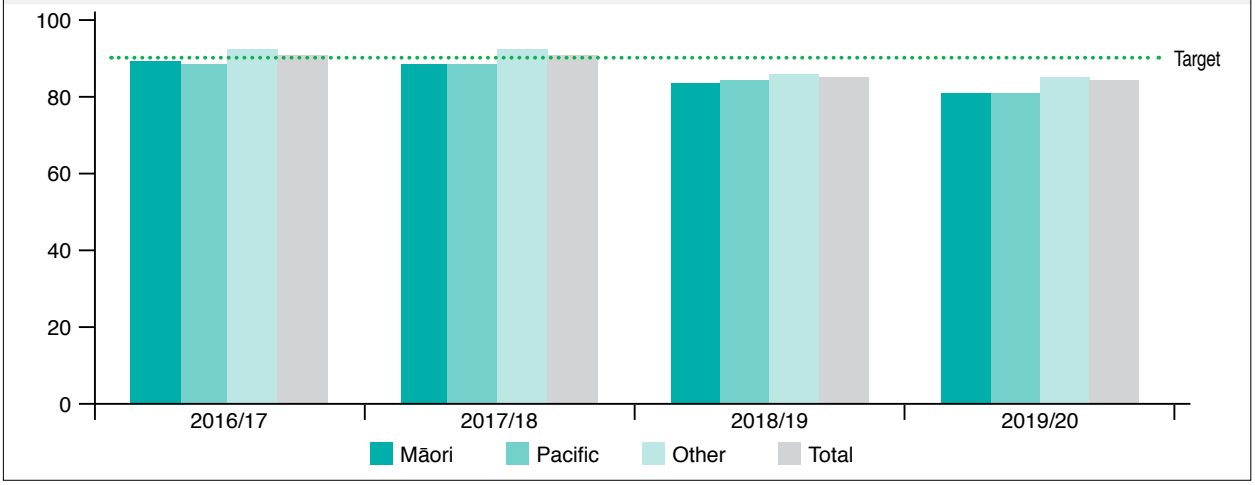
Effective partnerships are an essential part of providing the best service possible, discussions with regional colleagues at annual meetings remain an effective means of sharing approaches, successes, challenges, and opportunities to learn from each other about how uptake can be improved.

Long-term conditions are detected early and managed well

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 83% Pacific 84% Other 86% Total 85%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 81% Pacific 81% Other 85% Total 84%	

Our performance

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



We are disappointed to have not met the target and to see a slight decline from last year. Initiatives are in place to improve results including PHOs providing their general practices with a daily list of patients who are overdue for Cardiovascular Disease Risk Assessment (CVDRA). Practices use this list to call and follow-up patients to ensure they receive their CVDRA in a timely manner and any necessary preventative measures can be put in place early. COVID-19 impacted on the resource and time available in general practices, many patients also avoided clinics where they perceived a risk of coming into contact with COVID-19. PHOs are now prioritising follow-up with those patients who are most at risk of poor outcomes (patients whose previous risk score was above 10 percent). Achieving the target remains a priority for 2020/21. It is expected that initiatives such as incentivising the completion of CVDRAs via quality plans will contribute to improved performance in the future.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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%	66%	90%	65%	

Our performance

We are disappointed to have not met the target but CVDRA for Māori men aged 35-44 will remain a priority in 2020/21. This is a high risk target population and it is important to achieve this target if we are to improve health equity.

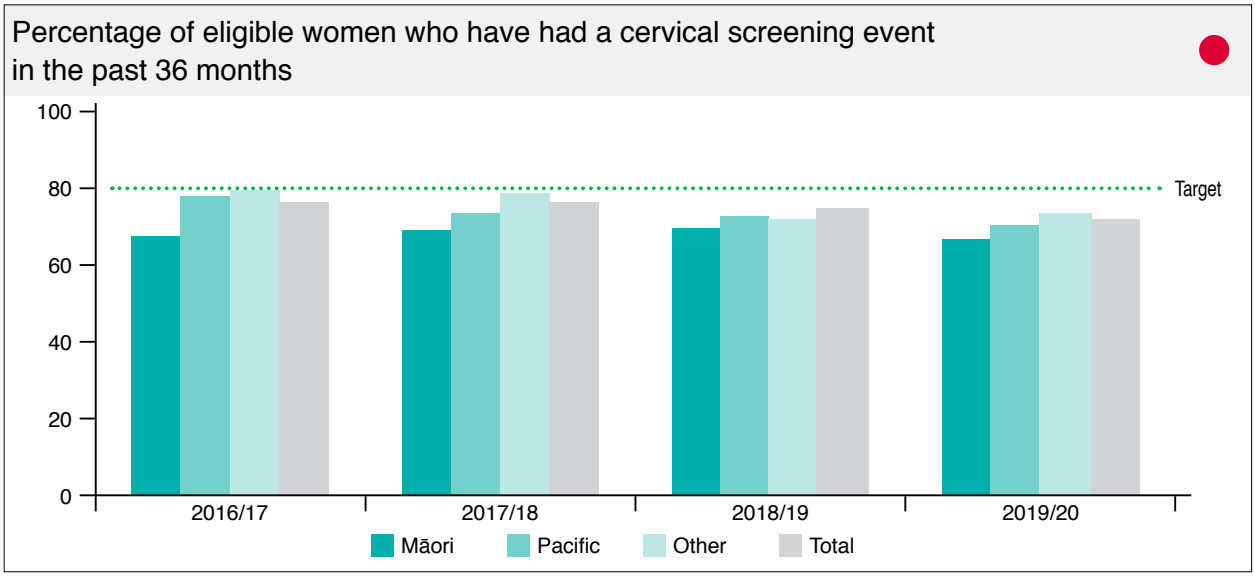
To help improve results some new initiatives have been implemented including all the PHOs having an updated common form that reflects the updated cardiovascular disease guidelines. This prompts the GP if the patient is eligible for CVDRA and should improve the number of risk assessments being completed. Each day the PHOs provide their general practices with a list of patients who are overdue for a CVDRA. The practice then contacts these patients to arrange for the check to be completed. PHOs also financially incentivise practices for completion of CVDRA for 35-44 year old Māori males. All of these initiatives are expected to improve results over the next year.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 69% Pacific 72% Other 71% Total 74%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 66% Pacific 70% Other 73% Total 71%	

Our performance

Percentage of eligible women who have had a cervical screening event in the past 36 months



While we have not achieved the target, many activities have taken place to improve results, and many opportunities have been identified for 2020/21 despite the challenges faced with COVID-19.

Improving results requires engagement with our target population and stakeholders.

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 these reports. Support to PHOs in screening overdue and significantly overdue women has also been provided. We have also provided additional support to rural practices in Te Kuiti and Taumarunui.

The DHB has also partnered with Anglesea Pharmacy to provide opportunistic cervical screening to priority women. Pre COVID-19 we were attending events such as Waka Ama and provided opportunistic screening at these events as well as education and support. We have continued to support the #SmearYourMea (#SYM) campaign and their "Ride for Talei" event. We are planning to hold more events in 2020/21 supporting a national #SYM day in 2020/21 and Cervical Screening Awareness Month.

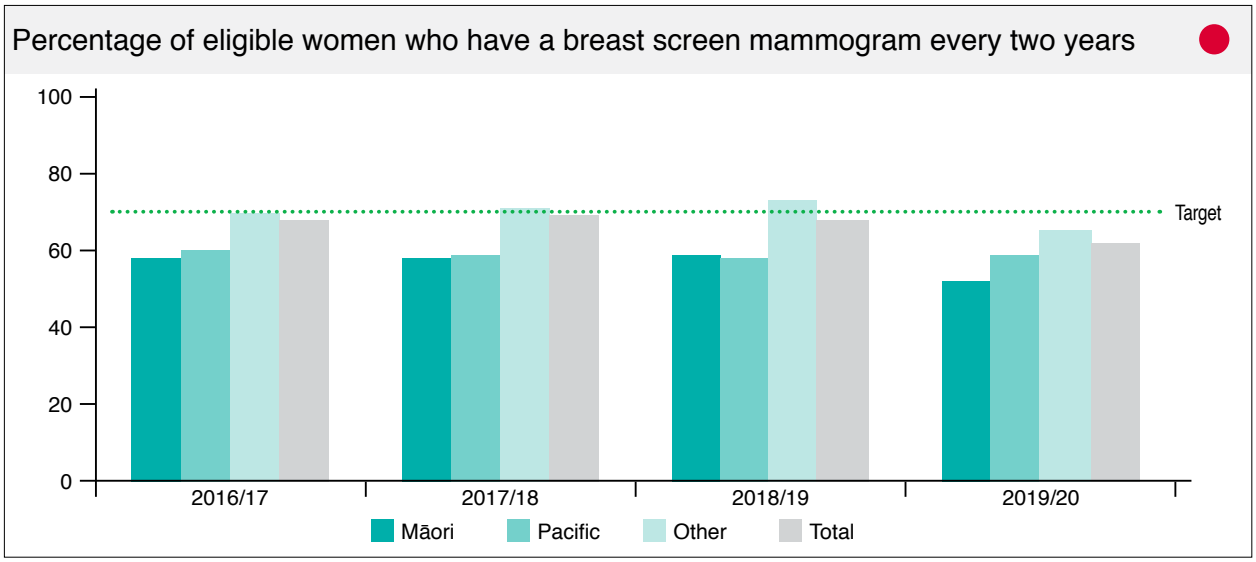
We have also been increasing our social media content. An online 'live stream' educational session was held with Plunket during the COVID-19 alert level four lockdown. This interactive session captured a reach of 21,000. We also upload weekly awareness posts via our Cervical Screening Waikato and Smear Your Mea Facebook pages. These pages have a combined reach of over 12,000.

For practice staff, we also produce a monthly newsletter, which is proving popular. For Cervical Screening Awareness Month we supported practices with their own awareness campaigns and also ran a "dress up your reception" competition. 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 to a minimum of two Saturday free clinics a month.

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. We will be extending our support to rural practices in 2020/21, in collaboration with our PHO partners, and plan on providing opportunistic cervical screening alongside the breast screening mobile visits in areas with high Māori and Pacific populations.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram every two years	Māori 58% Pacific 60% Other 70% Total 68%	Māori 59% Pacific 58% Other 73% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 52% Pacific 59% Other 65% Total 62%	

Our performance



Please note: The application of the 2018 census data has been applied midway through 2019/20 which the drop in coverage is attributed to.

While we have not achieved the target this year many activities have taken place to improve results and many opportunities have been identified for 2020/21 despite the challenges faced with COVID-19.

Screening capacity within Waikato DHB's current service equipment and facilities has impacted on its ability to meet coverage and screening targets. Waikato DHB is addressing this by procuring and implementing a third mammography machine at the Waiora Waikato hospital campus fixed screening site. BreastScreen Midland is also amending its mobile site visit to Cambridge to ensure the more rural mobile screening sites still receive services post COVID-19.

To try and increase screening targets a number of engagement activities took place including: the coordination 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. BreastScreen Midland also worked on improving Kaitiaki support during the mobile visits in Te Kuiti and Tokoroa, which saw an average of five percent increase in Māori screening participation compared to the last visit.

Work will continue on increasing community engagement in areas of highest need where Māori participation rates are low for Waikato.

Opportunities to make the service more accessible were identified and implemented. Some of the key actions include: implementing a pro-equity BreastScreen Midland invitation process, providing opportunistic screening through the Hauora ihub, increasing Saturday dual screening clinics (breast and cervical screening), scoping up other possible mobile sites around Hamilton to improve Māori screening, 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 2020/21.

BreastScreen Midland is also seeking to recruit into a new equity lead position to lead and support improving Māori breast screening coverage, with a focus on Waikato DHB.

BreastScreen Midland continues to work closely with the Ministry of Health on strategic policies for breast screening, focusing on opportunities to improve rescreening rates for priority women and strengthening vulnerable workforces. Collaboration with, and the providing of training and support to PHOs for their Support to Screening service contracts has been successful and will continue.

People stay well in their homes and communities

Fewer people admitted to hospital for avoidable conditions

Impact measure	Baseline 2018	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Ambulatory sensitive hospitalisation rate per 100,000 for 0-4 year olds	Māori 10,531 Pacific 10,942 Total 9260	Māori 11,440* Pacific 11,304* Total 7758*	Māori <10,886 Pacific <10,670 Total <9572	Māori 8387 Pacific 8852 Total 7008	
Impact measure	**Baseline 2018**	**Previous year 2018/19**	**Target 2019/20**	**Result 2019/20**	**Rating**
Ambulatory sensitive hospitalisation rate per 100,000 for 45-64 year olds	Māori 9081 Pacific 7446 Total 4451	Māori 9508 Pacific 8945 Total 3298	Māori <9158 Pacific <8459 Total <4355	Māori 8726 Pacific 9000 Total 4335	

**these results were not in the 2018/19 Annual Report so are unaudited.*

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.

We are pleased to have met all except one of the ASH targets set for 2019/20.

We will continue to focus on achieving the results through initiatives that increase access to primary care and services. Prevention and early intervention are key to reducing ASH rates. Health promotion is also essential through different mediums to obtain a wider audience. There have been efforts undertaken 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 2020/21. The system and service will be reviewed to gauge the effectiveness before other localities are added.

Output measure	Baseline 2014/15	Result 2019/20	Target 2019/20	Result 2019/20	Rating
Percentage of eligible population who have had their B4 School Check completed	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 91% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 42% Pacific 59% Other 66% Total 57%	

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.

Historically, a significant amount of this programme is undertaken in the second half of the financial year. The COVID-19 response coincided with this period which prevented the normal 'catching up' phase of the annual programme.

Detailed plans are in place to achieve the 90 percent target in 2020/21 as we have in previous years. In part this will be 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 2020/21 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 2018/19	Target 2019/20	Result 2019/20	Rating
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	3.9/100,000	2.9/100,000	1.2/100,000	3.5/100,000	●

Our performance

During the 2019/20 reporting year, there were 17 notified cases of acute rheumatic fever in the Waikato DHB district – this includes all confirmed, probable, and under investigation cases so may be subject to modification. This is an increase on last year's number, as we saw a significant number of cases during the summer months. Acute rheumatic fever remains one of many diseases of inequity – with our numbers reflecting ongoing inequities in health care quality and access, and also differential access to underlying social determinants of health.

While 17 cases may not seem like a large number, the impact an episode of acute rheumatic fever has on an individual and on their whānau is immense and lifelong, which is why it is important to resource rheumatic fever prevention and management initiatives sufficiently. Current Ministry of Health directed funding agreements remain in place for this financial year and are directed at increasing rheumatic fever awareness, providing free sore throat swabbing services to eligible populations (pharmacies), and supporting the Whare Ora programme to improve housing conditions.

The response to COVID-19 saw a temporary cessation of our pharmacy-led sore throat management services during lockdown. Equity and acute rheumatic fever prevention remained a focus of Waikato DHB however, with a return to empiric antibiotic treatment of priority populations presenting with a sore throat. Waikato DHB did not see the surge of cases through lockdown that other DHBs experienced.

People stay well in their homes and communities

More people maintain their functional independence

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Average age-of-entry to age related residential care:					
• Rest home	85 years	84 years	>84 years	86 years	
• Dementia	83 years	81 years	>80 years	82 years	
• Hospital	86 years	85 years	>85 years	84 years	

Our performance

Our targets for entry to secure dementia facilities and rest home level care have been achieved. Although close, the hospital level care target was not achieved.

It is possible that age-of-entry data for hospital level care 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).

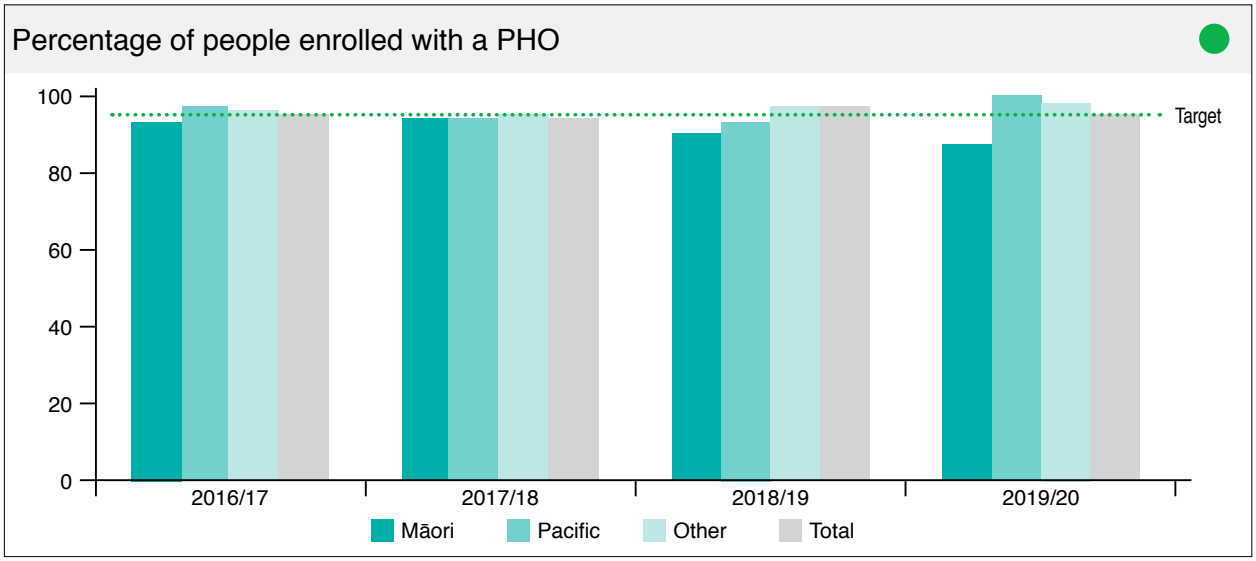
Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of older people receiving long-term home-based support have a comprehensive clinical assessment and an individual care plan	100%	100%	100%	Māori 100% Pacific 100% Other 100% Total 100%	

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 individual's needs and enables the older person to access the assistance they need while maintaining their independence.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of people enrolled with a PHO	Māori 91% Pacific 88% Other 96% Total 95%	Māori 90% Pacific 93% Other 97% Total 97%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 87% Pacific 100% Other 98% Total 95%	

Our performance



While the target has not been achieved for all ethnicities we are pleased that 95 percent of all people who live in the Waikato are enrolled with our PHOs and 87 percent of Māori have joined a PHO.

Initiatives to increase enrolment rates during 2019/20 have included ongoing communication with Anglesea Clinic Medical and Urgent Care 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 part enrolling inpatients and outpatients with a PHO and nominated general practice of the patient's choice.

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 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days	62%	96%	100%	94%	

Our performance

For 2019/20 there were 18,521 interventions provided by Disability Support Link (health of older people and disability services). This is a large increase compared with the previous year when there were a total of 13,534 interventions.

This increase in activity is a combination of two things:

- The service taking a more pro-active approach, using interRAI outcome scores to target more frequent reviews for more complex, vulnerable, older clients in the community
- Increased activity through the COVID-19 lockdown period with clients contacted and reassessed more frequently, to ensure they were safe.

The slight drop in the percentage of clients assessed within 20 working days is attributable to COVID-19. Through our service provision during the lockdown period, clients expressed a preference to rely on natural supports in the short-term and to undertake an assessment and accept a provider coming into their home as we moved out of lockdown.

Assessments can be often be delayed for reasons beyond the control of the service including:

- Social and family. For example, availability of client or family to be at the assessment. Clients often delay the assessment so a support person can be present, or the patient is temporarily staying with a family member who is providing support
- Not ready for assessment when the referral is received. For example, under another service providing short-term care and/or a rehabilitation service.

COVID-19 led to increased support across all of Disability Support Link and its associated services. The services average 18,000 interventions per year in total, in 2019/20 the number of interventions amounted to 22,544 interventions. In addition there was a further 7000-plus welfare checks undertaken ensuring our disability community was safe through the lockdown period.

The welfare checks identified some consistent themes:

- Some patients were fine, but were grateful that someone had been in touch and checked on them
- There was a lot of health literacy conversations as people were understandably anxious through the period
- Medication and equipment issues were able to be solved
- Clients were connected to volunteer groups who were able to collect shopping and other essential items
- Some clients had struggled as their natural supports had not been able to visit, so were able to increase that support through the home based providers.

Disability Support Link continues to build upon its existing services:

- Nurse practitioner led multi-disciplinary team meetings have been established in the community. This targets supporting our vulnerable older population and includes care managers, district nursing, social work, general practice, pharmacy and other agencies involved in the person's care
- Admission avoidance scheme (replaces the previous Primary Options Respite Care) – general practice are able to send direct referrals for wrap around supports to be put in place at short notice, helping to prevent unplanned and avoidable hospital admissions. In 2018/19, primary options respite care was provided on three occasions compared to 2019/20 where the admission avoidance scheme has an uptake of on average 25 occasions per month
- A new Specialist Case Management service has been established which works across health of older people, chronic health, mental health and disability support services. This takes a collaborative approach to supporting people who have complex behavioural issues who often are difficult to keep safe in our communities
- Disability Support Link Māori NASC has established seven "neutral" venues across the Waikato. One day per month the team make themselves available on the marae. The iwi provider will let people know when they will be visiting. The team makes themselves available for clients, whānau, providers and others if they have questions. This has been particularly effective in improving access and timely interventions.

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 Mental health clients discharged have a transitional (discharge) plan Average length of acute inpatient stay (mental health) Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives Number of new patients seen by the Waikato Hospital Palliative Care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days) Percentage of accepted referrals for MRI scans will receive their scan within 6 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 15/16) 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

We achieved the target	We almost met the target (within 10 percent)	We have not met the target

People receive timely and appropriate specialist care

Why does this matter?

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

Where people have end stage conditions it is important that they and their families are supported by well-functioning, quality palliative care that ensures people live comfortably.

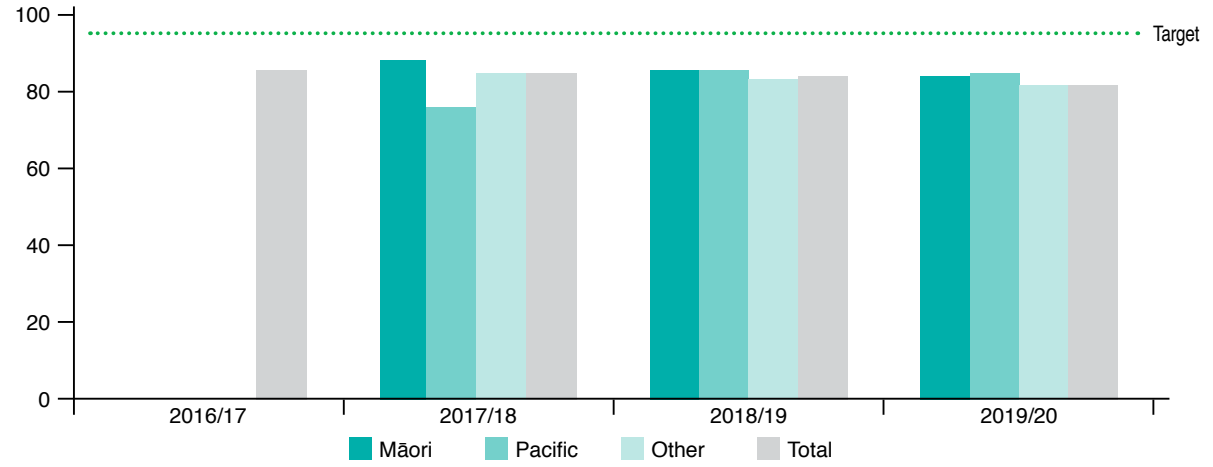
Achievement of this long-term impact will improve the quality of life for our population through early diagnosis and intervention to avoid further deterioration, timely corrective actions to relieve pain or illness, and appropriate supports to manage end stage conditions.

People receive prompt and appropriate acute and arranged care

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	Māori 92% Pacific 91% Other 91% Total 94%	Māori 86% Pacific 86% Other 83% Total 84%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 84% Pacific 85% Other 82% Total 82%	

Our performance

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



The usual trend of increased presentations year-on-year did not occur in 2019/20, instead there was a 4.5 percent decrease in the presentation rate. This decrease was directly attributable to the COVID-19 pandemic government lockdown alert levels, with lower levels of trauma occurring.

Prior to March 2019, the DHB continued to see the normal trend of approximately five percent annual increase in presentations. In March 2020, the Waikato Hospital ED experienced the beginning of four consecutive months in which presentations dropped significantly.

The Emergency Q app was implemented on 31 July 2019 (the beginning of the 2019/20 financial year). Over 5000 patients (6.1 percent of total presentations) have been redirected to a local urgent care centre using Emergency Q since implementation.

Admitted patients are more likely to breach the Ministry of Health six-hour target than non-admitted patients. Approximately 20 percent of patients who were admitted in the 2019/20 year breached the six-hour target. Waikato DHB have been working on the following actions to mitigate this:

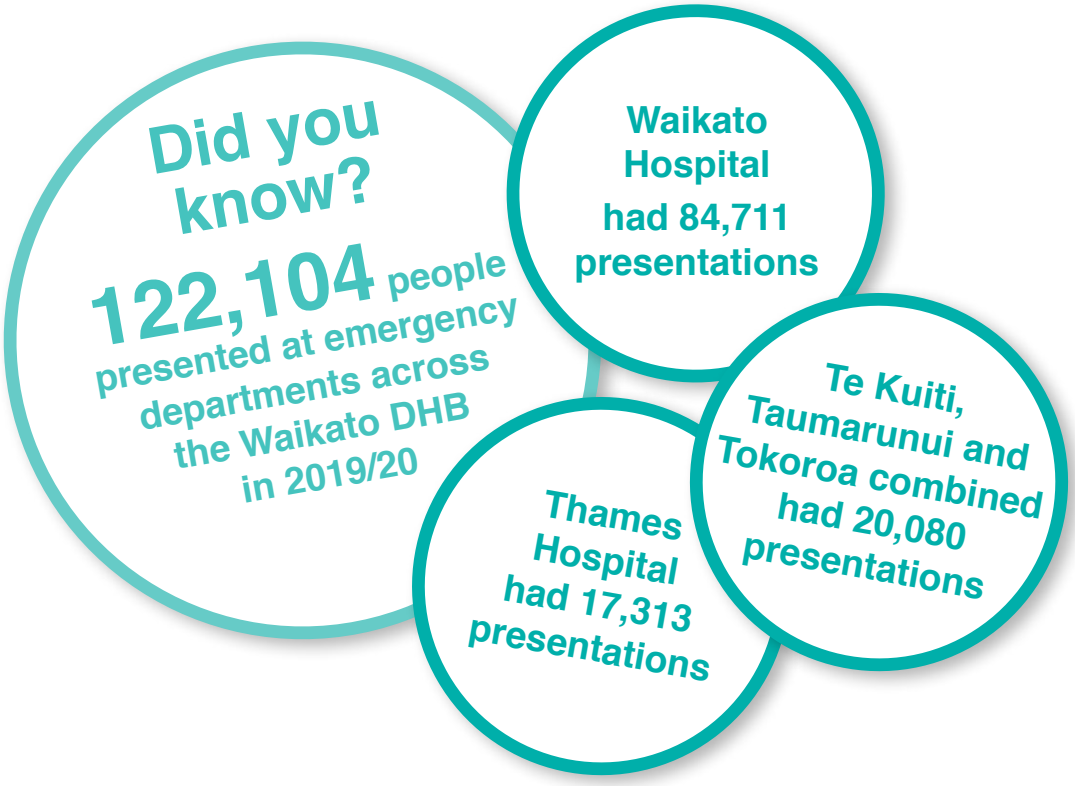
- Greater utilisation and a timelier response from the assessment units in surgery, medicine, women's health and paediatrics. The department is working with speciality colleagues to support an automatic referral and movement of patients to these units by the emergency medicine specialist using an agreed, standardised consistent pathway
- Undifferentiated patient management presents an opportunity in response to managing the complex, often frail, older and multi-morbidity patient. Internal medicine is actively developing services with a view to providing a consistent pathway via Acute Medical Unit and a general physician review 24 hours a day and seven days a week
- The clinical and management information systems can be a barrier to patient flow. The DHB does not have effective 'at a glance' information throughout the hospital which is transparent about hospital status and patient care needs. The implementation of Patient Flow Manager in 2020/21 will assist in alleviating this issue.

People receive timely and appropriate specialist care

Nine percent of the patients who are treated and discharged from the ED breach the Ministry of Health's six-hour target. Breaches are primarily driven from:

- delays in decisions to discharge a vulnerable/older patient to home or an alternative facility such as aged residential care. Often the time of the day and access to carers after hours impedes the ED's ability to discharge the patient. For the vulnerable/older/aged residential care group this is often about providing a bed for their overnight needs and having an active plan for an early next morning discharge. The management of the frail elderly is an ongoing focus for a team including NASC, ED and Older Persons and Rehabilitation clinicians. The options regarding admission avoidance and the use of the InterRAI assessment tool information are contributing to this work
- delays in receiving diagnostic information such as radiology and laboratory test and reporting. This will be resolved as the ED works with the relevant departments to establish mutually supported Service Level Agreements which reflect the urgency of tests requested and reporting timeframes
- lack of transportation and the financial ability of patients to pay for their own transport home (buses and taxis included) can be a contributing factor to delayed discharge.

A daily breach report is circulated to each service. The drive is for services to prevent recurrence and enabling services to improve models of care and staff rostering so that demand is met with the most appropriate team available and the trend of disease and presentation type that is most likely to lead to a breach.



Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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%	91%	90%	87%	

Our performance

The DHB achieved a result of 87 percent for 2019/20 for 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.

A number of initiatives have been implemented to improve this result for the 2020/21 year:

- Breast cancer surgery waitlists were cleared during the COVID-19 alert level 4 lockdown and alert level three periods and allowed for additional capacity from March 2020
- Dedicated gynaecology 'High Suspicion of Cancer' clinics commenced in March 2020
- Increased thoracic surgery capacity by adding an additional theatre list per week.

A number of initiatives have been deployed to address equity:

- Engagement with the newly created Clinical Equity Leadership Group to recognise and identify barriers to clinical or hospital care
- Engagement with Te Puna Oranga to minimise inequity in Faster Cancer Treatment (FCT), including addressing DNAs and identifying barriers to improve better outcomes for Māori and Pacific communities. Daily reports were generated to highlight any FCT patients who Did Not Attend (DNA) appointments relating to their FCT pathway. The clinical nurse specialist for equity and access monitored this report and pro-actively facilitated patient management and reviewed the overall system to mitigate delays where possible
- Daily reports were generated to highlight any DNAs for FCT patients through all parts of their pathways. The clinical nurse specialist for equity and access investigated the reason for the DNA and tried to assist the patient to attend the next appointment by finding solutions which work for each individual patient
- Worked with primary care to highlight potential DNAs early on in the pathway; this enabled the clinical nurse specialist equity and access to liaise with patients to ensure they were able to attend appointments.

A number of operational measures have been undertaken to improve performance:

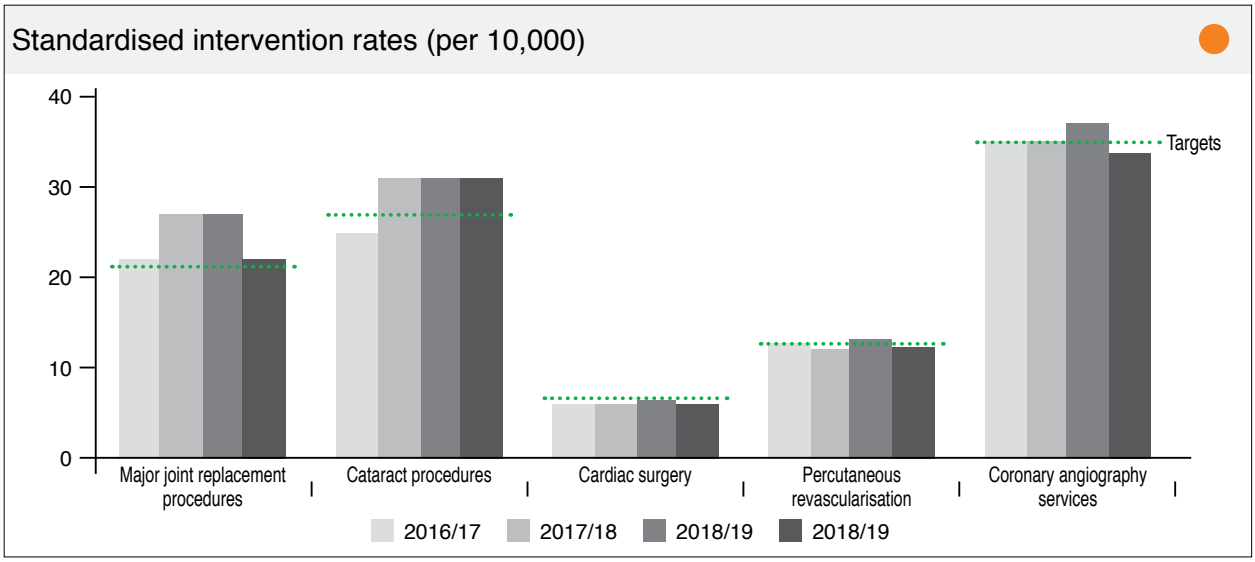
- FCT business manager and FCT nurse tracker have been working very closely with the clinical nurse specialists to monitor patient pathways from the initial date of referral and, where possible, assist patients to not breach
- Weekly coordinated meeting with gynaecology clinical nurse specialists to discuss individual patients and tracking pathways to ensure patients are discussed at Auckland multi-disciplinary meetings in a timely manner
- Ongoing monitoring of respiratory triaging and time to first specialist appointment
- Weekly urology waitlist meeting to discuss any patients triaged onto 62 day pathway
- Weekly general surgery waitlist meetings between FCT business manager, nurse tracker, clinical nurse specialist, elective care coordinator and booking clerk to ensure patients have a theatre operation date prior to breaching the health target.

People receive timely and appropriate specialist care

People have appropriate access to elective services

Impact measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures	27	27	21	22	
• Cataract procedures	25	31	27	31	
• Cardiac surgery	7.3	6.4	6.5	5.9	
• Percutaneous revascularisation	11.4	13.3	12.5	12.4	
• Coronary angiography services	33.9	37	34.7	33.8	

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 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 two of the targets, and is just shy of achieving the others.

The result this year has been impacted by a number of industrial actions and COVID-19 related events that have taken place during 2019/20 fiscal period.

We are committed to achieving and sustaining these health targets in the five areas indicated. We continue to work hard with our Cardiology colleagues to assist our DHB attaining the required objectives in the timelines required with new Planned Care Initiatives (PCI) that have begun to roll out of the DHB. These will be further developed and implemented into the health continuum in 2020/21. We look forward to seeing these improved results during the first two quarters of the fiscal period.

Did you know?
In 2019/20 we performed **28,014** elective operations

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of patients waiting longer than four months for their first specialist assessment	2.7%	3.6%	0.0%	19.2%	

Our performance

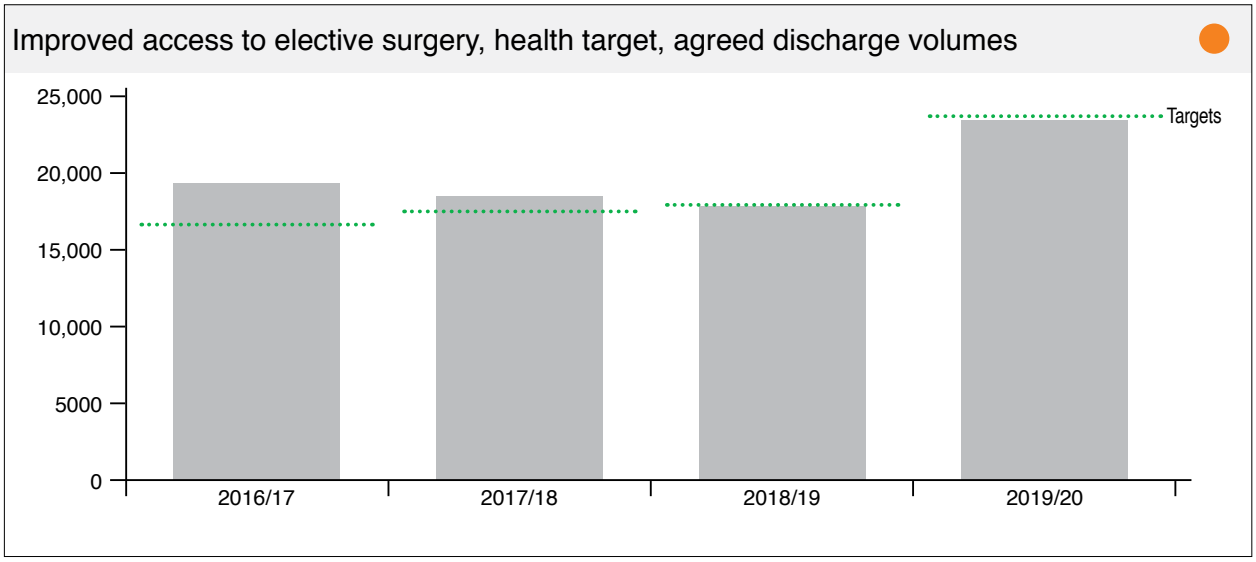
The target of patients waiting four months for first specialist attendances was significantly impacted by the national response to COVID-19. A large amount of first specialist attendance capacity was lost between mid-March and mid-May, with initial recovery focused on prioritising urgent appointments.

Transition and recovery plans have been developed at service level and additional funding to support recovery is currently being finalised with the Ministry of Health.

The production planning team are continuing to work on reporting and models that provide 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.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Improved access to elective surgery, health target, agreed discharge volumes	15,693	17,764	23,772	23,257	

Our performance



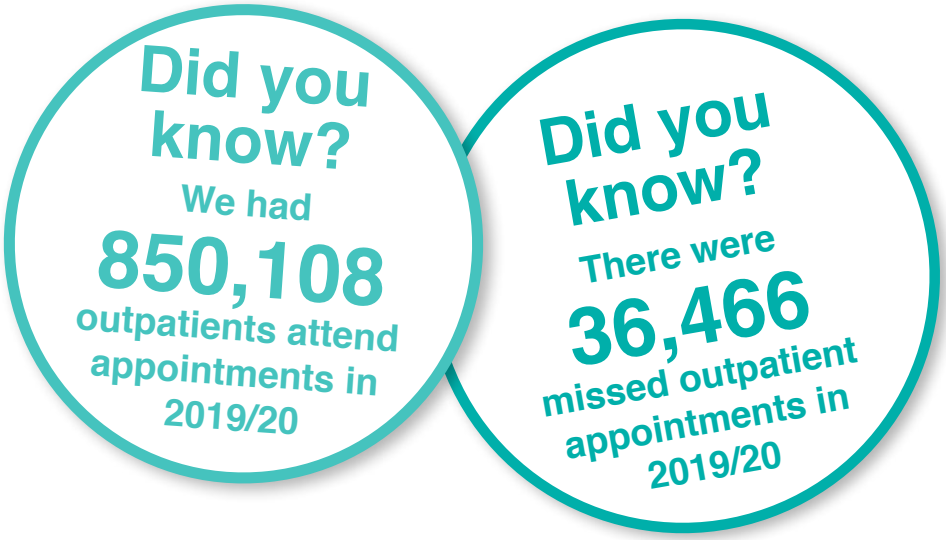
The target of elective surgery was significantly impacted by the national response to COVID-19. Theatre capacity was significantly affected from mid-March and mid-May, with only acute and time critical patients receiving elective procedures during this time. Initial recovery focused on prioritising urgent appointments.

Prior to COVID-19 we were on target to achieve 100 percent. The impact of COVID-19 saw our year end result at 91.5 percent.

Transition and recovery plans have been developed at service level and additional funding to support recovery is currently being finalised with the Ministry of Health.

The production planning team are continuing to work on reporting and models that provide 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.

People receive timely and appropriate specialist care



Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Did-not-attend percentage for outpatient services	Māori 21% Pacific 18% Other 7% Total 10%	Māori 20% Pacific 17% Other 6% Total 9%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 18% Pacific 16% Other 6% Total 8%	

Our performance

Performance in the overall DNA rate has continued to improve over the past 12 months with two of the targets being met, however there is still a significant equity gap between Māori, Pacific and other.

Following on from the Resource Review recommendations in June 2019 an analysis was completed of DNA rates from outpatient clinics by ethnicity to understand the current equity gap and performance by services. Clinics are either delivered in the Meade Clinical Centre or managed directly by the service in their own service area.

Two services identified as having the highest equity gap and non-attendance rates for Māori (diabetes and paediatric medicine) have focused on improvement activities to understand the issues and make changes to reduce the equity gap and improve attendance. Implementing access to refined and regular performance reporting has supported this improvement work at the same time as other initiatives such as:

- reminder phone calls 24 hours prior to appointment
- phone calls to rural patients when making first specialist attendance appointments to check on any issues that might impact on attendance e.g. transport, appointment times
- reviewed content of appointment letters
- determined key performance indicators (KPIs) for services
- equity and access nurse roles in some services
- data reviewed daily/weekly/monthly
- initiating Telehealth appointments, where appropriate.

We remain committed to reducing DNAs and will continue to implement initiatives that will drive progress towards achieving the target for Māori and Pacific in 2020/21. Achievement of this target will improve health outcomes, access and ensure we make best use of clinicians' time.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Elective surgical inpatient average length of stay	1.71 days	1.59 days	1.50 days	1.50 days	

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Acute inpatient average length of stay	3.89 days	2.40 days	2.30 days	2.50 days	

Our performance

Please note: The annual plan targets were set by the Ministry of Health using a national standardised measure, which requires the national dataset to compute. As this is not available to the DHBs to report against, an internal raw length of stay calculation has been used along with a comparison between financial year 2019 and financial year 2020. The targets previously used should not appear in the annual report alongside these results as they are not the same definition.

Waikato DHB has, and will continue to focus on, reducing presentations to ED by strengthening primary care services to improve accessibility and early intervention, ensuring the right patient receives the right care, in the right place, at the right time. The DHB has reformed the Waikato Primary and Community Care Alliance with representatives from primary care and other community health providers, with a view to ensuring the pathway for patients is clearly supported with appropriate service models in each locality.

Utilisation of the short stay acute medical assessment service and acute surgical assessment service has continued to be a focus during 2019/20 – with a particular emphasis on developing these services to be 24 hours a day, seven days a week in the coming year.

Internal Medicine acute average length of stay has increased. The Respiratory service continues to show a drop in the average length of stay. For the other services, there has been a notable increase in complex patients treated who have had long stays. General Medicine long stay patients went from 5.7 percent staying greater than 10 days during 2018/19 to 6.9 percent in 2019/20. Neurology had a similar result with an increase in the number staying greater than 50 days from two to five which impacts the average length of stay.

The positive initiatives introduced during the 2018/19 and 2019/20 year included General Medicine hot clinics, with community COPD services continuing to be reviewed and refined to be able to manage patients more effectively.

The reduction in the Cardiothoracic length of stay has been driven by faster decision-making around accepting patients for surgery in combination with leaving acute slots for acute patients at the end of the week meaning quicker access to theatres. In addition, there has been an increase in patients for inpatient Transcatheter Aortic Valve Implantation (TAVI) further reducing the length of stay.

The focus by the Renal and Oncology inpatient services to remain within its bed allocation has resulted in the combined patient length of stay remaining similar to last year. The cancer and regional directorate has compared its average length of stay to other DHBs using Hormone Replacement Therapy (HRT) data and it performs better or comparably to other large centres.

The Endocrinology service did have a significant increase in its average patient length of stay, but the volumes of patients were low (n=16) so a low number of complex patients distorted the overall average length of stay for this discipline.

Gynaecology acute and elective length of stay and bed allocation remains within the KPI metric and there is no change from the previous year. The average length of stay compares favourably to other tertiary DHBs utilising HRT data and is below the average DHB length of stay.

There has been a slight decrease in the acute length of stay for paediatric medicine, however, this is above the average DHB length of stay and reflects the complexity of childhood respiratory conditions over winter months.

The paediatric surgery acute length of stay has increased, however, this still remains within the overall DHB average length of stay and reflects the complexity of the acute paediatric admissions. The elective length of stay for paediatric surgery is low at 0.67 and compares favourably with other tertiary DHBs.

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 2018/19	Target 2019/20	Result 2019/20	Rating
28 day acute readmission rates	Māori 14% Pacific 8% Other 12% Total 12%	Māori 13% Pacific 6% Other 11% Total 12%	Māori <13% Pacific <13% Other <13% Total <13%	Māori 12% Pacific 4% Other 11% Total 11%	

Our performance

The 28 day readmission rate for 2019/20 was 11 percent. This shows a slight decrease from the previous year.

At the same time, the demand for mental health and addictions services in the Waikato district has continued to increase. A targeted plan to reduce and manage occupancy levels in our acute adult inpatient facility was implemented in 2019. This included a focus on supporting post-discharge recovery for our service users with work to ensure sustainable housing and a number of specific wrap-around resources were available to support tangata whaiora on discharge from hospital.

We are continuing to develop 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 2018/19	Target 2019/20	Result 2019/20	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 68% Pacific 55% Other 61% Total 63%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80%	**3 weeks** Māori 71% Pacific 59% Other 59% Total 64%	
	8 weeks Māori 93% Pacific 95% Other 90% Total 91%	**8 weeks** Māori 88% Pacific 78% Other 87% Total 87%	**8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**8 weeks** Māori 88% Pacific 78% Other 79% Total 83%	

Our performance

Child and youth mental health services continue to face very high demand for their services and this is reflected in the wait times reported by the provider arm for three and eight week categories.

A post implementation review of the Infant, Child and Adolescent Mental Health Service (ICAMHS) cluster was undertaken. The report identified strengths and weaknesses in the unique cluster models based in both urban and rural communities resulting in recommendations that Waikato DHB could improve service access, wait times and delivery.

A review of the Mental Health and Addictions child and youth model of care was planned to commence for quarter three but was unfortunately delayed due to COVID-19. The intention is to pursue this in 2020/21. The review will identify a model that will have a focus on improving access, ensuring people are seen in a timely manner, and that the service meet the targets set.

Interim solutions have also been reviewed between the cluster DHB provider arm and NGO services to ensure the interface that occurs builds the capacity of current pathways and processes.

Primary mental health options are also expected to commence 1 July 2020 which may reduce pressure points by offering alternative access points for youth.

Output measure	Baseline 2017/18	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Mental health clients discharged have a transitional (discharge) plan	37%	Māori 92% Pacific 96% Other 92% Total 92%	Māori 95% Pacific 95% Other 95% Total 95%	Māori NA Pacific NA Other NA Total 98%	

Our performance

Please note: Ethnicity will be reported from 2020/21. See narrative below.

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 2019/20 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 2020/21 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 DHB's over-arching strategy to eliminate equity gaps for all services delivered to the DHB's 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.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 20 days Pacific 18 days Other 18 days Total 19 days	Between 14 and 21 days	Māori 19.19 days Pacific 19.91 days Other 18.28 days Total 18.74 days	

Our performance

It's pleasing to see there has been a very slight reduction in the average length of stay across the acute adult inpatient units. This again is linked to the work we have done to reduce and manage occupancy in the acute adult inpatient facility.

Waikato DHB Mental Health and Addictions does not turn away people in need of hospital admission or discharge people to homelessness. For many of our tangata whairoa there are barriers to safe, recovery focused, community living and recovery. The work we undertook in 2019 to ensure improved access to housing, specific wrap-around support packages and individualised placements in supported accommodation, where appropriate, allowed for many people with long hospital stays to be discharged.

There remain a number of tangata whaiora, for whom appropriate discharge and support options from hospital are limited, even with these new initiatives, however we continue to work toward alternatives to hospital admissions and community living.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Rates of post-discharge community care	Māori 69% Pacific 73% Other 72% Total 87%	Māori 86% Pacific 69% Other 86% Total 85%	Between 90% and 100%	Māori 80% Pacific 87% Other 79% Total 80%	

Our performance

Throughout early 2019/20 the Mental Health and Addictions service focused on working to improve face-to-face follow-up with those people recently discharged from hospital (within seven days of discharge). We saw success and positive progress in this area, achieving our highest rates of face-to-face, post seven day discharge follow-up at 96 percent. Where face-to-face contact was not achieved within the specified seven days, we ensured follow-up to understand the barriers, made telephone contact with tangata whaiora and reviewed our discharge processes.

However, when COVID-19 arrived in New Zealand in March 2020 we had to change working practices and limit face-to-face contact in all but the most critical clinical scenarios. As a result of the COVID-19 pandemic there was a significant decrease in face-to-face contact. During the period of lockdown and through alert levels two, three and four, the service worked hard to ensure other methods of contact were maintained.

A targeted contact strategy was implemented using both virtual face-to-face, and enhanced phone contacts for our tangata whaiora, this not only ensured that clinical support for specific discharge follow-up was appropriate, but also provided wellbeing and psycho-social support checks.

The move to alert level one meant face-to-face contact could resume, during alert level one we have seen our post seven day discharge follow-up face-to-face contacts steadily increasing to more acceptable levels and we will continue to ensure that we proactively follow-up everyone discharged from our inpatient facility.

Did you know?

35 DHB funded NGOs provided mental health and/or alcohol and drug services in the community in 2019/20

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 4.92% Pacific 3.39% Other 4.71% Total 4.73%	**0-19 years** Māori 4.82% Pacific 3.28% Other 4.63% Total 4.64%	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 4.78%	
	20-64 years Māori 7.12% Pacific 4.34% Other 4.34%* Total 4.33%	**20-64 years** Māori 9.00% Pacific 4.14% Other 3.83% Total 4.89%	**20-64 years** Māori 8.96% Pacific 4.04% Other 3.83% Total 4.88%	**20-64 years** Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12%	
	65+ years Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**65+ years** Māori 2.56% Pacific 2.15% Other 2.33% Total 2.35%	**65+ years** Māori 2.48% Pacific 2.19% Other 2.29% Total 2.31%	**65+ years** Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	

**baseline was incorrectly published in 2019/20 Annual Plan. The correct figure is 3.60%*

Our performance

The targets above refer to the total percentage of the population who have accessed mental health services. The targets are kept in line with the national average. Monitoring access rates by age and ethnicity helps to ensure that access rates are comparable with other DHBs and highlight where we may need to consider new initiatives or investment. Specialist Mental Health and Addictions services are funded for those people who are most severely affected by mental illness or addictions. The Waikato DHB continues to place a focus on improving access and has increased our target annually to keep momentum towards further progress. This resulted in continuing to increase targets each year and the targets set for the 2019/20 year being met. Data indicated for the 2019/20 year 864 additional people were seen in comparison to the prior year. Of this total 106 were 0-19 years.

The sector continues to face very high demand within both the DHB provider arm and NGO services. Interface between these services has been critical to ensure access continues to improve.

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. The Waikato DHB continues to pursue both child and youth, and adult model of care reviews which were planned for quarter three but delayed due to COVID-19. The intention is to continue to pursue these 2020/21.

Primary mental health options are also expected to commence 1 July 2020 which may bring a reduction in secondary mental health presentations. The primary mental health initial roll out is targeting Māori, Pacific, youth and rural communities.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 aged residential care facilities have an advanced directive offers health providers an understanding of an 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 Advance Care Plan (ACP) service model started in April 2020 and is run by Te Kōhao Health who will spend time with, and help those who would like to complete an ACP which is then saved into the hospital system. The ACP is an alternative to an advanced directive and provides greater detail on a person's wishes. A current priority is encouraging people to consider ACP earlier in life so that they can support their own whānau to consider their own as part of the new model. The ACP includes what is important to someone in their life: religion, whānau, being at home as much as possible, quality of life etc. A kaupapa Māori ACP form is currently under development in the Midland regions area.The aged residential care facilities are able to raise awareness of ACP with support by Te Kōhao Health. Health promotors from Public Health will also raise awareness at Marae and liaise with Te Kōhao Health who will complete the follow-up.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Number of new patients seen by the Waikato Hospital palliative care service	1085	1244	727	740	●

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 740 new patients during the year, (20 percent Māori and 80 percent 'Other'). The 2019/20 year has seen the development of joint clinics with Oncology and Renal which provide 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 to better support our patients. Work has commenced, and will continue through 2020/21 on forming the next stage of the strategic leadership group and working groups for workforce prioritisation and service specification. A review of palliative care (complex pain and symptom management) was commissioned in June 2020, the review will commence in July 2020 and be completed by an independent reviewer that has significant sector experience. 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 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	94%	80%	95%	49%	●

Our performance

We are disappointed that we have not met the target. Since the beginning of 2020 we have seen a sustained focus on creating capacity within the cath lab in order to manage our elective demand, however the impact of the level four shut down relating to COVID-19 and delays in recruiting interventional senior medical officers have impacted on our ability to reduce the number of patients waiting longer than three months.

A sustained focus on prioritising our most critically urgent elective patients has seen our coronary waitlist reduce from 294 in January 2020 to 150 in quarter one 2020/21. We will now turn our focus to ensuring that elective patients are treated within the three month target.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	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 65% Pacific 66% Other 68% Total 67%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 67% Pacific 63% Other 73% Total 72%	● ● ● ●

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of accepted referrals for MRI scans will receive their scan within six weeks (42 days)	Māori 55% Pacific 53% Other 52% Total 48%	Māori 75% Pacific 72% Other 79% Total 78%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 72% Pacific 70% Other 73% Total 72%	● ● ● ●

Our performance

Although we have completed CT scanning of approximately 2200 patients per month and MRI of 1000 patients per month, the Ministry of Health targets for CT (95 percent) and MRI (90 percent) were not met; we have been achieving 60-70 percent against the target each month for both CT and MRI.

The lack of radiologists which in turn creates unfilled vacancies has resulted in many CT and MRIs going unreported for longer. A range of mitigations are in place ranging from active recruitment through to the use of offshore reporting for basic radiology.

However, we have seen an increase in the number of patients scanned within the six week target both for CT and MRI, but at the same time the number of referrals and those waiting has increased. In the last calendar year we have seen an increased referral rate of seven percent in both modalities.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	78%	73%	90%	98%	●

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	49%	57%	70%	88%	●

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date	70%	65%	70%	75%	●

Our performance:

Waikato DHB has achieved compliance across all three output measures in 2019/20.

Management of the colonoscopy waiting times has improved over the past year with many new systems and processes embedded supporting patient focused bookings, back filling of lists and increasing our nurse endoscopist workforce. In 2020/21 we aim to go live with Bowel Screening (March 2021) and we will be in a stronger position to meet and support both the symptomatic and screening pathways going forward given our record of compliance over the past year. We intend to manage both symptomatic and screening pathways the same way mitigating possible inequalities between the two pathways.

Two of our key continuous improvement initiatives are in reducing our “Did Not Attend” (DNA) rates and mitigating our inequalities across the colonoscopy pathway. The DNA rate sits around four to five percent and we have monitoring reports by ethnicity. We have a strong focus in managing our Māori and Pacific patients through the colonoscopy pathway in a timely manner. In addition we have been successful is recruiting Māori and Pacific staff into our office both in administrative and nursing roles. Further workforce development is planned with 2020/21 being the first year that Waikato DHB staff will complete the Māori gastroenterologist fellowship.

Output measure	Baseline 2014/15	Previous year 2018/19	Target 2019/20	Result 2019/20	Rating
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	100%	100%	●

Our performance:

Our community laboratory services continue to exceed KPIs on turnaround times and service requirements.

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.

> All the staff in Cath Lab are amazing – informative and reassuring and there is a very positive vibe that is appreciated.

Bronnie, granddaughter of Ward A4 patient, June 2020

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 appropriate preventative maintenance programme is in place across all portfolios; and
- manage the risk profiles of all fixed assets.

The following table summarises our three portfolios:

Asset portfolio	Assets class within portfolios	Asset purpose	2017/18 Net Book Value	2018/19 Net Book Value	2019/20 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.	$639 million	$725 million	$701 million
Equipment	Clinical equipment.	To facilitate the delivery of hospital services through the provision of fit for purpose clinical equipment.	$52 million	$49 million	$57 million
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.	$31 million	$28 million	$35 million

The 2019/20 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

We achieved the target	We almost met the target (within 10 percent)	We have not met the target

Property portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Rating
Waikato campus buildings relative earthquake risk. Note 1	Condition	7%	7%	6%	<1%	6%	●
Waikato campus building core services down time as a percentage of total operating hours, per annum. Note 2	Condition	0.67%	0.52%	0.78%	<1%	0.49%	●
Waikato campus building core services net operating hours per annum.	Utilisation	99%	99%	99%	>99%	99.5%	●
Waikato campus carparks as a percentage of total public car parking. Note 3	Functionality	5%	5%	13.3%	>13%	13.3%	●
Waikato campus building energy efficiency savings as a percentage of targeted energy consumption. Note 4	Functionality	7%	16%	14%	>7%	21%	●

Clinical portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Rating
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%	103%	100%	>90%	120%	●
For Waikato Hospital Radiology department CT scanners performing operationally to hospital requirements.	Functionality	100%	100%	100%	>99%	100%	●
Linear Accelerators (Oncology department) planned operating hours versus hours utilised.	Utilisation	95%	92%	85%	>86%	72%	●
For Waikato Hospital, planned theatre usage versus actual usage. Note 5	Utilisation	74%	76%	73%	100%	73%	●
For Waikato Hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	100%	100%	98%	100%	94%	●
For Waikato Hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. Note 6	Utilisation	92%	92%	88%	<93%	86%	●
For Waikato DHB, elective surgery completed as a percentage of Ministry of Health elective surgery targets for last 12 months. Note 7	Utilisation	102%	105%	99%	>100%	92%	●
For Waikato DHB, weighted average age of clinical Fixed Assets versus Suppliers weighted average life expectancy.	Condition / Functionality	N/A	89%	56%	>90%	68%	●

Information communication and technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2019/20 Result	Rating
Percentage of computer hardware used by staff less than five years old. Note 8	Condition	97%	82%	62%	>90%	66%	●
The availability of Clinical ICT systems across Waikato campus as a percentage of total hours per annum. Note 9	Condition	99.95%	99.80%	99.78%	100%	99.44%	●
For Waikato DHB wide ICT systems, number of critical priority one faults, measured per annum.	Condition	N/A	9%	14	<24	43	●
Waikato Hospital staff able to access clinical and non clinical system platforms remotely.	Utilisation	17%	29%	30%	>30%	67%	●
Percentage of time ICT systems running at peak through core network switches.	Utilisation	N/A	18%	19%	<30%	24%	●
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 to 10 scale. Note 10	Functionality	86%	92%	91%	>75%	75%	●
Percentage of ICT system incidents resolved within agreed department service levels.	Functionality	94%	93%	93%	100%	82%	●
Percentage of hardware devices compatible to support Windows 10 implementation project.	Functionality	N/A	N/A	N/A	100%	59%	●

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/m2 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 areas unable to work or there is an IT security breach
10. Six-monthly customer survey, target is 75 percent (7.5) or better. As at Dec 2019

> The professional who conducted the mammogram was fantastic... no fuss, clear explanations provided, fast, proficient and impressive.

Lindsay, Breast Care patient, June 2020

Part five:
Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2020

	Note	Group 2020 Budget $000	Group 2020 Actual $000	Group 2019 Actual $000	Parent 2020 Actual $000	Parent 2019 Actual $000
Revenue						
Patient care revenue	2	1,568,734	1,600,355	1,500,647	1,600,355	1,500,647
Other revenue	3	21,250	22,067	20,341	22,208	19,648
Finance revenue	4	767	521	1,093	288	872
Total income		**1,590,751**	**1,622,943**	**1,522,081**	**1,622,851**	**1,521,167**
Expenses						
Personnel costs	5	711,640	709,776	688,995	709,776	688,995
Depreciation	6	48,081	50,862	46,545	50,862	46,545
Amortisation and impairment cost	7	8,079	5,935	8,371	5,935	8,371
Outsourced services		69,930	85,545	97,043	85,545	97,043
Clinical supplies		161,075	168,074	159,291	168,074	159,291
Infrastructure and non-clinical expenses		79,982	78,768	83,999	78,768	83,999
Other district health boards		64,137	65,303	63,538	65,303	63,538
Non-health board providers		470,522	484,982	447,910	484,982	447,910
Other operating expenses	8	11,100	11,770	11,669	11,753	11,652
Finance costs	9	1,035	796	415	796	415
Capital charge	10	37,595	33,507	34,137	33,507	34,137
Total expenses		**1,663,176**	**1,695,318**	**1,641,913**	**1,695,301**	**1,641,896**
Share of joint venture surplus/(deficit)	11	-	(14)	68	-	68
Surplus/(deficit)		**(72,425)**	**(72,389)**	**(119,764)**	**(72,450)**	**(120,661)**
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	(51)	90,351	(51)	90,351
Other comprehensive revenue and expense for the year		**-**	**(51)**	**90,351**	**(51)**	**90,351**
Total comprehensive revenue and expense for the year		**(72,425)**	**(72,440)**	**(29,413)**	**(72,501)**	**(30,310)**

Explanations of major variances to budget are provided in Note 37.

The accompanying notes form part of the financial statements.

Statement of changes in equity for the year ended 30 June 2020

	Note	Group			Parent	
		2020 Budget $000	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Balance at 1 July		**641,230**	**579,404**	**582,389**	**578,659**	**582,063**
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(72,425)	(72,389)	(119,764)	(72,450)	(120,661)
Other comprehensive income/ (expense)		-	(51)	90,351	(51)	90,351
Total comprehensive revenue and expense for the year		**(72,425)**	**(72,440)**	**(29,413)**	**(72,501)**	**(30,310)**
Owner transactions						
Capital contribution		44,000	120,000	29,100	120,000	29,100
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	12	(57)	(278)	(478)	-	-
Correction - prior year equity accounting joint venture		-	-	-	(443)	-
Balance at 30 June	**12**	**610,554**	**624,492**	**579,404**	**623,521**	**578,659**

Explanations of major variances to budget are provided in Note 37.

The accompanying notes form part of the financial statements.

Statement of financial position as at 30 June 2020

	Note	Group 2020 Budget $000	Group 2020 Actual $000	Group 2019 Actual $000	Parent 2020 Actual $000	Parent 2019 Actual $000
Assets						
Current assets						
Cash and cash equivalents	13	7,877	27,058	8,756	18,218	-
Receivables	14	60,478	51,218	48,357	51,199	48,330
Prepayments	15	11,051	7,676	7,868	7,676	7,868
Inventories	16	11,339	12,649	12,218	12,649	12,218
Non-current assets held for sale	17	-	1,381	-	1,381	-
Total current assets		**90,745**	**99,982**	**77,199**	**91,123**	**68,416**
Non-current assets						
Property, plant and equipment	6	772,300	758,214	773,940	758,214	773,940
Intangible assets	7	45,054	34,782	27,626	34,782	27,626
Investment in joint venture accounted for using the equity method	11	491	429	443	-	443
Prepayments	15	-	12,872	4,608	12,872	4,608
Total non-current assets		817,845	806,297	806,617	805,868	806,617
Total assets		**908,590**	**906,279**	**883,816**	**896,991**	**875,033**
Liabilities						
Current liabilities						
Cash and cash equivalents	13	57,724	-	35,938	-	35,938
Borrowings	19	69	135	181	135	181
Employee entitlements	20	127,210	187,831	166,150	187,831	166,150
Trade and other payables under exchange transactions	21	79,513	64,635	65,778	64,618	65,763
Trade and other payables under non-exchange transactions	21	9,457	9,694	12,562	9,694	12,562
Provisions	22	714	1,044	987	1,044	987
Total current liabilities		**274,687**	**263,339**	**281,596**	**263,322**	**281,581**
Non-current liabilities						
Borrowings	19	50	50	185	50	185
Employee entitlements	20	15,625	9,786	14,117	9,786	14,117
Provisions	22	408	312	491	312	491
Restricted trust funds	23	7,266	8,300	8,023	-	-
Total non-current liabilities		23,349	18,448	22,816	10,148	14,793
Total liabilities		298,036	281,787	304,412	273,470	296,374
Net assets		**610,554**	**624,492**	**579,404**	**623,521**	**578,659**
Equity						
Crown equity (contributed capital)	12	353,255	429,255	311,449	429,255	311,449
Revaluation reserve	12	366,124	351,488	351,539	351,488	351,539
Retained earnings (accumulated deficit)		(109,428)	(156,794)	(84,329)	(157,222)	(84,329)
Trust funds	12	603	543	745	-	-
Total equity		**610,554**	**624,492**	**579,404**	**623,521**	**578,659**

Explanations of major variances to budget are provided in Note 37.

The accompanying notes form part of the financial statements.

For and on behalf of the governors

Dame Karen Poutasi
Commissioner
Waikato District Health Board
16 December 2020

Prof Margaret Wilson
Deputy Commissioner
Waikato District Health Board
16 December 2020

Statement of cash flows for the year ended 30 June 2020

	Note	Group			Parent	
		2020 Budget $000	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Cash flows from operating activities						
Operating receipts		1,583,529	1,618,790	1,522,179	1,618,933	1,521,486
Interest received		767	827	1,440	584	1,215
Payments to suppliers		(851,123)	(904,995)	(853,815)	(904,979)	(853,798)
Payments to employees		(709,023)	(692,427)	(641,390)	(692,427)	(641,390)
Interest paid		(1,602)	(796)	(415)	(796)	(415)
Payments for capital charge		(37,595)	(33,507)	(34,137)	(33,507)	(34,137)
Goods and services tax (net)		(1,000)	(1,573)	93	(1,573)	93
Net cash flows from operating activities	24	(16,047)	(13,681)	(6,045)	(13,765)	(6,946)
Cash flows from investing activities						
Purchase of property, plant and equipment		(25,716)	(36,632)	(39,577)	(36,632)	(39,577)
Purchase of intangible assets		(28,285)	(13,091)	(5,179)	(13,091)	(5,179)
Receipts from sale of property, plant and equipment		-	19	-	19	-
Net cash flows from investing activities		(54,001)	(49,704)	(44,756)	(49,704)	(44,756)
Cash flows from financing activities						
Capital contribution from the Crown		43,999	120,000	29,100	120,000	29,100
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		-	-	-	-	-
Repayment of borrowings		(206)	(181)	(313)	(181)	(313)
Net cash flows from financing activities		41,599	117,625	26,593	117,625	26,593
Net increase/(decrease) in cash and equivalents		(28,449)	54,240	(24,208)	54,156	(25,109)
Cash and cash equivalents at beginning of year		(21,398)	(27,182)	(2,974)	(35,938)	(10,829)
Cash and cash equivalents at end of year	13	(49,847)	27,058	(27,182)	18,218	(35,938)

Explanations of major variances to budget are provided in Note 37.

The accompanying notes form part of the financial statements.

1. Statement of accounting policies

Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2020, and were authorised for issue by the commissioners on 16 December 2020.

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 29 September 2020 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 2020/21 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) unless otherwise indicated.

Changes in accounting policies

There have been no changes in accounting policies since the date of the last audited financial statements. Adoption of the new group accounting standards has had no impact on Waikato DHB.

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:

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 does not intend to early adopt 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.

1. Statement of accounting policies (continued)

PBR FRS 48 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 2022 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 2023 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

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

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

Subsidiaries

Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the economic entity for the financial year. Consolidated financial statements have been prepared to include Waikato Health Trust due to the control that Waikato DHB has over the appointment and removal of the Trustees of Waikato Health Trust. Transactions between Waikato DHB and the Waikato Health Trust have been eliminated for consolidation purposes.

The group financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, expenses and cash flows of entities in the group on a line by line basis. All intra-group balances and transactions are eliminated on consolidation.

The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances. The consolidation of an entity begins from the date the Waikato DHB obtains control of the entity and ceases when control is lost.

Budget figures

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

Income tax

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

Goods and services tax (GST)

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

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

Commitments and contingencies are disclosed exclusive of GST.

Foreign currency transactions

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

1. Statement of accounting policies (continued)

Cost allocation

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

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

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Other indirect costs are assigned to outputs based on responsibility centre.

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

Critical accounting estimates and assumptions

In preparing these financial statements, the 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 20 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement, long service leave and holiday pay 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 population-based revenue

Waikato DHB is primarily funded through revenue received from Ministry of Health, 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 Ministry of Health is recognised as revenue when earned.

2. Patient care revenue (continued)

The fair value of revenue from Ministry of Health has been determined to be equivalent to the amounts due in the funding arrangements.

Ministry of Health contract revenue

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

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

ACC contract revenue

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

Revenue from other district health boards

Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. Ministry of Health 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 or entitlement is confirmed.

	Group		Parent	
Patient care revenue breakdown	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Non-exchange transactions				
Health and disability services (Crown appropriation revenue) [1]	1,333,397	1,255,171	1,333,397	1,255,171
Other Ministry of Health and government revenue	34,196	28,579	34,196	28,579
Patient co-payments	1,680	1,523	1,680	1,523
Revenue from other district health boards [2]	48,439	-	48,439	-
Exchange transactions				
Health and disability services (Ministry of Health)	37,755	31,620	37,755	31,620
ACC contract revenue	16,649	15,730	16,649	15,730
Revenue from other district health boards	99,563	138,809	99,563	138,809
Clinical Training Agency revenue	11,734	11,696	11,734	11,696
Other patient care related revenue	16,942	17,519	16,942	17,519
Total patient care revenue	1,600,355	1,500,647	1,600,355	1,500,647

1 - Performance against this appropriation is reported in the Statement of Performance on pages 53 to 95.

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 $1,297,088,000 (2019 – $1,206,301,000).

2 - As a result of the COVID-19 pandemic, inter-district flow revenue for the period March 2020 to June 2020 amounting to $48,439,821 was received and recognised based on estimated volumes as per Ministry of Health guidance.

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.

3. Other revenue (continued)

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.

	Group		Parent	
Other revenue breakdown	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Non-exchange transactions				
Donations and bequests received	1,605	1,742	137	150
Grants received	-	-	1,609	899
Exchange transactions				
Rental revenue	1,591	1,380	1,591	1,380
Gain on sale of property, plant and equipment	46	-	46	-
Other revenue	18,825	17,219	18,825	17,219
Total other revenue	22,067	20,341	22,208	19,648

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.

	Group		Parent	
Finance revenue (exchange transactions) breakdown	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Interest revenue	521	1,093	288	872
Total finance revenue	521	1,093	288	872

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.

	Group		Parent	
Personnel costs breakdown	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Salaries and wages	671,033	622,139	671,033	622,139
Increase/(decrease) in liability for employee entitlements	17,350	47,605	17,350	47,605
Defined contribution plan employer contributions	21,393	19,251	21,393	19,251
Total personnel cost	709,776	688,995	709,776	688,995

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.

6. Property, plant and equipment (continued)

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	10-57 years	1.8-10%
Clinical assets	2-18 years	5.5-50%
General assets	2-20 years	5-50%
Motor vehicles	5-11 years	9-20%

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.

6. Property, plant and equipment (continued)

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 revenue in the surplus or deficit.

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

Group Actual Cost	Freehold land $000	Freehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
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**
Balance at 1 July 2019	50,039	632,886	226,881	31,067	940,873
Additions	-	-	-	36,632	36,632
Transfers	-	19,191	28,275	(47,466)	-
Disposals	-	(75)	(629)	-	(704)
Revaluation adjustment		37			37
Transfer to non-current assets held for sale	(1,050)	(390)	-	-	(1,440)
Balance at 30 June 2020	**48,989**	**651,649**	**254,527**	**20,233**	**975,398**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
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 adjustment	-	(60,895)	-	-	(60,895)
Balance at 30 June 2019	**-**	**-**	**166,933**	**-**	**166,933**
Balance at 1 July 2019	-	-	166,933	-	166,933
Depreciation charge and impairment losses for the year	-	33,623	17,239	-	50,862
Disposals	-	96	(684)	-	(588)
Revaluation adjustment	-	36	-	-	36
Transfer to non-current assets held for sale	-	(59)	-	-	(59)
Reclassification adjustment	-	(109)	109	-	-
Balance at 30 June 2020	**-**	**33,587**	**183,597**	**-**	**217,184**
Carrying amounts					
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**
At 1 July 2019	50,039	632,886	59,948	31,067	773,940
At 30 June 2020	**48,989**	**618,062**	**70,930**	**20,233**	**758,214**

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 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 adjustment	5,563	23,893	-	-	29,456
Balance at 30 June 2019	**50,039**	**632,886**	**226,881**	**31,067**	**940,873**
Balance at 1 July 2019	50,039	632,886	226,881	31,067	940,873
Additions	-	-	-	36,632	36,632
Transfers	-	19,191	28,275	(47,466)	-
Disposals	-	(75)	(629)	-	(704)
Revaluation adjustment	-	37	-	-	37
Transfer to non-current assets held for sale	(1,050)	(390)	-	-	(1,440)
Balance at 30 June 2020	**48,989**	**651,649**	**254,527**	**20,233**	**975,398**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000
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 adjustment	-	(60,895)	-	-	(60,895)
Balance at 30 June 2019	**-**	**-**	**166,933**	**-**	**166,933**
Balance at 1 July 2019	-	-	166,933	-	166,933
Depreciation charge and impairment losses for the year	-	33,623	17,239	-	50,862
Disposals	-	96	(684)	-	(588)
Revaluation adjustment	-	36	-	-	36
Transfer to non-current assets held for sale	-	(59)	-	-	(59)
Reclassification adjustment	-	(109)	109	-	-
Balance at 30 June 2020	**-**	**33,587**	**183,597**	**-**	**217,184**
Carrying amounts					
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**
At 1 July 2019	50,039	632,886	59,948	31,067	773,940
At 30 June 2020	**48,989**	**618,062**	**70,930**	**20,233**	**758,214**

Valuation

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

6. Property, plant and equipment (continued)

The impact of COVID-19 pandemic on asset values due to the change in building cost inflation is unknown at 30 June 2020.

Buildings

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

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

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

Restrictions

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

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 $0.19 million (2019: $0.3 million). Note 19 provides further information about finance leases.

Property, plant and equipment under construction

Buildings work in progress at 30 June 2020 is $10.7 million (2019: $12.7 million) and capital commitments is $1.3 million (2019: $3.4 million). Plant, equipment and vehicles work in progress at 30 June 2020 is $9.5 million (2019: $18.4million) and capital commitments is $4.2 million (2019: $6.6 million).

7. Intangible assets

Accounting policy

Software acquisition and development

Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with developing and maintaining the Waikato DHB's website are recognised as an expense when incurred.

Information technology shared services rights

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

7. Intangible assets (continued)

Amortisation

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

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

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

Impairment of intangible assets

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

Movements for intangible assets are as follows:

Group 2020 Actual	Internally generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
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**
Balance at 1 July 2019	2,689	70,294	13,714	86,697
Additions	-	-	13,091	13,091
Disposals	-	(711)	-	(711)
Transfers	1,983	7,106	(9,089)	-
Balance at 30 June 2020	**4,672**	**76,689**	**17,716**	**99,077**
Accumulated amortisation and impairment losses				
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**
Balance at 1 July 2019	372	58,699	-	59,071
Amortisation and impairment charge for the year	648	5,287	-	5,935
Disposals	-	(711)	-	(711)
Balance at 30 June 2020	**1,020**	**63,275**	**-**	**64,295**
Carrying amounts				
At 1 July 2018	1,217	7,863	21,738	30,818
At 30 June 2019	**2,317**	**11,595**	**13,714**	**27,626**
At 1 July 2019	2,317	11,595	13,714	27,626
At 30 June 2020	**3,652**	**13,414**	**17,716**	**34,782**

7. Intangible assets (continued)

Parent 2020 Actual	Internally generated	Other	Work in progress	Total
Cost	$000	$000	$000	$000
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**	**13,714**	**86,697**
Balance at 1 July 2019	2,689	70,294	13,714	86,697
Additions	-	-	13,091	13,091
Transfers	1,983	7,106	(9,089)	-
Disposals	-	(711)	-	(711)
Balance at 30 June 2020	**4,672**	**76,689**	**17,716**	**99,077**
Accumulated amortisation and impairment losses				
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
Balance at 1 July 2019	372	58,699	-	59,071
Amortisation and impairment charge for the year	648	5,287	-	5,935
Disposals	-	(711)	-	(711)
Balance at 30 June 2020	1,020	63,275	-	64,295
Carrying amounts				
At 1 July 2018	1,217	7,863	21,738	30,818
At 30 June 2019	2,317	11,595	13,714	27,626
At 1 July 2019	2,317	11,595	13,714	27,626
At 30 June 2020	3,652	13,414	17,716	34,782

There are no restrictions over the title of Waikato DHB's 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.

8. Other operating expenses (continued)

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	
Breakdown of other expenses	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Allowance for credit losses on receivables	639	761	639	761
Audit fees for the audit of the financial statements	271	246	254	229
Audit related fees for assurance and internal audits	1	15	1	15
Board and committee members' remuneration and expenses	15	302	15	302
Koha and donations	138	164	138	164
Operating lease expenses	10,614	9,367	10,614	9,367
Loss on disposal of property, plant and equipment	92	814	92	814
Total other operating expenses	**11,770**	**11,669**	**11,753**	**11,652**

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	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Interest and financing expenses	796	415	796	415
Total finance cost	**796**	**415**	**796**	**415**

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	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Capital charge	33,507	34,137	33,507	34,137
Total capital charge	**33,507**	**34,137**	**33,507**	**34,137**

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 2020 was 6% (2019:6%).

11. Investments in joint venture

Accounting policy

The Waikato DHB Group has adopted the new group standards PBE IPSAS 34 to 38 in preparing these financial statements. In adopting these standards, the accounting policies for investment in subsidiaries and joint ventures has been updated. Disclosures have also been updated for the new requirements of these standards.

There has been no change in the accounting treatment of investment in joint venture as Waikato DHB Group continue to measure the investment using the equity method.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint control is the agreed sharing of control of an arrangement by way of a binding arrangement which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

Investments in joint ventures are measured at cost in the Waikato DHB Parent financial statements.

Investments in joint ventures are accounted for in the group financial statements using the equity method of accounting. Under the equity method of accounting, the investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the group share of the change in net assets of the entity after the date of acquisition. The group share of the surplus or deficit is recognised in the group surplus or deficit. Distributions received from the investee reduce the carrying amount of the investment in the group financial statements.

If the share of deficits in the entity equals or exceeds the interest in the entity, the group discontinues to recognise its share of further deficits. After the group interest is reduced to zero, additional deficits are provided for and a liability recognised only to the extent that the group has incurred legal or constructive obligations or made payments on behalf of the entity. If the entity subsequently reports surpluses, the group will resume recognising its share of those surpluses only after its share of the surpluses equals the share of the deficits not recognised.

a) General information

Name of entity	Principal activities	Interest held at 30 June 2020	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b) Carrying amount of investment

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Opening balance	443	375	443	375
Share of joint venture surplus/(deficit)	(14)	68	-	68
Correction – prior year equity accounting joint venture	-	-	(443)	-
Closing Balance	**429**	**443**	**-**	**443**

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

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Current assets	1,544	1,488	-	1,488
Non-current assets	5,977	3,817	-	3,817
Current liabilities	(1,851)	(1,303)	-	(1,303)
Non-current liabilities	(5,241)	(3,559)	-	(3,559)
Net assets	**429**	**443**	**-**	**443**
Revenue	3,726	3,478	-	3,478
Expenses	(3,740)	(3,410)	-	(3,410)
Share of surplus/(deficit) of joint venture	**(14)**	**68**	**-**	**68**

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 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)
Balance at 30 June 2019	**745**	**311,449**	**351,539**	**(84,329)**	**579,404**
Balance at 1 July 2019	745	311,449	351,539	(84,329)	579,404
Total comprehensive revenue/(expense)	75	-	(51)	(72,464)	(72,440)
Contributed capital – deficit support funding	-	120,000	-	-	120,000
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(277)	-	-	-	(277)
Other movement	-	-	-	(1)	(1)
Balance at 30 June 2020	**543**	**429,255**	**351,488**	**(156,794)**	**624,492**

Trust funds

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

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

Parent Reconciliation of movement in equity	Crown equity $000	Revaluation reserve $000	Retained earnings $000	Total equity $000
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)
Balance at 30 June 2019	**311,449**	**351,539**	**(84,329)**	**578,659**
Balance at 1 July 2019	311,449	351,539	(84,329)	578,659
Total comprehensive revenue/(expense)	-	(51)	(72,450)	(72,501)
Contributed capital – deficit support funding	120,000	-	-	120,000
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Correction – prior year equity accounting joint venture	-	-	(443)	(443)
Balance at 30 June 2020	**429,255**	**351,488**	**(157,222)**	**623,521**

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 2020 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 23.

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Cash at bank/(overdraft) and cash on hand	49	58	49	58
Advance to/(from) New Zealand Health Partnerships Limited	18,169	(35,996)	18,169	(35,996)
Trust funds	8,840	8,756	-	-
Total cash and cash equivalents	**27,058**	**(27,182)**	**18,218**	**(35,938)**

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 shared credit risk characteristics and days past due. The expected loss rates are based on the payment profile of transaction over a period of 24 months before 30 June 2020 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.

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Ministry of Health trade receivables	6,849	3,508	6,849	3,508
Other trade receivables	7,623	8,216	7,623	8,216
Less: Allowance for credit losses	(1,397)	(1,234)	(1,397)	(1,234)
Total trade receivables	**13,075**	**10,490**	**13,075**	**10,490**
Ministry of Health accrued revenue	19,081	19,287	19,081	19,287
Other accrued revenue	19,062	18,580	19,043	18,553
Total receivables	**51,218**	**48,357**	**51,199**	**48,330**
Total receivables comprises:				
Receivables from non-exchange transactions	2,913	6,996	2,913	6,996
Receivables from exchange transactions	48,305	41,361	48,286	41,334

The expected credit loss rates for receivables at 30 June 2020 are based on the payment profile of invoices issued over the past two 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.

14. Receivables (continued)

The impact of the COVID-19 pandemic on credit loss history is minimal due to the customer type and nature of the receivable balances.

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

The allowance for credit losses at 30 June 2020 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 2020					
Expected credit loss rate	0.32%	13.16%	20.34%	44.05%	
Gross carrying amount ($000)	48,943	623	772	2,277	52,615
Lifetime expected credit loss ($000)	155	82	157	1,003	1,397
1 July 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

Parent					
30 June 2020					
Expected credit loss rate	0.32%	13.16%	20.34%	44.05%	
Gross carrying amount ($000)	48,924	623	772	2,277	52,596
Lifetime expected credit loss ($000)	155	82	157	1,003	1,397
1 July 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

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

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Opening allowance for credit losses at 1 July	1,234	1,133	1,234	1,133
Increase in loss allowance made during the year	467	699	467	699
Receivables written off during the year	(476)	(660)	(476)	(660)
Receivables recovered during the year	172	62	172	62
Balance at 30 June	**1,397**	**1,234**	**1,397**	**1,234**

15. Prepayments

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Current portion				
Prepayments	7,676	7,868	7,676	7,868
Total prepayments	**7,676**	**7,868**	**7,676**	**7,868**
Non-current portion				
Prepayments	12,872	4,608	12,872	4,608
Total prepayments	**12,872**	**4,608**	**12,872**	**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	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Pharmaceuticals	1,167	1,100	1,167	1,100
Surgical and medical supplies	7,189	7,249	7,189	7,249
Other supplies	4,293	3,869	4,293	3,869
Total inventories	12,649	12,218	12,649	12,218

The amount of inventories recognised as expense due to change in stock value during the year was $35,334 (2019: $55,752), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $18,192 for 2020 (2019: $377,419). 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 2020 was $Nil (2019: $Nil). No inventories are pledged as security for liabilities.

17. Non-current assets held for sale

Accounting policy

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

Any impairment losses for write-downs of non-current assets held for sale, while classified as held for sale, are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Breakdown of non-current assets held for sale				
Non-current assets held for resale include:				
Land	1,050	-	1,050	-
Buildings	331	-	331	-
Total non-current assets held for sale	1,381	-	1,381	-

The group owns land and buildings which have been classified as held for sale following the commissioner's approval to sell the properties as they will provide no future use to the group. The sale is expected to be completed by December 2020.

The accumulated property revaluation reserve recognised in equity for these properties is $1,262,158.

18. Derivative financial instruments

Accounting policy

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

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

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current. The notional principal amount of outstanding forward foreign exchange contracts in NZ$ was $ Nil (2019: $Nil). The foreign currency principal amounts were $ Nil (2019: USD Nil).

19. 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	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Current portion				
Loan from Energy Efficiency and Conservation Authority	15	61	15	61
Finance leases	120	120	120	120
	135	**181**	**135**	**181**
Non-current portion				
Loan from Energy Efficiency and Conservation Authority	-	15	-	15
Finance leases	50	170	50	170
	50	**185**	**50**	**185**
Analysis of finance leases				
Minimum lease payments payable:				
No later than one year	120	120	120	120
Later than one year and not later than five years	50	170	50	170
Later than five years	-	-	-	-
Total minimum lease payments	**170**	**290**	**170**	**290**
Future finance charges	(1)	(8)	(1)	(8)
Present value of minimum lease payments	**169**	**282**	**169**	**282**
Present value of minimum lease payments payable:				
No later than one year	119	112	119	112
Later than one year and not later than five years	50	170	50	170
Later than five years	-	-	-	-
Total present value of minimum lease payments	**169**	**282**	**169**	**282**

19. Borrowings (continued)

Finance Leases

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

The fair value of finance leases is $169,000 (2019: $282,000). Fair value has been determined by using a discount rate of 0.24% (2019:1.12%).

Description of finance leases

The DHB has entered into contracts for the supply of consumables and reagents which includes the use of clinical equipment.

At expiration of the agreements, the ownership of the equipment will transfer to Waikato DHB, so has been deemed to be finance leases.

20. Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

Waikato DHB recognises a sabbatical leave liability to the extent that paid sabbatical leave absences in the coming year are expected to be greater than the sabbatical leave entitlements earned in the coming year. The amount is calculated based on the unused sabbatical leave entitlement that can be carried forward at balance date, to the extent that Waikato DHB anticipates it will be used by staff to go on future sabbatical leave.

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.

20. Employee entitlements (continued)

	Group		Parent	
	2020 Actual	2019 Actual	2020 Actual	2019 Actual
Current portion	$000	$000	$000	$000
Liability for long service leave	3,542	3,248	3,542	3,248
Liability for retirement gratuities	3,450	3,366	3,450	3,366
Liability for annual leave	129,851	115,498	129,851	115,498
Liability for sick and sabbatical leave	2,547	1,434	2,547	1,434
Liability for continuing medical education leave and expenses	13,498	10,983	13,498	10,983
PAYE payable	11,377	10,668	11,377	10,668
Salary and wages accrual	23,566	20,953	23,566	20,953
	187,831	**166,150**	**187,831**	**166,150**
Non-current portion				
Liability for long service leave	1,704	1,395	1,704	1,395
Liability for sabbatical leave	-	4,586	-	4,586
Liability for retirement gratuities	8,082	8,136	8,082	8,136
	9,786	**14,117**	**9,786**	**14,117**

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 advice from an independent actuary. Two discount rates for retirement and long service leave are used, 0.4% and 0.1%, respectively. (2019: 1.4% and 1.2% respectively) and a salary inflation factor of 3.0% (2019:3.0%) 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 District Health Boards (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 the 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 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

20. Employee entitlements (continued)

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process. Waikato DHB has assessed that further audit work is required to reach a reliable estimate of its historic non-compliance under the MOU.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, the Waikato DHB recognises it has an obligation to address any historical non-compliance under the MOU. The DHB has made estimates and assumptions to determine a potential liability based on its review of payroll processes for instances of non-compliance with the Act and against the requirements of the MOU.

The liability has been estimated by

- selecting a sample of current and former employees;
- calculating the underpayment for these employees over the full period of liability; and
- extrapolating the result across all current and former employees

This 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 significant uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

21. Trade and other payables

Accounting policy

Short-term payables are recorded at their face value.

	Group		Parent	
	2020 Actual	2019 Actual	2020 Actual	2019 Actual
Payables under exchange transactions	$000	$000	$000	$000
Creditors	63,938	65,397	63,921	65,382
Revenue received in advance	697	381	697	381
Total payables under exchange transactions	**64,635**	**65,778**	**64,618**	**65,763**
Payables under non-exchange transactions				
ACC levy payable	851	679	851	679
GST payable	7,555	9,128	7,555	9,128
Accrual – non-exchange expenses	1,288	2,755	1,288	2,755
Total payables under non-exchange transactions	**9,694**	**12,562**	**9,694**	**12,562**
Total payables	**74,329**	**78,340**	**74,312**	**78,325**

Creditor and other payables are non-interest bearing and are normally settled on 10 to 30-day terms. Therefore the carrying value of creditors and other payables approximates their fair value.

22. Provisions

Accounting policy

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

	Group		Parent	
	2020 Actual	2019 Actual	2020 Actual	2019 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	957	933	957	933
Motor vehicle repairs on disposal	87	54	87	54
	1,044	**987**	**1,044**	**987**
Non-current liabilities				
Motor vehicle repairs on disposal	312	491	312	491
	312	**491**	**312**	**491**

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 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**
Balance at 1 July 2019	933	545	1,478
Additional provisions made/released	1,354	53	1,407
Amounts used	(1,330)	(199)	(1,529)
Balance at 30 June 2020	**957**	**399**	**1,356**

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 programme, 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.

22. Provisions (continued)

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 practicable
- 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 2020. 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% (2019:11.6%) 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 1.70% per annum (2019:1.72%); and
- a discount factor of 1.08% for 30 June 2020 (2019:1.35%).

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

Motor vehicle repairs on disposal

In respect of a number of its leased vehicles, Waikato DHB is required to make provision for motor vehicles repairs for return to owner at the end of the lease of the motor vehicles.

23. Restricted trust funds

Movements are as follows:	Group 2020 Actual $000 Waikato Health Trust	Group 2019 Actual $000 Waikato Health Trust
Balance at 1 July	8,023	7,545
Transfer from accumulated funds	277	478
Balance at 30 June	**8,300**	**8,023**

The restricted trust funds represent the reserved funds held by the Waikato Health Trust. Reserved and partially reserved funds are donated or bequeathed for specific purposes. The Trustees are required to manage these funds in accordance with the trust deed or the wishes of the donor. Partially reserved funds are externally bequeathed and bound by specific governing statements. Fully reserved funds are funds externally bequeathed that are held in perpetuity. The fund is not reduced and interest earned is transferred to a general fund where distributions can be made.

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

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

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

	Note	Group 2020 Actual $000	Group 2019 Actual $000	Parent 2020 Actual $000	Parent 2019 Actual $000
Net surplus/(deficit)		(72,389)	(119,764)	(72,450)	(120,661)
Add/(less) non-cash items:					
Depreciation	6	50,862	46,545	50,862	46,545
Amortisation	7	5,935	8,371	5,935	8,371
Bad and doubtful debts	14	467	699	467	699
Share of joint venture (surplus)/deficit	11	14	(68)	-	(68)
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	3,8	46	814	46	814
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	16	(431)	(766)	(431)	(766)
(Increase)/decrease in gross receivables	14	(3,328)	1,538	(3,336)	1,534
(Increase)/decrease in prepayments	15	(8,073)	(2,447)	(8,073)	(2,447)
Increase/(decrease) in employee entitlements	20	17,350	47,605	17,350	47,605
Increase/(decrease) in trade and other payables	21	(4,012)	11,104	(4,013)	11,104
Increase/(decrease) in other provisions	22	(122)	324	(122)	324
Net cash flows from operating activities		**(13,681)**	**(6,045)**	**(13,765)**	**(6,946)**

25. Capital commitments and operating leases

Capital commitments	Group 2020 Actual $000	Group 2019 Actual $000	Parent 2020 Actual $000	Parent 2019 Actual $000
Buildings	1,326	3,378	1,326	3,378
Plant, equipment and vehicles	4,235	6,655	4,235	6,655
Intangible assets	4,187	2,767	4,187	2,767
Total capital commitments	**9,748**	**12,800**	**9,748**	**12,800**

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

Non-cancellable operating lease commitments

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

	Group 2020 Actual $000	Group 2019 Actual $000	Parent 2020 Actual $000	Parent 2019 Actual $000
Not later than one year	7,804	8,567	7,804	8,567
Later than one year and not later than five years	26,495	30,945	26,495	30,945
Later than five years	16,599	20,446	16,599	20,446
	50,898	**59,958**	**50,898**	**59,958**

Waikato DHB leases a number of buildings, vehicles and office equipment under operating leases. The leases typically run for a period of 3-35 years for buildings, 1-3 years for office equipment and 6 years for vehicles. In the case of leased buildings, lease payments are adjusted every 1-11 years to reflect market rentals. None of the leases includes contingent rentals.

A portion of the total non-cancellable operating lease expense relates to the lease of motor vehicles. Waikato DHB does not have an option to purchase the assets at the end of the lease term. There are no restrictions placed on Waikato DHB by its leasing arrangements.

26. Contingencies

	Group		Parent	
	2020 Actual	2019 Actual	2020 Actual	2019 Actual
Contingent liabilities	$000	$000	$000	$000
Personal grievances	465	325	465	325
Legal proceedings and disputes by third parties	40	-	40	-
	505	**325**	**505**	**325**

The contingent liabilities relate to a number of claims involving third party and and employment issues which may result in legal action, or legal action is in progress. The actual timing and amounts will be determined by outcome of personal grievance processes and legal proceedings. Where a claim is covered by insurance, the value declared as a contingent liability is limited to the insurance excess.

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 2018 Waikato DHB was unable to determine the impact of the interpretation of compliance with the Holidays Act.

In 2019 and 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 2020 (2019:$Nil).

27. Client funds

Waikato DHB administers certain funds on behalf of clients. These funds are held in a separate bank account and any interest earned is allocated to the individual client balances. Therefore, the transactions during the year and the balance at 30 June are not recognised in the Statement of Comprehensive Revenue and Expense, Statement of Financial Position or Statement of Cash Flows.

	2020 Actual $000	2019 Actual $000
Balance at 1 July	45	32
Receipts	109	94
Payments	(97)	(81)
Balance at 30 June	**57**	**45**

28. Financial instruments

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

Financial instrument categories	Group		Parent	
	2020 Actual	2019 Actual	2020 Actual	2019 Actual
Financial assets measured at amortised cost	$000	$000	$000	$000
Cash and cash equivalents	27,058	8,756	18,218	-
Receivables – credit impaired	51,218	48,357	51,199	48,330
Total financial assets measured at amortised cost	**78,276**	**57,113**	**69,417**	**48,330**
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	-	35,938
Trade and other payables (excluding income in advance)	73,632	77,959	73,615	77,944
Borrowings – loans	185	366	185	366
Total other financial liabilities	**73,817**	**114,263**	**73,800**	**114,248**

Financial assets are measured on an amortised cost basis using the expected credit risk model.

Financial instrument risks

Waikato DHB's activities expose it to a variety of financial instrument risks. Waikato DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Credit risk

Credit risk is the risk that a third party will default on its obligation to Waikato DHB, causing it to incur a loss.

Waikato DHB places its cash balances with high-quality financial institutions via a national DHB shared banking arrangement facilitated by New Zealand Health Partnerships Limited.

Concentrations of credit risk from trade receivables are limited due to ACC and Ministry of Health being the largest single debtors (7% and 51% respectively, at 30 June 2020). 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.

The impact of the COVID-19 pandemic on the collectability of trade receivables was considered and, as a high proportion of receivables are Crown entities (86% at 30 June 2020), the risk of higher expected credit loss rate is considered low.

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.

The impact of the COVID-19 pandemic on credit loss history relating to receivables is minimal due to the customer type and nature of the receivable balances.

28. Financial instruments (continued)

Credit quality of financial assets

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

	Group		Parent	
Counterparties with credit ratings	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Cash and cash equivalents				
AA	49	58	49	58
AA-	8,840	8,756	-	-
Total cash and cash equivalents	8,889	8,814	49	58
Counterparties without credit ratings				
New Zealand Health Partnership Limited	18,169	(35,996)	18,169	(35,996)
Receivables				
Counterparty with no defaults in the past	50,753	47,933	50,734	47,906
Counterparty with defaults in the past	465	424	465	424
Total receivables – credit impaired	51,218	48,357	51,199	48,330

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 2020 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Loans from Energy Efficiency and Conservation Authority	15	15	15	-	-	-	-
Finance leases	170	170	60	60	50	-	-
Trade and other payables	73,632	73,632	73,632	-	-	-	-
	73,817	**73,817**	**73,707**	**60**	**50**	**-**	**-**

	Parent 2020 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Loans from Energy Efficiency and Conservation Authority	15	15	15	-	-	-	-
Finance leases	170	170	60	60	50	-	-
Trade and other payables	73,615	73,615	73,615	-	-	-	-
	73,800	**73,800**	**73,690**	**60**	**50**	**-**	**-**

	Group 2019 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	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 months or less	6-12 months	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**	**-**	**-**

28. Financial instruments (continued)

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 DHB's exposure to fair value interest rate risk is limited to its cash balance held under a contract with New Zealand Health Partnership Limited through a national DHB shared banking arrangement. New Zealand Health Partnership Limited actively manages this risk. The exposure to fair value interest rate risk for long-term borrowings is low due to long-term borrowings generally being held to maturity.

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.

Sensitivity analysis

For the year ended 30 June 2020, if floating interest rates had been 1% higher/lower, with all other variables held constant, the result for the year would have been approximately $157,000 higher/lower (2019: $47,000 lower/higher).

Currency risk

Currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Waikato DHB's currency risk is mainly limited to purchases of large clinical equipment from overseas and licence payments. Waikato DHB uses forward currency contracts or options to hedge its foreign currency risk. Waikato DHB hedges trade payables denominated in a foreign exchange currency for large transactions and where necessary the forward exchange contracts or options are rolled over at maturity.

The group has no unhedged foreign-denominated payables at balance date (2019: $ Nil).

It is estimated that a general increase of one percentage point in the value of NZ dollars against other foreign currencies would not have a material effect on the net result.

29. Capital management

Waikato DHB's capital is its equity, which comprises Crown equity, accumulated surpluses/deficits, revaluation reserves and trust funds. Equity is represented by net assets.

Waikato DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives. Waikato DHB has complied with the financial management requirements of the Crown Entities Act 2004 during the year. Waikato DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure that it effectively achieves its objectives and purposes, while remaining a going concern.

30. Related parties

Ownership

Waikato DHB is a Crown entity in terms of the Crown Entities Act 2004, and is a wholly owned entity of the Crown. The Crown significantly influences the role of Waikato DHB as well as being its major source of revenue. During the year Waikato DHB received $1.42 billion (2019:$1.33 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2020 was $25.9 million (2019:$22.8 million). Waikato DHB incurred a capital charge of $33.5 million (2019:$34.1 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 commissioners.

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 2020 of $16.6 million (2019:$15.7 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 2020 was $148.0 million (2019:$138.8 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2020 was $65.3 million (2019:$63.5 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 30 June 2020 totalled $26.2 million (2019 $19.0 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 2020, HealthShare Limited had total assets of $37.605 million (2019:$26.525 million) and total liabilities of $35.460 million (2019:$24.309 million).

During the year Waikato DHB received $1.539 million (2019: $1.823 million) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $11.494 million (2019:$7.150 million) for services provided.

As at 30 June 2020 Waikato DHB owed Healthshare Limited $1.099 million (2019: $691,000) and Healthshare Limited owed Waikato DHB $973,000 (2019: $684,000). The Group's investment in HealthShare Limited has been accounted for using the equity method.

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 2020 are Andrew McCurdie and 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 $1.609 million (2019:$0.899 million). There was $Nil owing to Waikato DHB at 30 June 2020 (2019:$Nil).

30. Related parties (continued)

New Zealand Health Partnerships Limited

New Zealand Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2019:6,948,005) shares being 10.17% (2019:10.17%). Waikato DHB does not have a controlling interest in New Zealand Health Partnership Limited.

31. Key management personnel remuneration

Key management personnel

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

Compensations

There were no loans to board members or commissioners during the year ended 30 June 2020 (2019:$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 2020 (2019:$Nil).

Remuneration

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

Commissioner and deputy commissioners	2020 Actual	2019 Actual
Commissioner	$	$
Dame Karen Poutasi	221,092	30,138
Deputy commissioners		
Andrew Connolly	14,300	6,000
Chad Paraone	60,000	6,000
Prof Margaret Wilson	80,205	4,565
	375,597	**46,703**

	2020 Actual	2019 Actual
Board members	$000	$000
Salaries and other short-term benefits	-	278
Contributions to superannuation schemes	-	-
Members	-	11
Executive management team		
Salaries and other short-term benefits	3,947	4,282
Contributions to superannuation schemes	162	138
Full-time equivalent members	11	13.6

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.

31. Key management personnel remuneration (continued)

	No. of meetings eligible to attend 2020	No. of meetings actually attended* 2020	Remuneration 2020 Actual	2019 Actual
Board members			$	$
Sally Webb (chair person)	-	-	-	46,938
Margaret Wilson (deputy chair)	-	-	-	22,123
Sally Christie	-	-	-	23,199
Crystal Beavis	-	-	-	23,699
Phillippa Mahood	-	-	-	22,949
Mary Anne Gill	-	-	-	22,699
Martin Gallagher	-	-	-	23,449
Sharon Mariu	-	-	-	23,386
Clyde Wade	-	-	-	24,011
Dave Macpherson	-	-	-	23,449
Tania Hodges	-	-	-	22,449
Bob Simcock	-	-	-	-
			-	278,351

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

In May 2019, the Minister of Health replaced the Board of Waikato DHB with a commissioner and three deputy commissioners.

Non-Board members who attended committee meetings	No. of meetings eligible to attend 2020	No. of meetings actually attended* 2020	Remuneration 2020 Actual	2019 Actual
John McIntosh	6	6	1,500	750
Te Pora Thompson-Evans	18	15	3,750	2,500
David Slone	6	6	1,500	1,000
Paul Malpass	6	6	1,500	500
Judy Small	6	6	1,500	750
Fungai Mhlanga	6	5	1,250	250
Rachel Karalus	6	6	1,500	-
Glen Tupuhi	6	6	1,500	750
Gerri Pomeroy	6	6	1,500	-
Kahu McClintock	-	-	-	500
Ron Scott	-	-	-	500
Mark Arundel	-	-	-	750
Arama Chase	-	-	-	500
Mere Balzer	-	-	-	1,500
Tureiti Moxon	-	-	-	1,750
Christine Rankin	-	-	-	500
			15,500	12,500

32. Termination payments to employees

During the year, payments were made to 33 employees (2019:36) in respect of the termination of employment with Waikato DHB.

	2020 Actual $000	2019 Actual $000
Amount paid	1,505	1,043

33. Waikids early childhood centre – Waikato Hospital

	Group		Parent	
	2020 Actual $000	2019 Actual $000	2020 Actual $000	2019 Actual $000
Summary of transactions relating to Waikids:				
Subsidy funding – Ministry of Education	214	202	214	202
Equity funding – Ministry of Education	34	32	34	32
Other income	11	12	11	12
Personnel costs	(262)	(218)	(262)	(218)
Minor equipment purchases	(5)	(19)	(5)	(19)
Administration costs	(30)	(9)	(30)	(9)
Surplus/(Deficit) for the year	(38)	(0)	(38)	(0)
Accumulated surplus attributed to Waikato Early Childhood Centre				
Balance at 1 July	200	200	200	200
Surplus/(Deficit) for the year	(38)	(0)	(38)	(0)
Balance at 30 June	162	200	162	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.

$330,294 of the personnel costs are offset from the total of $592,511.

Approved project costs of $38,468 for personnel expenses have been funded from retained earnings/ accumulated surplus attributed to Waikids Early Childhood Centre.

34. Impact of COVID-19 on the Waikato DHB

On 11 March 2020, the World Health Organization declared the outbreak of COVID-19 a pandemic and two weeks later the New Zealand Government declared a State of National Emergency. From this, the country was in lockdown at alert level 4 for the period 26 March to 27 April and remained in lockdown at alert level 3, thereafter, until 13 May.

During this period, the Waikato DHB, designated an essential service, continued to operate. Activity during alert level 4 was lower than planned with elective and outpatient activity restricted in anticipation of possible COVID-19 demands. The Coordinated Incident Management System was activated to ensure that the organisation's response to the pandemic was appropriate.

An assessment of the impact of COVID-19 on the results of Waikato DHB at 30 June 2020 and its future viability has been performed and the effect on our operations is reflected in these financial statements, based on the information available to the date these financial statements are signed.

- Land and Buildings: An independent valuer, P.D. Todd, carried out a desktop assessment of Land and Buildings at year end taking COVID-19 impact into account. At this time, it is difficult to determine the full on-going impact of COVID-19 on Land and Buildings valuation due to the potential change in building cost inflation. No adjustment has been made to the Land and Buildings Revaluation Reserve of $351.5 million as at 30 June 2020.
- Other asset and liability balances have no indicators for impairment or restatement as a result of COVID-19 due to their nature or low value.
- Revenue: The bulk of Patient Care revenue is secured from funding from the Ministry of Health.
- Expenses: Additional direct costs incurred associated with supporting the response to the pandemic $24.9 million have partly been funded by the Ministry of Health $16.2 million. To support the national recovery of domestic suppliers, Waikato DHB enacted early payment of domestic suppliers.

35. Subsequent event

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

36. Comparative information

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

37. Explanation of financial variances from budget

Waikato DHB recorded a net group deficit of $72.4 million against a budgeted deficit of $72.4 million with a favourable variance against budget of $0.04 million.

An unbudgeted decrease in revaluation reserve resulted in an unfavourable variance of $0.02 million against budgeted comprehensive revenue.

Variances in comprehensive revenue and expenses

The unfavourable comprehensive revenue against budget includes:

- Revenue is $32.2 million favourable mainly due to additional funding for extra health services delivered together with reimbursement of specific costs incurred (materially offset in expenses)
- Personnel costs are $1.9 million favourable mainly due to vacancies (partially off-set in outsourced personnel)
- Outsourced services and personnel are $15.6 million unfavourable. Variances include the use of outsourced diagnostic services and deferred recruitment for internal capacity
- Clinical supplies expense is $7.0 million unfavourable mainly due to diagnostic supplies and implants and prostheses together with additional costs relating to treatment of Whakaari White Island patients. Higher direct costs incurred for COVID-19 (partially offset in revenue for lab testing reimbursement) were offset by lower activity during the COVID-19 period. Non-health board provider expenses are $14.5 million unfavourable mainly due to costs incurred for which additional funding was received (offset in revenue)
- Capital charge expense is $4.1 million favourable largely due to an unbudgeted change in the 2018/19 financial year Crown Equity relating to retained earnings and undrawn capital funding for that year.

Variances in statement of changes in equity

Total equity is $13.9 million favourable to budget. This includes:

- Opening Crown Equity is $61.8 million lower than budgeted as the 2019/20 budget was cast before the end of the 2018/19 year and did not include a higher than anticipated deficit
- Higher than budgeted equity contribution received $76.0 million.

Variances in financial position

Current assets are $9.2 million higher than budgeted due mainly to a higher bank balance caused by a higher than budgeted equity contribution received, offset by lower than budgeted receivables (due to timing).

Non-current assets are $11.5 million lower than budget. This is mainly as a result of an over forecast 2019 purchase of fixed assets and land and buildings revaluation adjustment (offset in the revaluation reserve variance to budget). In the current financial year, licence to pay costs $7.8 million was reclassified as term prepayments. No adjustment has been made to the fair value of land and buildings for the impact of COVID-19 pandemic as it cannot currently be determined.

Current liabilities are $11.3 million lower than budget. This includes:

- Bank overdraft is $57.7 million lower than budget mainly due to a higher than budgeted equity contribution received
- Employee entitlements are $60.6 million higher than budget mainly due to the 2018/19 financial year impact of Holidays Act compliance liabilities being included after the 2019/20 budget was cast, and less leave being taken than anticipated

37. Explanation of financial variances from budget (continued)

- Trade and other payables are $14.6 million lower than budgeted which includes the impact of the decrease in payment terms for local suppliers as a part of the response to the COVID-19 pandemic
- Non-current liabilities are $4.9 million lower than budget mainly due to a decrease in the year end accrued liabilities, offset by an increase in restricted trust funds held.

Variances in cash flows

- Net cash outflows from operating activities are $2.4 million lower than budget due mainly to timing variances across a number of areas
- Net cash outflows from investing activities are $4.3 million lower than budget due to a transfer of prepaid licenses from software to prepayments $7.8 million offset by higher than planned capital spend
- Net cash inflows from financing activities are $76.0 million higher than budget due to a higher than budgeted equity contribution received.

38. Statement of Performance Expectations for the 2020/21 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 2020 the 2020/21 SPE was in draft format. As a result of the COVID-19 pandemic, extension of time to 15 August was given to all DHBs by the Minister of Health.

The SPE was approved by the commissioners late August 2020.

Part six: Audit report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Waikato District Health Board and group's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of the Waikato District Health Board (the DHB) and group. The Auditor-General has appointed me, J R Smaill, 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 DHB and group on his behalf.

We have audited:

- the financial statements of the DHB and group on pages 102 to 140, that comprise the statement of financial position as at 30 June 2020, 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 DHB and group on pages 54 to 94.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the DHB and group on pages 102 to 140:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; 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.

Unmodified opinion on the performance information

In our opinion, the performance information of the DHB and group on pages 54 to 94:

- presents fairly, in all material respects, the DHB and group's performance for the year ended 30 June 2020, 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 16 December 2020.This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. 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 on the financial statements and unmodified opinion on the performance information

As outlined in note 20 on pages 126 and 127, the DHB and group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

The provision for employee entitlements includes a provision of $38.463 million for the estimated amounts owed to current and past employees. Due to the complex nature of health sector employment arrangements, the DHB and group's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $34.844 million provision as at 30 June 2019. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

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 the basis for our qualified opinion on the financial statements and the basis for our opinion on the performance information.

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements and performance information.

The DHB and group is reliant on financial support from the Crown

Note 1 on page 106 summarises the Commissioner's use of the going concern assumption in preparing the financial statements. The Commissioners have considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the DHB and group will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Commissioners going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the DHB and group over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Note 34 on page 138 to the financial statements and pages 54 to 55 of the performance information outlines the impact of Covid-19 on the DHB and group.

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

The Commissioners are responsible on behalf of the DHB and 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 DHB and group for assessing the DHB and 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 DHB and 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 DHB and 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 DHB and 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 DHB and 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 DHB and 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 DHB and 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 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 1 to 53, 95 to 101, 141 and 148 to 152, 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 DHB and 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: *International Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

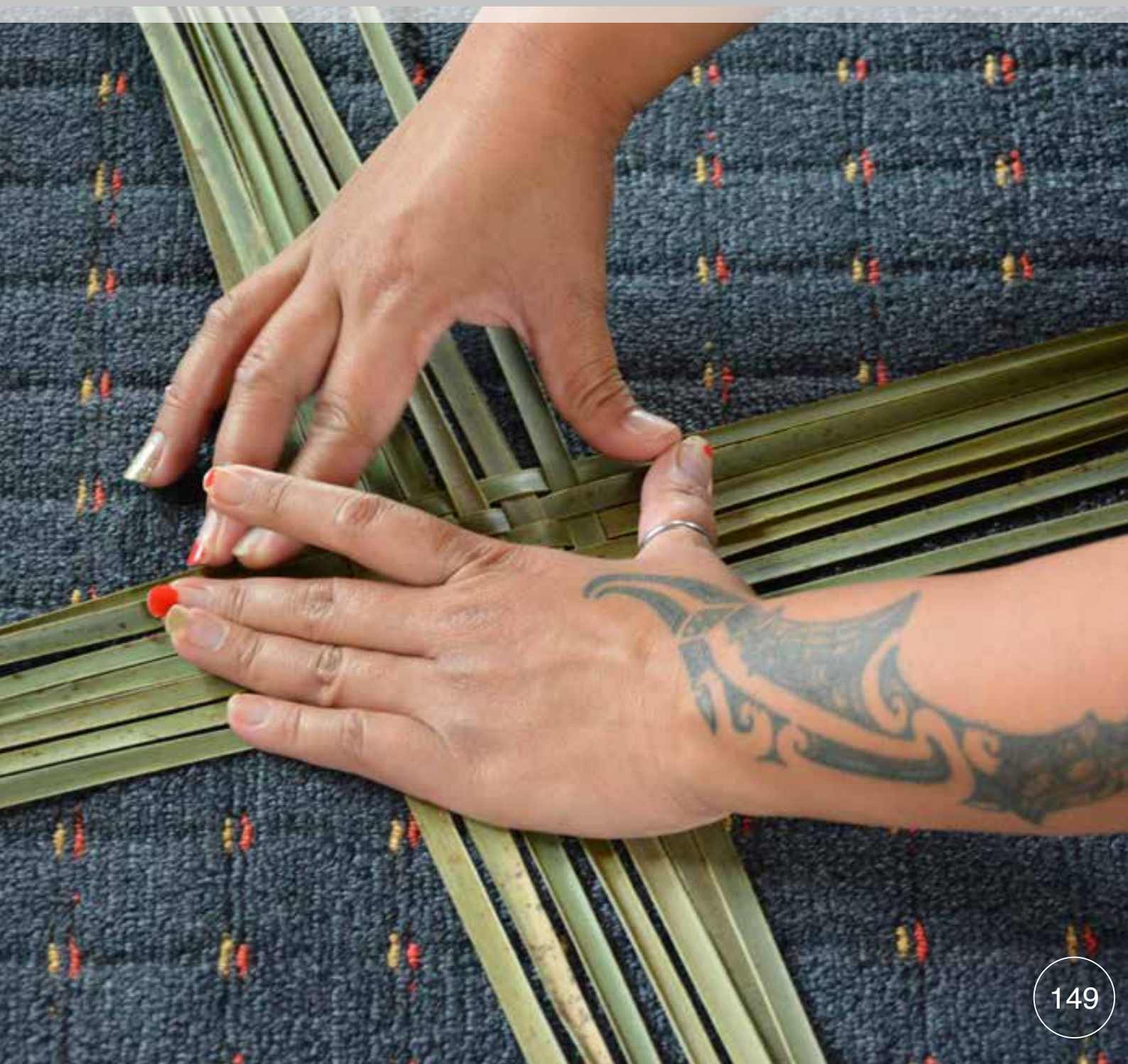
Other than the audit, we have no relationship with, or interests in, the DHB and group.

JR Smaill
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

> The Social Worker has been an excellent support and navigator for our family while our mum/ grandmother has been in Ward A4. She has an exceptional wealth of knowledge, has been a fabulous communicator and at one of the most trying times of my Nan's journey. She always held her welfare at the centre of her focus. I cannot thank her enough for all that she has done.

Bronnie, granddaughter of Ward A4 patient, June 2020

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
ACP	Advance Care Plan
API	Asset Performance Indicators
ASH	Ambulatory Sensitive Hospital Admissions • Hospital admissions that are considered as avoidable
CE	Chief Executive
CHF	Community Health Forum
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CT	Computed Tomography
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
DNA	Did Not Attend • When a patient does not attend their scheduled appointment without notification
ED	Emergency Department
EEO	Equal employment opportunities
FCT	Faster Cancer Treatment • A healthcare pathway
FTE	Full Time Equivalent • Refers to staffing levels
GP	General Practice
HDU	High Dependency Unit
HPV	Human Papilloma Virus
HR	Human Resources
HRT	Hormone Replacement Therapy
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
ICT	Information communication and technology
ICU	Intensive Care Unit
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
KPI	Key Performance Indicators
LMC	Lead Maternity Carer

Acronym	Meaning
LOS	Length of Stay
MDS-HC	Minimum Dataset Homecare Assessment Tool
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment and Service Coordination
NGO	Non-Government Organisation
NHI	National Health Index Number • A unique identifier that is assigned to every person who uses health and disability services in New Zealand
NICU	Newborn Intensive Care Unit
NIR	National Immunisation Register
NRT	Nicotine Replacement Therapy
NZ	New Zealand
NZPHD	New Zealand Public Health and Disability Act 2000
OPR	Older Persons and Rehabilitation
PCI	Planned Care Initiatives
PHN	Public Health Nurse
PHO	Primary Health Organisation
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SMO	Senior Medical Officer
SPE	Statement of Performance Expectations
TAVI	Transcatheter Aortic Valve Implantation
WKTO	Whaanau Kori Tamariki Ora – Active Families, Healthy Kids

Waikato District Health Board
Private Bag 3200
Hamilton 3240
New Zealand
www.waikatodhb.health.nz