E93

Statement of Intent

2015 / 2016

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Central to understanding this Statement of Intent, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (stewardship).

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http://www.waikatodhb.health.nz/strategy

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EXECUTIVE SUMMARY

This Statement of Intent provides short term measures, as well forecast standards of performance over the medium term. It is intended for use by our staff, our primary care partners, our provider organisations, our regional colleagues and is public information.

The New Zealand public health service continues to face challenges and pressures from factors like an ageing population, rapidly rising costs, increased demand and workforce shortages. Already we are seeing the impacts of an ageing population:

- In 2011 there were four people in the workforce for every person 65 years and over;
- By 2031 there will be just half that number with two people in workforce for every over-65 year old;
- Increasing numbers of people are reaching the 85 year old plus category, often with a high degree of frailty and high health need.

If we want to achieve our outcomes in the face of these challenges and pressures we must take a whole of system transformational approach.

The burden of disease is unfairly distributed in our society; long term conditions and risk factors such as smoking, obesity and diabetes contribute to serious health disparity. The health of Māori remains an area in which we must do better, and more detail is to be found in Ki te Taumata o Pae Ora, our Māori Health Plan. Other communities who experience disparity include Pacific people, rural communities, people with disabilities and areas like the physical health of people with serious mental health and addiction problems.

The funding environment remains constrained as health consumes an ever increasing portion of total government expenditure. As ever, our financial performance will be an area of focus. We have instituted a “sustaining a healthy future for Waikato DHB” approach which has a focus on developing quality and cost effectiveness.

There is a general acceptance that if we are to grow a strong health and disability sector we must focus on four areas:

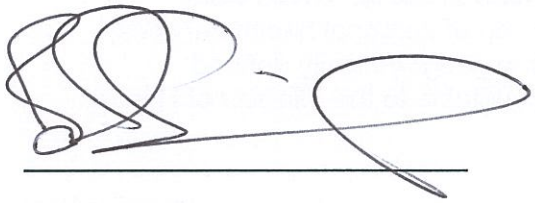
1 Better integration of services within health and across the social sector: Strengthening integration within health and across government to support the most vulnerable, reduce inequalities and address issues outside the health and disability system that impact on health. We will continue to work with our primary care alliance partners, other DHBs, local government and groups such as the youth social sector trials to better meet the health needs of our population.
2 Improving the way services are purchased and provided: Ensuring funding models support change, building and supporting the key enablers and drivers of change: workforce, health information and capital.
3 Continuing to lift quality and performance: Driving performance through measuring and rewarding the right things to improve quality.

4 Supporting leadership and capability for change: Supporting strong governance, clinical and executive leadership and capability across the health sector.

Current and projected constraints on funding mean we must continue to make the most of our resources. We need to identify and make short term savings as well as work on medium and long term actions to improve our processes, which mean:

- Improving productivity
- Planning and working more co-operatively
- Being more effective in quality improvement, innovation and implementation of ideas
- Identifying and achieving savings year on year

SIGNATORIES



Signed by Bob Simcock

Chair, Waikato District Health Board

Sally Christie

Deputy Chair, Waikato District Health Board

MODULE ONE: INTRODUCTION AND STRATEGIC INTENTIONS

1.1 Introduction

Waikato DHB was established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD) and 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 for a geographically defined population[1]. Waikato DHB is a Crown Entity and is accountable to the Minister of Health.

We receive funding from Government to undertake our functions[2]. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. We are both a funder and provider of health services. In 2015/16 we will receive approximately $1,289 million in funding from the Government and Crown agencies for health and disability services for the Waikato population.

Our provider division will receive approximately 60 per cent of the service funding with the remaining 40 per cent being utilised to fund services including those provided by non-government organisations, primary care, pharmacy and laboratories.

The Ministry of Health and National Health Board also have a role in the planning and funding of some services. Some services are funded and contracted nationally, for example disability support services for people aged less than 65 years, public health services, specific screening programmes, some mental and addictions services, elective services, Well Child and primary maternity services, some Māori health services, postgraduate clinical education and training, as well as Māori and Pacific provider development.

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. We are responsible for monitoring and evaluating service delivery, including audits of the services we fund.

The costs of providing services to people living outside of our district are met by the DHB of the patient and are referred to as 'inter-district' services or Inter-District Flows. Likewise, where we do not provide the service, we have funding arrangements in place enabling our district residents to travel outside the district. We also deliver against service delivery contracts with external funders, such as the Accident Compensation Corporation (ACC). We closely monitor Inter-District Flows and ACC volumes to ensure our ability to provide for our own population is not adversely affected by demand from outside the district.

[1] See module 1.5.1 for a map of Waikato DHB
[2] See module 1.6 for detail about Waikato DHBs' functions

In order to achieve the planned outputs, impacts and outcomes as outlined in our Annual Plan, we may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or vary any current agreement for the provision or procurement of any health and disability support service. These agreements (or variations) may contain any terms or conditions acceptable to the DHB.

Waikato DHB has a role to play in shifting our health system to a wellness model, and we will continue to improve how we work with our partners across the system to deliver on the expectations, outcomes, goals, objectives and the strategic priorities we are charged with contributing to each year.

1.1.2 Performance Story

The diagrams presented on the following pages provide a high level summary of our performance story and demonstrate the link between our outcomes and our stewardship areas. The right hand column of the diagram indicates the relevant module of this Plan for further details.

National Performance Story

Health and Disability System Outcomes	New Zealanders live longer, healthier, more independent lives		The health system is cost effective and supports a productive economy	Module One
Ministry of Health's High-level Outcomes	New Zealanders are healthier and more independent	High-quality health and disability services are delivered in a timely and accessible way	The future of the health and disability system is assured	
Overarching Health Sector Goal	Better, Sooner, More Convenient Health Services for all New Zealanders			

Regional Performance Story

Midland Vision	All residents of Midlands DHBs lead longer, healthier and more independent lives "Healthy Communities – Integrated Healthcare"					Module One
Regional Strategic Outcomes	To improve the health of the Midland population			To eliminate health inequalities		
Regional Strategic Objectives	Improve Māori health outcomes	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB Performance Story

Our Vision	Te Hanga Whaioranga Mo Te Iwi Building Healthy Communities							Module One
Our Outcomes	To improve the health of our population			To reduce or eliminate health inequalities				
Our Strategic Priorities	Financials	Regional Collaboration	Quality Improvement	Addressing Chronic Conditions	Organisational and Workforce Development	Integrated Care	Rural	

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	Module Two
Intermediate Impacts	• Fewer people smoke • Reduction in vaccine preventable diseases • Improving health behaviours	• Children and adolescents have better oral health • Long term conditions are detected early and managed well • Fewer people are admitted to hospital for avoidable conditions • People maintain functional independence	• People are seen promptly for acute care • People have appropriate access to elective services • Improved Health Status for People with a Severe Mental Illness and / or Addiction • More people with end-stage conditions are supported	
Outputs[3]	• Percentage of eight months olds will have their primary course of immunisation on time	• Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	• Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	

Stewardship

Stewardship	Workforce	Organisational Performance Management	Clinical Integration / Collaboration / Partnerships	Information	Module Five

[3] Only examples of the outputs are presented here. For the full set of measures see module three

The outputs part of the service performance section of our performance story diagram contains examples of measures contained in the statement of performance expectations. There are more than 30 output measures in total we will be monitoring.

1.2 National Operating Environment

The Minister of Health with Cabinet and the Government develops policy for the health and disability sector. The Minister is supported by the Ministry of Health and its business units, advised by the Ministry, the National Health Board, Health Workforce New Zealand, the National Health Committee and other ministerial advisory committees. Accident services are funded by Accident Compensation Corporation.

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

1.2.1 Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of the Treaty. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

1.2.2 Health Sector Challenges and Pressures

Major, long-term systematic pressures are shaping the way health services will be delivered in the future. These not only impact on New Zealand, but on a majority of health systems across the world. These challenges and pressures include:

- There are substantial variations in outcomes for different populations, particularly for Māori and Pacific peoples, people with disabilities, people living in rural areas and those living in more socioeconomically deprived areas;
- With increasing diversity in our population, the health system needs to be flexible to meet changing needs and expectations of services;
- Changing population health needs and patterns of health and ill-health (e.g. the impact of long-term conditions such as diabetes and risk factors such as high body mass index, multiple comorbidities that increase with age, population growth and ageing);
- An ageing and unevenly distributed workforce, which does not currently match the anticipated future demand for health and disability services;
- More expensive treatments and increasing costs, and changing public expectations of services and treatments;

- Providing excellent health care whilst ensuring the cost of the health system is sustainable (historically health spending has grown faster than Gross Domestic Product).

Waikato DHB faces a situation of being tasked with continuing to fund and provide high quality services within the context of tight financial constraints. To achieve this we must continue to work with our contracted providers, our communities and other key stakeholders to develop new and better ways of delivering services and providing models of care that meet the changing needs of our population.

1.3 Regional Operating Environment

Waikato DHB is one of five DHBs[4] that make up the Midland Region. In 2015/16 all five Midland DHBs will continue to progress activities towards regional cooperation in a planned manner. Collectively the Midland DHBs have developed and agreed a Midland DHB Regional Services Plan.

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 implementation activities from our regional services plan as well as directly funding regional work and positions. HealthShare[5] is tasked with co-ordinating the delivery of regional planning and implementation on behalf of the Midland DHB region.

1.4 Local Operating Environment

Waikato DHB oversees funding for all levels of care including primary care such as general practitioners (GPs), nurses, pharmacists and community health services. Waikato DHB also oversees funding for hospital services, aged care services and services provided by non-government health providers, including Māori and Pacific providers. We are responsible for the provision of a number of health services in our district. These services include:

- five hospital sites
- two continuing care facilities
- one mental health inpatient facility
- 20 community bases

The parties funded by Waikato DHB to deliver services to our population include:

- 57 aged related residential care facilities (rest homes)
- 76 pharmacies
- 75 GP practices
- 18 Māori providers

[4] Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato
[5] See module 5.2.1 for more detail

- two Pacific providers
- three primary health alliance partners

Waikato DHB continues to assess the changes in its operating environment to ensure the services funded and/or provided are aligned to our outcomes.

1.4.1 Geography and Population

Our DHB serves a population of 391,770 and covers 21,220 square kilometres. It stretches from northern Coromandel to close to Mt Ruapehu in the south and from Raglan on the west coast to Waihi on the east.

Our district takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui. Six Iwi are located within the Waikato DHB area. More detailed information on our Māori population is outlined in Ki te Taumata o Pae Ora, our Māori Health Plan.

A detailed breakdown of our population is presented in the following table.

Waikato DHB projected population by age and ethnicity for 2015/16

Age Group	Ethnicity			
	Māori	**Pacific**	**Other**	**Total**
00 – 24	46,155	5,385	86,690	138,230
25 – 44	21,165	3,190	71,325	95,680
45 – 64	15,950	2,010	79,650	97,610
65 – 74	3,465	420	30,925	34,810
75+	1,560	240	23,640	25,440
Total	88,295	11,245	292,230	391,770

Our large rural population presents diverse challenges in service delivery and accessing health services. Significant points of interest in terms our population include:

- the population is expected to increase in Waikato but at a slower rate than the rest of New Zealand
- we are more rural than New Zealand as a whole
- we have a population that is getting proportionately older (the 65 plus age group is projected to increase by 52 per cent between 2011/12 and 2025/2026)
- the population of children and young people is predicated to decline by 2026
- we have a Māori population which is growing at a slightly faster rate than other population groups and is estimated to be 23.3 per cent by 2026
- we have a population of Pacific people who make up an estimated 2.5 per cent of our population
- a higher percentage of people in our DHB live in areas of low socio-economic status compared to the New Zealand average (24.10 per cent live in areas classified as quintile five or most deprived, compared to a national average of 20 per cent)
- Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in areas of low socio-economic status
- inequalities in health tend to be highest for people living in areas identified as quintile four and five and these people are likely to experience lower life expectancy and higher rates of chronic conditions
- high numbers of the Māori population in our district live in areas identified as quintile four and five

1.4.2 Health Profile

Understanding our health profile plays an important part in our decision making processes. This information helps us focus on where we can make the greatest gains in terms of our strategic outcomes, as well as for planning and prioritisation of programmes at an operational level. Key points of interest in terms of the health profile of the population are[6]:

[6] Sourced from our latest Health Needs Assessment

- the main cause of early death is cardiovascular disease followed by cancer
- one in five people in the 'Other' ethnicity grouping are cigarette smokers, for Māori one in two smoke and for Pacific people, one in three smoke
- Māori women continue to have the highest smoking prevalence
- higher percentages of Māori and Pacific children are overweight or obese, compared to 'Other', but in all ethnic groups there has been a significant increase in overall body weight
- cardiovascular disease mortality rates increased with increasingly low socio-economic status among both Māori and non-Māori
- Māori are disproportionately represented in the most deprived areas and therefore at higher risk of death from cardiovascular disease compared to non-Māori
- people with diabetes have double the risk of myocardial infarction, and between two and eight times greater risk of heart failure, than people without diabetes
- avoidable deaths for cancer are higher in the Waikato than for New Zealand
- as a whole Māori deaths to cancer were highest among all ethnic groups aged 45-64 years in the Waikato
- Māori patients with diabetes were nine times more likely to have an admission for renal disease than European with diabetes
- Māori were diagnosed with Type 2 diabetes at a mean age of 48 years, Indians at 49 years and Pacific people at 50 years compared with Europeans at 59 years
- age standardised rates of hospitalisation for respiratory infections in 2006 among Māori and Pacific People (379.7 and 368.8 per 100,000 population respectively) were almost twice as high as Other at 199.34 per 100,000 population
- dental caries (tooth decay) is one of the top five cause of preventable hospital admissions for children
- Māori and Pacific children have a lower percentage of caries free teeth, and a higher rate of missing and filled teeth
- the general pattern was for Māori to have the highest prevalence across all mental health disorders, followed by Pacific people

1.5 Nature and Scope of Functions

We collaborate with other health and disability organisations (such as our primary care alliance partners), key stakeholders and our community to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration, we aim to ensure that health and disability services are well coordinated and cover the full continuum of care, with the patient at the centre. We expect these collaborative partnerships to also allow the sharing of resources, reduction in duplication, variation and waste across the health system to achieve the best outcomes for our community. As a DHB we:

- plan in partnership with key stakeholders such as our primary care alliance partners, the strategic direction for health and disability services
- plan regional and national work in collaboration with the National Health Board and other DHBs
- fund the provision of the majority of the public health and disability services in our district, through the agreements we have with providers
- provide hospital and specialist services primarily for our population and also for people referred from other DHBs
- promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives

1.6 Strategic Intentions

1.6.1 Our Vision

Te Hanga Whaioranga Mo Te Iwi – Building Healthy Communities

1.6.2 National Strategic Intentions

The Government has set a clear goal for the health system to make care better, sooner and more convenient. Waikato DHB is one of the agencies charged with giving effect to this overarching goal. There are two identified health system outcomes for New Zealand as detailed in our performance story diagram. Further detail relating to these outcomes can be found in the Ministry of Health Statement of Intent 2014 to 2017. The outcomes are:

1. New Zealanders live longer, healthier, more independent lives
2. The health system is cost effective and supports a productive economy

These health system outcomes support the achievement of wider Government priorities and are not expected to change significantly over the medium term. Waikato DHB contributes to these system outcomes as well as the Ministry of Health's outcomes of:

1. New Zealanders are healthier and more independent
2. High-quality health and disability services are delivered in a timely and accessible way
3. The future of the health and disability system is assured

Positive health outcomes are a consequence of activities across the social sectors, not just the health sector. Initiatives such as Better Public Services and Social Sector Trials are examples of where the health sector and the social sectors are working together to deliver a collective impact.

1.6.2.1 Minister's Letter of Expectations

The Minister of Health has outlined his expectations for the 2015/16 year. The expectations reinforce the Government's ongoing commitment to protecting and growing New Zealand's public health services. The key areas highlighted in the letter of expectations are:

- DHBs need to budget and operate within allocated funding and have detailed plans to improve year-on-year financial performance. This includes improvements through national, regional and sub-regional initiatives.
- Strong clinical leadership and engagement utilised in all aspects of DHBs' core business. DHB governance, senior management and clinical leaders working together to ensure we are heading in the same direction.

- Integrating primary care with other parts of the health system is vital for better management of long-term conditions, mental health and addictions, an ageing population and patients in general. A key to better health is earlier intervention and population based initiatives delivered in the community.
- DHBs must remain focused on achieving and improving performance against the health targets, particularly the primary care targets. DHBs will work directly with primary health organisations to drive performance against the relevant health targets.
- Strengthening the link between physical activity and keeping New Zealanders healthy. All DHBs are expected to be considering what they can do to help reduce the incidence of obesity in New Zealand.

1.6.2.2 National Health Targets

Improving performance across the sector is fundamental to the outcomes of New Zealanders living longer, healthier and more independent lives and the health system being cost effective and supporting a productive economy. One of the mechanisms used to monitor our performance is the nation-wide health targets. Meeting these targets makes a practical difference to individuals and families by improving access to services, reducing waiting times or preventing harmful conditions. The following table outlines our target levels for each of the six health targets.

Waikato DHB Health Targets 2015/16

Health Target	Long Term Target	Waikato DHB Target 2015/16
Shorter Stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%
Improved Access to Elective Surgery	The volume of elective surgery will be increased by an average of 4,000 discharges per year.	15,858
Faster Cancer Treatment	85 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 by July 2016, increasing to 90 percent by June 2017.	85%
Increased Immunisation	95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	95%
Better Help for Smokers to Quit	• 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking • 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking	95% 90%

Health Target	Long Term Target	Waikato DHB Target 2015/16
	• Progress towards 90 percent of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered brief advice and support to quit smoking.	90%
More Heart and Diabetes Checks	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years	90%

1.6.2.3 Better Public Services

The Government has set 10 challenging results for the public sector (which includes DHBs) to achieve over the next five years. The area that health is taking a major role in is outlined in the following table.

Better Public Service Result	National Target
Result 2: Increase participation in quality early childhood education	In 2016, 98 percent of children starting school will have participated in quality early childhood education.
Result 3: Increase infant immunisation rates and reduce the incidence of rheumatic fever	• Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017 • Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by June 2017.
Result 4: Reduce the number of assaults on children	By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5 percent.

1.6.2.4 Social Sector Trials

The Social Sector Trials involve Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered. They test what happens when a local organisation or individual directs cross-agency resources, as well as local organisations and government agencies to deliver collaborative social services. There are four Social Sector Trials in our district in the following areas:

- Taumarunui
- Waitomo District
- South Waikato District; and
- Waikato District

1.6.2.5 Whānau Ora

Whānau ora is an approach that supports whānau to identify and achieve their own aspirations. It is a key cross-government work programme jointly implemented by a number of sectors, particularly health, education and social services.

1.6.2.6 Policy Drivers

Four important policy drivers have been identified through which the health sector may best utilise resources to achieve better sooner more convenient health care. They are:

1. Better Public Services (including Social Sector Trials): DHBs must work more effectively with other parts of the social sector. The Government's Better Public Services targets and the Social Sector Trials will help drive this integrated approach that puts the patient and user at the centre of service delivery. DHBs are expected to work closely with other sectors such as education and housing specifically.
2. Regional collaboration: means DHBs working together more effectively, whether regionally or sub-regionally.
3. Integrated care: includes both clinical and service integration to bring organisations and clinical professionals together, to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.
4. Value for Money: is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

1.6.3 Regional Strategic Intentions

Midland DHBs have agreed a strategic approach to assist the region to move forward in the same direction. This includes a shared vision, two strategic outcomes and six objectives. The strategic outcomes and objectives[7] for the region are summarised below and further detail is provided in the Midland DHBs Regional Services Plan 2015/16.

1.6.3.1 Regional Vision

All residents of Midlands DHBs lead longer, healthier and more independent lives.

"Healthy Communities – Integrated Healthcare"

1.6.3.2 Regional Strategic Outcomes

Strategic Outcome 1: Improve the health of the Midland populations

Health and wellbeing is everyone's responsibility. A core function of DHBs is to promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

[7] As identified in our performance story diagram (module 1.2)

Strategic Outcome 2: Eliminate health inequalities

The DHBs in the Midland Region remain committed to working to eliminate health inequalities in its populations. This occurs in partnership with key stakeholders and our community (i.e. clinical leaders, Iwi, Primary Health Organisations and non-Government organisations) and in collaboration with other DHBs and the Ministry of Health regional and national work.

1.6.3.3 Regional Objectives

The region has agreed six regional objectives, which are:

- Regional Objective 1: Improve Māori health outcomes
- Regional Objective 2: Integrate across continuums of care
- Regional Objective 3: Improve quality across all regional services
- Regional Objective 4: Improve clinical information systems
- Regional Objective 5: Build the workforce
- Regional Objective 6: Efficiently allocate public health system resources

1.6.3 Local Strategic Intentions

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2015/16. Our strategic intent represents a continuation from previous years, as the challenges we face are not short term issues easily resolved within a 12 month period.

Our local strategic outcomes listed below align directly to the regional strategic outcomes.

1. To improve the health of the Waikato DHB population
2. To reduce or eliminate health inequalities

Many factors influence outcomes. In contributing to these outcomes we will have a real impact on the lives of our populations. Many of the activities we plan to implement in 2015/16 will contribute across a number of our outcomes, priorities and impacts.

The local priorities have been included in our overall performance story to ensure items important to us that are not explicitly covered in the regional strategic intent are included. Our local priorities are presented in the table on the following page.

At a local level, we plan to be monitoring life expectancy as an outcome indicator. We will link into regional work around the following regional indicators as appropriate.

Strategic Priority	Description
Financials	Ensuring delivery on agreed financial forecasts and the ability to live within our means
Quality improvement	Constantly seeking opportunities to get better at how we function and improve effectiveness
Organisational and workforce development	Building a sustainable health workforce to serve future generations
Addressing chronic conditions	These conditions are the leading cause of ill health and premature death in New Zealand. They disproportionately affect low income earners, Māori and Pacific people.
Rural	A significant number of our people live in areas we consider as rural. We are planning for clinical sustainability in rural health services and exploring opportunities to get the workforce better joined up.
Integrated Care	Health systems need to be re-balanced to respond better to the changing pattern of need generated by long term conditions and the technological opportunities becoming available, so that they foster professional team working and closer relationships between provider organisations, encourage and support much more patient self-care and take greater pains to prevent long term conditions developing in the first place.
Regional collaboration	Improving clinical services quality and viability across the Midland region and reducing duplication of effort and bureaucracy

1.7 Key Risks and Opportunities

By its nature, the health sector is complex and challenging. We have identified the following risks and opportunities as being particularly relevant for 2015/16.

1.7.1 Health Inequalities

We are committed to reducing or eliminating the effects of health disparities through, firstly, identifying them and, secondly, through funding and providing universal programmes which include a focus on reducing disparities as well as specific programmes that target disparities and improve access to services. It should be noted that long term conditions, particularly those that are exacerbated by tobacco use, and maternal smoking (particularly in the third trimester) are significant contributors to health disparity. The approach we take includes:

- implementing our Māori Health Plan;
- promoting screening services too hard to reach groups to increase early detection of disease;
- implementing services that target communities with identified health inequalities;
- setting targets by ethnicity or by high needs;
- supporting kaupapa Māori services and ‘for Pacific by Pacific’ services;

- increasing the capability of the Māori and Pacific workforce across our district;
- using an equity lens as part of decision-making processes (e.g. the Health Equity Assessment Tool);
- engaging with our Disability Support Advisory Committee to provide advice and inform decision making;
- engaging with Iwi Māori Council to provide advice and inform decision making;
- engaging with community health forums and expert advisory groups to provide and receive advice (e.g. our AgeWISE advisory group and our rural health advisory group).

A challenge for DHBs in the Midland Region is to configure health service delivery in a way that takes account of the complex relationships between the key social determinants of health (such as housing quality, education and employment), while recognising that a number of public and private agencies influence health outcomes.

1.7.2 Fiscal Discipline

The ongoing pressure of the financial environment is one of the factors driving the need for the health system to transform. This means seeking efficiency gains and improvements in purchasing, productivity and the quality of our operation and service delivery.

1.7.3 Health System Workforce Shortages

The health workforce is made up of a wide variety of occupational groups employed by a number of different organisations. Workforce shortages, particularly in rural and provincial areas, are a key threat to the health system's ability to provide a full range of accessible, high-quality health services.

Work is occurring at a national, regional and local level to mitigate the impact of workforce shortages. Detail on a number of the strategies in place to mitigate the impact of this challenge is set out in module five.

1.7.4 System Integration

A growing commitment to the achievement of more effective system integration in partnership with primary care and other appropriate stakeholders is fundamental to strengthening our healthcare system. As in previous years, we have engaged with our primary care partners as part of our planning process. It was identified that improvements needed to be made with this process so, Waikato DHB will be working with our primary care alliance partners in late 2015 to improve the engagement process around annual planning. This process will inform the development of the 2016/17 annual planning documents.

Evidence shows that integrating primary care with other parts of the health system is vital for better management of long term conditions, responding to the pressure of an ageing population and in managing acute demand. Hospital demand is growing at a rapid rate, and as more hospital admissions occur due to preventable causes, we need to examine what could be improved in regard to how we deliver our services.

1.7.5 Regional Collaboration

There are potentially significant gains to be made from DHBs working together in new and innovative ways, both in cost savings and better patient wellbeing. Regional services' planning is a vehicle to progress regional system integration and regional service development opportunities. It is vital that this is a whole of system approach and as such, it is vital for primary care to be engaged in developments in this arena.

1.8 Key Measures of Performance

1.8.1 Long Term Impact - People Take Greater Responsibility for their Health

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. It is expected a focus on this impact will reduce the number of presentations in primary care and admissions to hospital and specialist services associated with long term conditions.

1.8.1.1 Fewer People Smoke

Why is this important?

Smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Supporting our population to say "no" to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

How will we know we are succeeding?

While a number of initiatives and interventions occur in this area, we will focus on monitoring the percentage of people taking up smoking.

Measure	Baseline 2009	Target 2015	Target 2016	Target 2017
Percentage of Year 10 students who have never smoked[8]	60.5%	75.7%	Increased percentage	

1.8.1.2 Reduction in Vaccine Preventable Diseases

Why is this important?

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole

[8] Reporting is based on school year and based on surveying a sample of schools in New Zealand

population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

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

How will we know we are succeeding?

We will know we have succeeded by reducing our admissions for vaccine preventable diseases.

Measure	Baseline 2009/10	2015/16	2016/17	2017/18
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old	12.98	Less than 23.61	Reduction in admissions for vaccine preventable diseases	

1.8.1.3 Improving Health Behaviours

Why is this important?

Good nutrition is fundamental to health and to the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year.

How will we know we are succeeding?

By seeing a reduction in obesity, a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices.

Measure	Baseline	2015/16	2016/17	2017/18
Percentage of New Zealand population aged 15 years plus considered obese	28.3%	Decrease		

1.8.2 Long Term Impact - People Stay Well in their Homes and Communities

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease

through education, screening, early detection and timely provision of treatment. Primary care is a vital point of continuity and effective coordination across the continuum of care, particularly in improving the management of care for people with long-term conditions.

Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

1.8.2.1 Children and Adolescents have Better Oral Health

Why is this important?

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

How will we know we are succeeding?

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

Measure	Baseline 2010	Target 2015	Target 2016	Target 2017
Mean decayed missing and filled teeth score of Year 8 children[9]	1.60	1.14	1.12	Decrease

1.8.2.2 Long Term Conditions are Detected Early and Managed Well

Why is this important?

Early detection will lead to successful treatment, or a delay / reduction the need for secondary and specialist care. This is expected to enable more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage cardiovascular disease. It is one of the largest causes of death in New Zealand, and disproportionately affects Māori. Often by the time heart problems are detected, the underlying cause is usually well advanced.

[9] This measure covers a calendar year period to line up with the school year

How will we know we are succeeding?

Measure	Baseline	Target 2015/16	Target 2016/17 and 2017/18
Ambulatory sensitive hospital admissions per 100,000 for congestive heart failure	80	Less than 80	Decrease

1.8.2.3 Fewer people are admitted to hospital for avoidable conditions

Why is this important?

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver Better, Sooner, More Convenient Healthcare for all New Zealanders.

How will we know we are succeeding?

When we reduce the ratio of actual to expected avoidable hospital admissions for our population.

Measure	Baseline 2013/14	Target 2015/16	Target 2016/17	Target 2017/18
The number of ambulatory sensitive hospital admissions per 100,000 population (0-74 age group)	80	Less than 80	Decrease	

1.8.2.4 People Maintain Functional Independence

Why is this important?

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

How will we know we are succeeding?

Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires Aged Residential Care. As we do not currently capture this information, our best proxy indicator is to increase the average age at which an older person enters Aged Residential Care.

Measure	Baseline 2010/11	2015/16	2016/17	2017/18
Average Age of Entry to Aged Related Residential Care	Rest home – 84.1 Dementia – 83.6 Hospital – 80.6	Greater than or equal to 84.1 years of age Greater than or equal to 83.6 years of age Greater than or equal to 80.6 years of age	Increase	

1.8.3 Long Term Impact - People Receive Timely and Appropriate Specialist Care

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, we are operating under increasing demand and workforce pressures. The expectations around reducing waiting times, coupled with the current fiscal situation, mean we need to develop innovative ways of treating more people and reducing waiting times with limited resources. This reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

1.8.3.1 People Are Seen Promptly Acute Care

Why is this important?

Long stays in Emergency Departments are linked to overcrowding of the Emergency Department, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in an Emergency Department improves the health services DHBs are able to provide.

The duration of stay in Emergency Department is influenced by services provided in the community to reduce inappropriate Emergency Department presentations, the effectiveness of services provided in Emergency Departments and the hospital and community services provided following exit from an Emergency Department. Reduced waiting time in

Emergency Departments is indicative of a coordinated 'whole of system' response to the urgent needs of the population. Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to.

How will we know we are succeeding?

When we see an increase in the percentage of people who visit our Emergency Departments and are admitted, discharged or transferred within six hours.

Measure	Baseline 2010/11	Target 2015/16	Target 2016/17 and 2017/18	
Percentage of patients admitted, discharged or transferred from emergency departments within six hours	85%	95%	95%	95%

1.8.3.2 People Have Appropriate Access to Elective Services

Why is this important?

Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing. Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

How will we know we are succeeding?

To meet the appropriate level of access, we want to ensure that our Standard Intervention Rates (SIRs) meet national expectations for cardiac procedures.

Measure	Baseline 2010/11	Target 2014/15	Target 2015/16 and 2016/17
Standardised Intervention Rates (per 10,000)	Major joint replacement: 21 Cataract procedures: 27 Cardiac surgery: 6.23 Percutaneous revascularization:	 21 27 6.5 	 Maintain Maintain Maintain

	TBC Coronary angiography services: TBC	12.5 34.7	Maintain Maintain

1.8.3.3 Improved Health Status for People with a Severe Mental Illness and / or Addiction

Why is this important?

It is estimated that at any one time, 20 percent of the New Zealand population will have a mental illness or addiction, and 3 percent are severely affected by mental illness. There is also a high prevalence of depression with the economic downturn and other pressures. The World Health Organisation (WHO) predicts that depression will be the second leading cause of disability by 2020. We have an ageing population, which places increased demand from people over 65 for mental health and addiction services appropriate to their life stage.

Our goal is to build on our existing relationships, by offering programmes to individuals and groups from a broad range of ages – children and youth, adults and older people.

Measure	Baseline 2010/11	Target 2014/15	Target 2015/16 and 2016/17
28 day acute re-admission rates	13%	Less than or equal to 15%	Decrease

How will we know if we are succeeding?

If we improve access, and provide services to people at the right time, and in the right place, and can expect to see a reduction in our 28 day readmission rate. This will, in turn, assist in reducing pressure on our hospital services.

1.8.3.4 More People with End-Stage Conditions are Appropriately Supported

Why is this important?

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process. Rehabilitation and Support Services contribute to this impact. Programmes include palliative care, aged residential care, respite care and home based support services.

How will we know we are succeeding?

Palliative care is being accessed, but we want to target those with greatest need. The Palliative Care Council has identified inequalities of access to palliative care based on diagnosis (evidence of under-utilisation by those with non-malignant conditions), with a lack of suitable service provision for children and young people. We would like to see an increase in palliative support for this group.

The development of Waikato Palliative Care Plan is expected to occur in 2015/16. Once agreed, the plan will detail a high level 'road map' for palliative care and end of life for the Waikato district. This plan will take into account a significant number of national, regional and local initiatives which include increased hospice funding, palliative care health needs analysis and updated service specifications.

Through the process to develop this plan, it is expected that the key measures for monitoring performance in this area will be identified. This will enable Waikato DHB to further refine our performance story for our intermediate impact of more people with end stage conditions are appropriately supported.

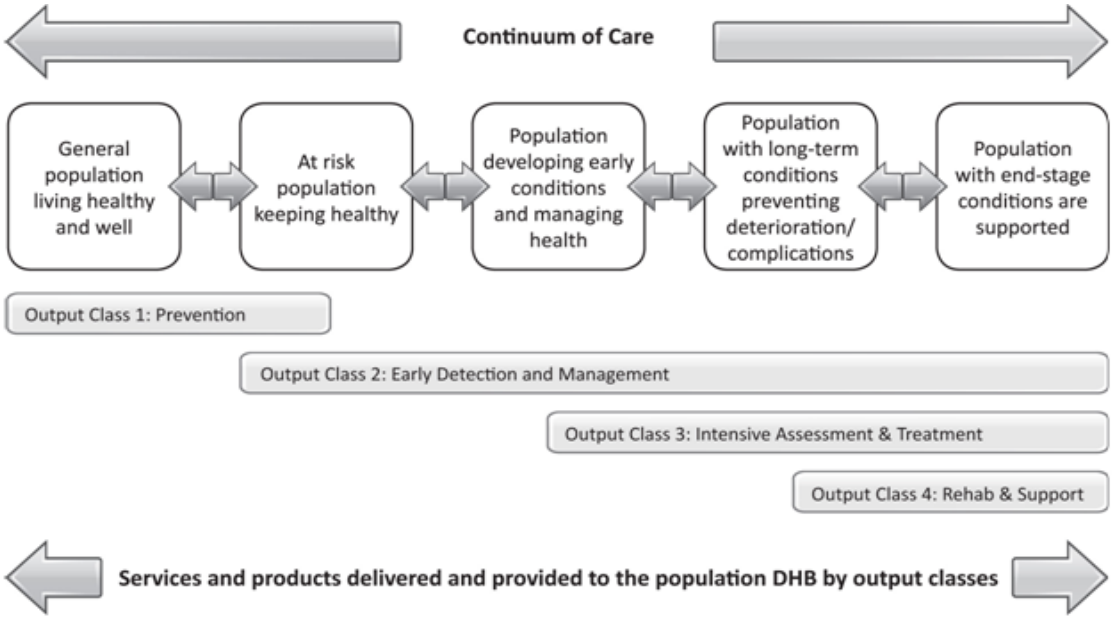
MODULE TWO: STATEMENT OF PERFORMANCE EXPECTATIONS

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2015/16. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect 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 (see modules 1 and 2). Where possible, we have included with each measure past performance as baseline data.

Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and / or our Board on our performance related to this activity.

2.1 Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures (appendix 8.3). The four output classes that have been agreed nationally are defined in appendix 8.2. They represent a continuum of care, as follows:



2.2 Guide to Reading the Statement of Service Performance

The following points provided should be kept in mind when reading the rest of this module:

- Further detail of the performance story logic and rationale is contained in section 1.2
- Baseline and figures for the output performance measures are for the 2010/11 financial year unless otherwise stated
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once.
- Measurement type key: Qn = Quantity T = Timeliness QI = Quality
- There are some services we provide that support the rest of the health system so we have included these in a "Support Services" section of our performance story
- Detailed information about the rationale for each output measure is provided in appendix 8.4

2.3 People Take Greater Responsibility for their Health

2.3.1 Fewer People Smoke

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
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	1	Qn	81%	95%
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	1	Qn	84%[10]	90%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	1	Qn	90%[11]	90%

2.3.2 Reduction in Vaccine Preventable Diseases

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn/T	76%[12]	90%

[10] For the 2013/14 year
[11] For the 2014/15 year
[12] As at 31 July 2012

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	tbc	95%
Percentage of four year olds are fully immunised by age five years reported for each three month period quarterly.	1	Qn	tbc	95%
Percentage of girls have received HPV dose three[13]	1	Qn	tbc	65%
Seasonal influenza immunisation rates in the eligible population (65 years and over).	1	Qn/T	63%	75%

2.3.3 Improving Health Behaviours

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
• Exclusive or fully breastfed at lead maternity carer discharge (4-6 weeks)[14] • Exclusive or fully breastfed at 3 months • Receiving breast milk at 6 months	1	Qn/T	73% 55% 62%	68% 54% 59%
The number of people participating in Green Prescription programmes	1	Qn	5802[15]	4480
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	1	Qn	93.8%	93.8%
Percentage of total primary schools participating in Project Energize	1	Qn	98.8%	98.8%

[13] For 2015/16 it is the 2002 birth cohort measured at 30 June in 2016
[14] Baseline for these measure is 1 January 2014 – 30 June 2014
[15] For the 2014/15 year

2.4 People Stay Well in their Homes and Communities

2.4.1 Children and Adolescents have Better Oral Health[16]

Outputs	Output Class	Measure Type	Baseline 2009	Target 2015
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	43%	85%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	11%	7%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	66%	72%

2.4.2 Long Terms Conditions are Detected Early and Managed Well

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	42%	90%
Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months	2	Qn/T	77%	80%
Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years.	2	Qn/T	63%	70%

2.4.3 Fewer People are Admitted to Hospital for Avoidable Conditions

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of eligible population who have had their B4 school checks completed	1	Qn/T	81%[17]	90%
Acute rheumatic fever initial hospitalisation target rates and numbers (per 100,000 total population),	2 and 3	Qn	Rate 4.8 Number 18	Rate 1.6 Number 6

[16] Childhood oral health measures are for a calendar year
[17] Baseline is 2011/12

2.4.4 People Maintain Their Functional Independence

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/t	100%	100%
Percentage of people enrolled with a primary health organisation	2	qn	97%	100%
Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days	4	qn	81%	100%

2.5 People Receive Timely and Appropriate Specialist Care

2.5.1 People Are Seen Promptly for Acute Care

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Acute re-admission rate	3	Ql	6.7%	tbc
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	3	Qn/T	tbc	85%
Percentage of patients who require radiation or chemotherapy are treated with four weeks	3	Qn/T	100%	100%
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	3	Qn	13%	Less than 16%

2.5.2 People Have Appropriate Access to Elective Services

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	5.6%	0
Improved access to elective surgery, health target, agreed discharge volumes	3	Qn	12,373	15,858
Did-not-attend percentage for outpatient services	3	Qn/T	10%	Less than 10%

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Inpatient Average Length of Stay (elective) Inpatient Average Length of Stay (elective)	3 3	Qn/T	Tbc days Tbc days	1.71 days 2.64 days

2.5.3 Improved Health Status for People with a Severe Mental Illness and / or Addiction

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
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	Qn/T	43% 70%	80% seen within 3 weeks 95% seen within 3 weeks
Percentage of child and youth with a transition (discharge) plan	3	Qn/T	TBC	95%
Average length of acute inpatient stays	3	Qn/T/QI	13.89 days	Between 14.00 and 21.00 days
Rates of post-discharge community care	3	Qn/T/QI	82%	90% - 100%

2.5.4 More People with End-Stage Conditions are Supported Appropriately

Outputs	Output Class	Measure Type	Baseline	Target 2015/16
Number of first attendances at the Waikato DHB hospital palliative care outpatient service	3	Qn	408	Less than 50

2.6 Support Services

Outputs	Output Class	Measure Type	Baseline 2013/14	Target 2015/16
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three	2	T	Tbc	95%

Outputs	Output Class	Measure Type	Baseline 2013/14	Target 2015/16
months				
Percentage of accepted referrals for CT scans, and percentage of accepted referrals for MRI scans will receive their scan within than six weeks (42 days)			66% 30%	95% - CT 85% - MRI
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)			Tbc	75%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)			Tbc	65%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 120 days			Tbc	100%
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	Qn/T	99.6%	99.6%
Total number of pharmaceutical items dispensed in the community	2	Qn	5,339,890	Between 5,300,000 and 5,500,000

MODULE THREE: FINANCIAL PERFORMANCE

Table: Statement of Prospective Comprehensive Income

Forecast Statement of Comprehensive Income	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
REVENUE						
Patient care revenue	1,206,336	1,233,579	1,273,544	1,302,701	1,331,239	1,360,023
Other operating income	16,099	16,043	16,365	15,764	16,888	18,066
Finance income	1,338	1,681	1,200	2,930	2,969	2,990
TOTAL REVENUE	1,223,773	1,251,303	1,291,109	1,321,395	1,351,096	1,381,079
EXPENSES						
Personnel costs	482,822	491,829	511,598	521,825	532,269	542,917
Depreciation	34,427	33,298	36,747	39,763	41,766	42,822
Amortisation	4,005	3,840	7,658	7,368	8,634	8,978
Outsourced services	52,965	48,672	50,052	51,016	53,191	57,117
Clinical supplies	127,366	132,451	143,554	146,570	149,646	152,788
Infrastructure & non-clinical expenses	69,897	77,265	61,033	62,856	63,634	64,970
Other district health boards	48,895	50,659	56,661	57,052	57,446	57,843
Non-health board provider expenses	373,285	388,715	392,493	401,751	411,347	421,028
Finance Costs	10,248	9,700	10,700	11,952	11,915	11,210
Capital Charge	16,015	17,881	18,385	18,783	18,847	19,039
TOTAL EXPENSES	1,219,925	1,254,310	1,288,880	1,318,936	1,348,695	1,378,712
Share of profit of Associates and Joint venture		-	-	-	-	-
SURPLUS/(DEFICIT)	3,848	(3,007)	2,229	2,459	2,401	2,367
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	30,681		-	-	-	-
TOTAL COMPREHENSIVE INCOME	34,529	(3,007)	2,229	2,459	2,401	2,367

Waikato DHB plan includes a surplus budget. To achieve a budgeted surplus position an ambitious savings plan is required and so there is risk that if savings are not achieved then we will not achieve our surplus position.

Table: Statement of Prospective Position

Forecast Statement of Financial Position	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
CROWN EQUITY	239,656	234,455	234,491	234,750	234,957	235,130
CURRENT ASSETS:						
Bank balances, deposits and cash	17	16	20	20	20	7,850
Receivables	27,688	38,908	39,183	39,465	39,733	40,010
Inventory	9,064	9,937	10,007	10,077	10,147	10,218
	36,769	48,861	49,210	49,563	49,900	58,079
CURRENT LIABILITIES:						
Short Term Loans	1,533	234	234	121	121	121
Payables and Accruals	102,781	116,313	111,672	110,838	112,307	104,986
Payroll Accruals	70,692	71,894	73,115	74,358	75,622	76,908
	175,006	188,440	185,021	185,317	188,050	182,015
Net Working Capital	(138,237)	(139,579)	(135,811)	(135,754)	(138,150)	(123,936)
NON CURRENT ASSETS:						
Fixed Assets	597,500	594,028	610,443	625,227	626,767	601,664
Investments	6,807	7,184	7,184	7,184	6,597	6,010
	604,307	601,212	617,627	632,411	633,364	607,674
NON CURRENT LIABILITIES:						
Payroll Liabilities	14,058	14,744	14,691	29,274	27,623	25,974
Term Loans	212,355	212,434	232,634	232,634	232,633	222,634
	226,413	227,178	247,325	261,908	260,257	248,608
NET ASSETS	239,656	234,456	234,491	234,750	234,957	235,130

3.1 Fixed Assets

Fixed assets carrying value is reviewed annually and there are no material issues in valuation. We conduct annual desktop revaluations and revalue periodically in accordance with international financial reporting standards. Our last full asset revaluation was on 30 June 2014.

3.1.2 Disposal of Land

We follow the processes as set out in legislation and administered by the Ministry of Health. The process for disposal of land that we follow is:

- Identify that there is no service need for a piece of land either now or for the foreseeable future;
- Seek by resolution from the Board, endorsement of the view that there is no service need for the land and also by resolution obtain approval for the disposal process to be commenced;
- Advertise that the land is to be disposed of and seek public comment on the proposal;
- As a result of submissions received seek either Board confirmation or amendment of the proposal to dispose of the land;
- Obtain Ministerial approval;
- Obtain an up-to-date valuation of the land;
- Invite tangata whenua to consider purchase of the land;
- Dispose of the land on the open market if tangata whenua are not interested.

We cover a significant area and have many parcels of land required by historical patterns of service delivery. All land is assessed on an annual basis against the models of service delivery to apply for the future. If it is concluded that land is not required for the foreseeable

future, then the legislative process for disposal of land is followed with a view to obtaining a maximum price for Waikato DHB.

3.13 Movements in Equity

Table: Statement of Prospective Movements in Equity

Forecast Statement of Movements in Equity	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
Crown equity at start of period	207,321	239,656	234,455	234,491	234,750	234,957
Surplus/(Deficit) for the period	3,848	(3,007)	2,229	2,455	2,401	2,367
Increase in Revaluation Reserve	30,681	-	-	-	-	-
Equity Injection from Crown	-	-	-	-	-	-
Distributions to Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in Equity	-	-	1	(2)	-	-
Crown equity at end of period	239,656	234,455	234,491	234,750	234,957	235,130

Table: Statement of Prospective Cashflow

Forecast Statement of Cashflows	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
OPERATING CASHFLOWS						
Cash was provided from Crown Agencies and other income sources	1,215,097	1,237,529	1,289,564	1,318,112	1,347,789	1,377,741
Cash was disbursed to employees, suppliers and payment of finance charges	(1,154,168)	(1,187,614)	(1,232,537)	(1,258,482)	(1,285,127)	(1,314,432)
	60,929	49,915	57,027	59,630	62,663	63,308
INVESTING CASHFLOWS						
Cash was provided from assets and equity	1,338	1,681	1,200	2,930	2,969	2,990
Cash was disbursed to purchase of assets and investments	(48,013)	(34,044)	(60,820)	(61,915)	(51,353)	(26,110)
	(46,675)	(32,363)	(59,620)	(58,985)	(48,384)	(23,120)
FINANCING CASHFLOWS						
Cash was provided from proceeds of borrowings and equity movements	9,471	(12,937)	7,159	222	(15,859)	(25,155)
Cash was disbursed to repayment of borrowings	-	-	-	-	-	-
	9,471	(12,937)	7,159	222	(15,859)	(25,155)
Net increase/(decrease) in cash held	23,725	4,615	4,567	867	(1,580)	15,033
Add Opening cash balance	(39,492)	(15,767)	(11,152)	(6,585)	(5,718)	(7,298)
CLOSING CASH BALANCE	(15,767)	(11,152)	(6,585)	(5,718)	(7,298)	7,735
Made up from:						
Bank balances, deposits and cash	(15,767)	(11,152)	(6,585)	(5,718)	(7,298)	7,735

Our building programme is complete. For borrowings, we are using a mix of terms of between 5 years and 10 years to manage long term interest rate risk.

Revenue Banking of $58 million (excl. GST) paid to Ministry of Health is received back as revenue and is now fully repatriated.

3.2 Capital Expenditure / Investment

New capital expenditure projects budgeted for the next four years are outlined in the following table.

New Capital Expenditure	2015/16 $M	2016/17 $M	2017/18 $M	2018/19 $M
Under $50,000	2	2	2	2
Over $50,000 (excluding campus reconfiguration)	49	59	49	24
Campus Redevelopment	9	0	0	0
Contingency	1	1	1	1
Total Capital Expenditure	61	62	52	27

We understand that approval of our Annual Plan is not approval of any particular business case. Some business cases will still be subject to approval by the Ministry of Health, National Health Board and Treasury prior to any recommendations being made to the Minister of Health. The Board also requires management to obtain final approval in accordance with delegations of authority prior to purchase or construction commencing.

Strategic capital spend includes:

Project Name	Business Case Start Date	Business Case Completion Date	Business Case Expected Approval Date	Approx. $	Crown Cap Requirement
Education Centre Extension	2014/15	2015/16	2015/16	$25.0m	$0
Clinical Workstation eSpace (Regional Project)	2014/15	2015/16	2015/16	$10.4m	$0
Medicines Reconciliation (Regional Project)	2015/16	2016/17	2016/17	$3.9m	$0
Building A - Adult	2018/19	2019/20	2019/20	$29.1m	$0
Building B & C - Adult	2019/20	2020/21	2020/21	$41.9m	$0

Note 1: The Clinical Workstation is the capital component. In addition it is estimated that there is a further $10 million operating cost associated with change and non-capitalisable costs.

Note 2: Buildings A, B and C are ward blocks. Menzies (our current main ward block) will be demolished when new wards are available for use.

We have the following existing financing facilities:

- Ministry of Health ($211.7 million) of which $211.7 million has been drawn down at end of June 2015. This facility includes:
  - $125 million for Service Campus Redevelopment;
  - $40 million for conversion of equity repayment to debt;
  - $6.7 million for the forensic rebuild. This project is complete and the loan is fully drawn down;
- Private financing of $20.2 million for the car park building is currently available and we are using the national shared banking arrangement to fund. Conversion of this approved loan to crown funding is no longer an option. As this is a necessary cash inflow we have included $20.2m in our plan as an equity injection or a crown loan and will be requesting this funding.

We also use the following facility under the Health Benefits Limited Shared Banking Arrangement in accordance with the Operating Policy Framework to manage our working capital requirements:

- Working capital facilities of no greater than 1/12 of crown revenue paid to the provider.

The business case for the service and campus reconfiguration specified the future financing and equity structure required to support the programme, and our Annual Plan has been prepared on the basis of these planned financing arrangements.

3.3 Other Measures and Standards Necessary to Assess DHB Performance

The key financial indicators are set out in the following table.

Treasury Covenants	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
Equity to Total Assets	34%	37%	36%	35%	35%	37%
Interest covered	4.11	3.80	4.36	4.15	4.43	4.76
Debt to Debt + Equity	52%	49%	50%	50%	50%	48%

There are no plans to repay equity (except for the annual payment of $2 million as per FRS-3 Accounting for Property, Plant and Equipment) in the next three years.

The following tables set out the planned financial performance by division.

Table: Prospective Financial Targets and Measures DHB Provider

DHB Provider Forecast Statement of Financial Performance	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
REVENUE						
Patient care revenue	730,153	741,685	767,771	784,953	801,075	817,331
Other operating income	16,099	16,043	16,365	15,764	16,888	18,066
Finance income	1,338	1,681	1,200	2,930	2,969	2,990
TOTAL REVENUE	747,590	759,409	785,336	803,647	820,932	838,387
EXPENSES						
Personnel costs	481,160	490,167	509,666	519,858	530,259	540,867
Outsourced Services	52,355	48,293	49,799	50,758	52,927	56,848
Clinical Supplies and Patient Costs	139,109	144,615	156,882	161,897	166,108	170,416
Infrastructure & Non-clinical Supplies	121,468	129,280	120,584	124,228	127,685	128,728
Internal Recharges	(2,315)	(2,319)	(2,317)	(2,375)	(2,434)	(2,495)
TOTAL EXPENSES	791,776	810,036	834,614	854,366	874,545	894,364
SURPLUS/(DEFICIT)	(44,187)	(50,627)	(49,278)	(50,719)	(53,613)	(55,977)

Table: Prospective Financial Targets and Measures DHB Governance

DHB Governance Forecast Statement of Financial Performance	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
REVENUE						
Patient care revenue	5,557	5,289	5,292	5,326	5,364	5,401
Other operating income	-	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	5,557	5,289	5,292	5,326	5,364	5,401
EXPENSES						
Personnel costs	1,662	1,662	1,932	1,971	2,010	2,050
Outsourced Services	611	379	253	258	264	269
Clinical Supplies and Patient Costs	-	-	-	-	-	-
Infrastructure & Non-clinical Supplies	1,381	540	611	1,167	649	663
Internal Recharges	2,315	2,319	2,317	2,375	2,434	2,495
TOTAL EXPENSES	5,969	4,900	5,113	5,771	5,357	5,477
SURPLUS/(DEFICIT)	(412)	389	180	(445)	7	(76)

Table: Prospective Financial Targets and Measures DHB Funding

DHB Funding Forecast Statement of Financial Performance	2013/14 $000 ACTUAL	2014/15 $000 FORECAST	2015/16 $000 PLANNED	2016/17 $000 PLANNED	2017/18 $000 PLANNED	2018/19 $000 PLANNED
REVENUE						
Patient care revenue	1,134,211	1,167,669	1,211,200	1,239,491	1,267,145	1,295,027
Other operating income	-	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	1,134,211	1,167,669	1,211,200	1,239,491	1,267,145	1,295,027
EXPENSES						
Governance Administration	5,257	5,289	5,292	5,326	5,364	5,401
Personal Health	835,682	862,306	885,406	909,509	932,867	956,413
Mental Health	115,676	117,488	128,583	129,468	130,362	131,264
Disability Support	123,021	128,547	133,855	134,782	135,711	136,647
Public Health	736	994	1,000	1,007	1,014	1,022
Maori Services	5,393	5,814	5,738	5,780	5,820	5,860
TOTAL EXPENSES	1,085,765	1,120,438	1,159,873	1,185,872	1,211,138	1,236,607
SURPLUS/(DEFICIT)	48,446	47,232	51,327	53,619	56,007	58,420

3.4 Any Significant Assumptions

The following are the key assumptions used in the build-up of next year's budget and the outer years:

Key Assumptions	2015/16	2016/17	2017/18	2018/19
CFA revenue growth assumptions are in line with information provided in the funding envelope and includes cost pressure and demographic growth	2.5%	2.2%	2.2%	2.2%
Employee agreement assumptions	1.9%	2.0%	2.0%	2.0%
Payments to NGO's (cost pressure)	0.61%	0.70%	0.70%	0.70%
Payments to suppliers	2.0%	2.1%	2.2%	2.1%
Interest payments (average)	5.0%	5.0%	5.0%	5.0%
Capital charge	8.0%	8.0%	8.0%	8.0%

Depreciation is charged to the statement of comprehensive income using the straight-line method. Land is not depreciated. Depreciation is set at rates that will write-off the cost or fair value of the assets, less their estimated residual values, over their useful lives.

Risk	Mitigation Strategy
Savings are required in 2015/16 and the outer years. Our saving target includes $43.4 million that we are still working to determine how we deliver these savings.	• Develop realistic savings plans. • Focus on process change to deliver enduring savings. • Use proven methodologies. • Monitor closely and take corrective action quickly. • Be brave and tackle the hard issues.
To achieve the result, the savings plan needs to be achieved. We do not have a good record of achieving savings plans so there will be some challenges.	• Freeze capital. • Cap full time equivalents. • Service reductions where there is low impact on our outcome of improving the health of our population.
The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages. Although a wage increase percentage has been included in the assumptions, some employee representatives may have an expectation of wage increases that differ from the budgeted levels. A one percent increase or decrease in wage rates equates to approximately $4.9 million in additional payroll costs	Potential strategies include: • Negotiate lower than inflation or close to zero per cent increases. • Use sinking lid and other containment mechanisms to constrain full time equivalents.
There is risk that cost increases for the provider arm purchasing of goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures. A one per cent increase or decrease in the cost of provider arm goods and services equates to approximately $2.3 million in additional expenditure.	• Review contracting arrangements and negotiate more favourable terms. • Participate in national procurement initiatives to take advantage of bulk purchasing.
There is financial risk in terms of the inherent uncertainty as to the total amount of funding that will be appropriated to health beyond the current year and how this funding will be allocated by the Population Based Funding (PBF) formula. In addition, PBF is a fixed annual funding allocation in an environment where the District Health Board funds demand driven contracts that have the risk of the demand exceeding the forecast levels.	

3.6 Any Additional Information and Explanations to Fairly Reflect the Operations and Position of the DHB

The accounting policies used in the preparation of the financial statements can be found in appendix 8.6. There have been no significant changes in the accounting policies.

3.7 Subsidiaries

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

MODULE FOUR: STEWARDSHIP

In delivering on our functions as a DHB and participating in the health sector, we have a broad set of responsibilities and interact with a diverse range of individuals and groups. To be as effective as possible, we must have capable leadership, an engaged workforce, a healthy organisational culture, sound relationships, robust and rigorous systems and the right infrastructure and assets.

This module describes how we intend to perform our functions and conduct our operations to achieve the outputs and impacts[18] we seek to deliver. It provides further detail on the resources / inputs portion of our performance story[19].

4.1 MANAGING OUR BUSINESS

The environment we are operating in is changing, and there are a number of implications which will affect DHBs. The levels of our success over the next few years will depend on our ability to adapt to the changing environment as we continue to improve the health of the Waikato DHB population and reduce or eliminate health inequalities.

4.1.1 Our people

The central part of our capability is our people. Providing health and disability services now and into the future depends on our having a workforce that is well matched to the health needs of the community, and appropriately skilled and located. We will look to create an environment to unleash innovation by staff empowerment.

Key points of note about our workforce (as at 31 March 2015) are:

- We employed 6560 staff (5481 full time equivalents);
- 78 percent of staff were female;
- There continue to be 53 different ethnicities employed, working together to provide health services;
- Māori make up 9 percent of the workforce;
- NZ non-Māori make up the single largest ethnic group of employees (53 percent).

The following table highlights the various areas of occupation

[18] See module 1.1.2 (service performance)
[19] See module 1.1.2

Table: Waikato DHB Workforce Demographics as at 31/03/2015

Numbers / Distribution		Staff Type					
Measure	**Category**	**Medical**	**Nursing**	**Allied / technical**	**Support**	**Mgmt / Admin**	**Total**
Gender Count	Female	280	2679	926	206	991	5082
	Male	470	363	197	197	197	1478
Gender Distribution	Female	37%	88%	79%	51%	83%	77%
	Male	63%	12%	21%	49%	17%	23%
Ethnicity Count	Māori	15	272	125	74	129	615
	Non-Māori	735	2770	1052	329	1059	5,945
Ethnicity Distribution	Māori	2%	9%	11%	18%	11%	9%
	Non-Māori	98%	91%	89%	82%	89%	91%
Staff Type Count	Waikato DHB	750	3042	1177	403	1188	6560
Staff Type Distribution	Waikato DHB	11%	46%	4%	6%	18%	

4.1.2 Organisational Performance Management

Our performance is assessed on both non-financial and financial measures. The table in section 4.5.2 of this module provides an overview of the external reporting. Our overall planned performance as a funder and provider of health services for 2015/16 is outlined in this plan and will be reported to our senior management, Board and the Ministry of Health on a regular basis.

4.1.2.1 Non-financial performance reporting

Non-financial performance, which relates to volume and performance expectations for health service provision (by Health Waikato, primary health organisations and the non-government organisations we fund), is monitored regularly. It is one of the tools we use to identify issues and inform decision-making to improve our performance.

As a funder we monitor the agreements we have with providers through effective portfolio management which includes regular performance reports and data analysis. We also monitor the quality of services provided through reporting of adverse incidents, routine audits, service reviews and issues-based audits.

We report quarterly to the Ministry of Health on the required measures in the DHB Non-Financial Monitoring Framework and regularly feed into benchmarking and quality programmes to compare our performance with other providers. We support the national expectation that the public should be informed about health system performance by publishing our performance against the national health targets.

We report to our Board through our regular narrative reporting process on performance against our Annual Plan. These reports are provided and discussed in Board Meetings and are available to the public as part of the relevant Board agenda.

4.1.2.2 Financial performance reporting

As part of our annual planning process we submit a set of financial templates to the Ministry of Health. The templates inform the tables and narrative presented in module four. We report monthly to the Ministry of Health against the financial templates. We report on our financial performance monthly to our Board. This report includes commentary and financials as well as actions planned to improve financial performance.

As part of our financial reporting we include full time equivalent (FTE) reporting. This covers areas like:

- Accrued FTE
- Management / Administration FTE Cap
- Clinical FTE
- Out Sourced Services FTE

The information on our financial performance is one of the tools used by the organisation to identify issues and inform decision-making to improve our performance.

4.1.3 Funding and Financial Management

The following table sets out our key financial indicators:

Summary	2013/14 $M ACTUAL	2014/15 $M FORECAST	2015/16 $M PLANNED	2016/17 $M PLANNED	2017/18 $M PLANNED	2018/19 $M PLANNED
Revenue	1,224	1,251	1,291	1,321	1,351	1,381
Net Surplus/(Deficit)	4	(3)	2	2	2	2
Total Fixed Assets	604	601	618	632	633	608
Net Assets	245	239	240	240	242	245
Term Borrowings and Liabilities	226	227	247	262	260	249

Summary	2013/14 $M ACTUAL	2014/15 $M FORECAST	2015/16 $M PLANNED	2016/17 $M PLANNED	2017/18 $M PLANNED	2018/19 $M PLANNED
Net Surplus/(Deficit)	4	(3)	2	2	2	2

4.1.4 National Health Sector Agencies

We are expected to align our planning with the planning intentions key national agencies. Each of these national agencies has initiatives for the 2015/16 year, which will impact on our DHB. The national agencies are:

- Health Shared Services
- National Health Promotion Agency
- Health Quality and Safety Commission
- Health Workforce New Zealand

- National Health Information Technology Board
- National Health Committee
- PHARMAC

The actions we plan to undertake are set out in module two.

4.1.5 Risk Management

We run a top-down and bottom-up approach to risk management that aligns with the NZ Standard. Risk Plans are prepared at the service level, coordinated through the Quality and Risk Department and then used as the basis for the Board's overarching Risk Plan which is signed off by the Audit and Risk Management Committee of the Board. Risks identified by the services tend to be more operational and those identified by the Board more environmental. The Risk Plan is used to drive the Internal Audit Plan, the Quality Plan and service improvement initiatives including the replacement of capital equipment and patient safety projects. Where appropriate, risks identified by the Board will be disseminated to the services for inclusion in relevant plans.

4.1.6 Performance and Management of Assets

We have developed a formal asset management plan in accordance with Ministry of Health requirements. Our asset management plan is informed by our long term financial model. Our long term financial model covers a 20 year period and provides a high level view on capital affordability of 'big ticket items'.

For the items identified as 'non big ticket', there is a rolling three year process. As part of this process a comprehensive annual prioritisation exercise is undertaken, which includes a quarterly review to identify any potential need for re-prioritisation.

4.1.7 Shared Decision-making

4.1.7.1 Clinical governance

As we move forward and respond to the challenges, pressures and opportunities we face, strong clinical engagement and leadership is required. This happens on many levels across our organisation. We have an established Board of Clinical Governance which has the identified purposes of:

- supporting the Chief Executive in ensuring high standards of clinical quality by monitoring relevant systems, standards, indicators of performance and plans and, where necessary, require the Health Waikato Executive to remedy / improve organisational performance in respect of those matters
- clinical governance is the framework through which Waikato DHB is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. More specifically, it involves:

- an emphasis on quality (including the use of the various techniques available to advance clinical quality), and patient-centred care.
- partnership, extending to joint decision-making, between the various clinical professions and managers comprising our workforce and between the executive and clinical staff generally, but without compromising individual accountability.
- the organisation at all levels having the information it needs (including that relating to quality) to make sound decisions

4.1.7.2 Māori participation

We have a governance relationship, through a memorandum of understanding, with local Iwi/Māori represented by Iwi Māori Council. Iwi Māori Council has representatives from:

- Pare Hauraki
- Ngāti Maniapoto
- Ngāti Tuwharetoa
- Te Runanga O Kirikiriroa (representing urban Māori)
- Pare Waikato
- Raukawa
- Whanganui Iwi

The memorandum of understanding underpins a "good faith" relationship between the parties by recognising the legitimacy of the Iwi and Te Runanga O Kirikiriroa to represent the interests of Māori, as well as the legitimacy of the Board as the statutory body charged with the determination, prioritisation and funding of health and disability services.

We have a number of established mechanisms to enable Māori to participate in and contribute to strategies for Māori health gain. These include:

- Ministerial appointments to the Waikato DHB Board
- Iwi Māori Council
- Kaumātua Kaunihera
- Te Puna Oranga (Māori Health Service)

4.1.7.3 Primary Health Alliance Leadership Teams

Alliance Leadership Teams (ALTs) have been established across the Midland region with our primary care partners; the Midlands Health Network, the National Hauora Coalition and Hauraki PHO. The ALTs are populated by clinical leaders and managers from across primary and secondary care.

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

4.1.7.4 Community Input

We regularly engage with a number of advisory groups, working groups, consumer groups and community health forums. Their advice and input assists in the development of DHB strategies and plans.

Community Health Forums are made up of local people representing specific geographical regions. They support and advise us about local health issues, activities and priorities for their community. They are also mechanisms for ensuring communities are kept involved in and informed of DHB activities and issues. A review the Community Health Forums commenced in late 2014/15 with a focus on building and strengthening community input. We expect the review to be completed in 2015/16 and recommendations for improvement to be identified.

4.2 Building Capability

This section outlines the capabilities we will need in the next three to five years as well as touching on the approach in the short term to work towards developing these.

4.2.1 HealthShare Limited

HealthShare Limited, established in 2001, is a regional Shared Services Agency jointly owned by Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato District Health Boards. From August 2011 HealthShare Limited has taken on an expanded role as a regional provider of non-clinical service and now provides operational support in a number of areas identified as benefiting from a regional solution.

The Midland region DHBs determine the services that HealthShare Limited will provide, and the level of these services, on an annual basis. These determinations are made through the Regional Services Plan and regional business case processes. Categories of possible regional service delivery include:

- Activities that support future regional direction and change through the development of regional plans
- Facilitating the development of clinical service initiatives undertaken by regional clinical networks and regional action groups that support clinical service change
- Key functions that support and enable change through the ongoing development of the region's workforce and information systems
- Back office service provision that can drive efficiencies at a regional level, alongside new national back office shared services.

The annually agreed regional services form the basis for HealthShare Limited's Business Plan which specifies the company's performance framework; the services to be provided; and the associated performance measures. The Business Plan also details, at a service level, the activities that have been purchased by the shareholding DHBs.

4.2.2 Information Communications Technology

The Midland Regional IS service will implement the Midland Region Information Services Plan and advance National Health IT Board priorities, specifically the implementation of the National Health IT Plan priority areas. Work in this area is done within the context of the affordability envelope of the Midland DHBs.

The process of prioritising the Information Communications Technology work effort is done via the IS executive group with is comprised of clinical leaders and business leaders from each of the Midland DHBs. This group reviews the programmes of work and provides recommendations to the regional capital committee for funding decisions.

Further information is available in the Midland DHBs Regional Service Plan for 2015/16.

4.2.3 Integrated Contracting

We have been participating in the Whānau ora integrated agreements developments across the health and social services sectors. This process is being led by the Ministry of Social Development) who has nominated the providers. This involves bringing together services across agencies (for example Ministry of Social Development, Ministry of Justice, Waikato DHB) to work with a defined population to ensure increased cohesion of service delivery.

We will look to take up integration opportunities as appropriate. When making decisions on integration, considerations we will take into account are:

- consistent population coverage
- position in the continuum of health services
- history of service / contract delivery
- integrating agreements will not result in service gaps

4.2.4 Capital and Infrastructure Development

Capital expenditure is planned and prioritised at both a Midland regional and local level. DHBs capital intentions, which span 10 years, are consolidated to form a regional view. Large clinical investments are collaborated with the aim of achieving best fit for the region.

The Midland region capital committee meets regularly to consider and approve business cases requiring regional sign-off. Business cases are prepared and approved at a local Board level before submission to the regional capital committee for approval.

At a local level, our long term financial model covers a 20 year period and provides a high level view on capital affordability of ‘big ticket items’. For the items identified as ‘non big ticket’, there is a rolling three year process. As part of this process a comprehensive annual

prioritisation exercise is undertaken, which includes a quarterly review to identify any potential need for re-prioritisation.

During 2012/13 an exercise was undertaken to assess the seismic status of the Waikato DHB building stock. The work undertaken was similar to what hundreds of organisations have done since the 2011 Christchurch earthquake. An independent seismic evaluation of all Waikato DHB buildings, following revised national building standards, has resulted in a number of pieces of work. They include:

- Boiler House upgrade project;
- Laundry seismic upgrade;
- Hilda Ross House building demolition;
- Thames Campus – front entry and front ex ward (theatre) building had an IL3 20-30 percent DBS rating. Full design documentation has been completed. Works will be tendered which are to strengthen the shear walls. When completed the building seismic rating will be lifted to IL3 35-40 percent DBS;
- Tokoroa Campus – wards 1 and 2 had an IL3 20 percent rating. Works to the building's footings will lift the seismic rating to IL3 70 percent DBS;
- Taumarunui Campus – dining room had a rating of IL3 5 percent. Works to the building's roof structure, pile foundations and replacing the heavy tiled roof will lift the seismic rating to IL2 70 percent.

4.2.5 Collaboration

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

4.2.5.1 Regional Collaboration

In addition to the work happening regionally around our Regional Service Plan development and implementation, there is work occurring in other areas. An example of such an area is Public Health. There are four Public Health Units in the Midland Region:

- Toi Te Ora Public Health Service servicing the Bay of Plenty and Lakes DHBs
- Te Puna Waiora, Tairawhiti District Health
- Public Health Unit, Taranaki DHB
- Population Health, Waikato DHB

Midland DHBs public health units are working together to develop and enhance the planning and delivery of public health services. In 2015/16 public health units in the Midland Region will maintain and continue developing regional linkages and contacts, share information, contribute to the National Public Health Clinical Network and collaborate on several projects across the region. The regional network will also contribute public health input to the regional plans of other clinical services.

4.2.5.2 Local Collaboration

We work with other agencies (for example Ministry of Education, Ministry of Justice, Ministry of Social Development, Police, Tertiary Education Commission, Housing NZ as well as other central government agencies and local government) to improve the determinants of health.

Examples of intersectoral collaboration include:

- Youth Social Sector Trials
- Whānau Ora Integrated Contracts
- Project Energize
- Waikato Spatial Plan
- Accident Compensation Corporation and DHB relationship
- Healthy Homes initiatives

4.2.6 Long Term Demand Forecasting

We are experiencing an increasing mismatch of health service demand, supply and affordability. Increases in service delivery in one area can mean that less resource will available in another other areas. The health sector cannot continue to operate in the same way as it has been if we expect to be clinically and financially sustainable into the future.

Long term demand forecasting is one of the tools we must use to inform decisions around reforming health sector configurations and related models of care if we are to move forward with a sustainable, affordable and fit for purpose health sector. These reforms have already begun in the shape of:

- Programmes like the better, sooner, more convenient health care initiatives
- Expectations for closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals
- Regional service planning.

We will continue to participate in demand forecasting work as well as exploring the use of modelling and simulation techniques to assist in shaping services. These techniques can improve both efficiency and quality of services through a range of applications including:

- Waiting time reduction
- Scheduling
- Bed capacity management
- Workforce planning
- Commissioning

4.3 Workforce

The health and disability sector continues to face increased demand for services along with rising public expectations as to how services are delivered. There is also a strong requirement for simpler, more standardised ways of doing things to release resources for better use elsewhere and build a platform to develop a workforce with more generic skills that is flexible and able to work in integrated service models across hospital and community settings. We will continue to work with the Regional Director of Training and support the regional approach.

4.3.1 Managing Our Workforce within Fiscal Restraints

Waikato DHB has been undertaking activities to build our workforce capability and capacity since 2008. The issues now as then are similar:

- we still have an ageing workforce - our average age is 47 and it is higher in our rural and small town workforces
- it is still not easy to attract health professionals to rural and semi-rural locations
- if nothing changes, the demand for services will exceed the workforce's capacity.

To continue to answer the above issues in 2015/16 we think we need to focus on the following:

- Reliable workforce data;
- Recruitment to hard to fill areas;
- Pathway to health careers;
- Care assistant training;
- Leadership competencies;
- First line manager skills;
- Nurse prescribing;
- Dedicated education units;
- Vulnerable children;
- Nursing skill mix;
- Nurse Practitioners.

4.3.2 Strengthening Our Workforce

Much of the service based workforce development is covered in the Regional Services Plan. The Waikato DHBs workforce plan includes only those things which are specific to the organisation which aren't already covered in the Regional Services Plan. Much of the 2014/15 work needs to continue until it is completed and some has transferred to business as usual.

4.3.3 Safe and Competent Workforce

Waikato DHB continues to have a strong focus on safety and competence for our workforce. Waikato DHB continues to support the regional approach, utilising the Regional Director of Training, to address workforce requirements.

4.3.4 Child Protection Policies

The Vulnerable Children Act 2014 sets priorities for improving the wellbeing of vulnerable children and ensuring children's agencies work together to improve the wellbeing of vulnerable children. Key is the requirement of agencies working with children to adopt, report on and require child protection policies.

Waikato DHB has adopted a robust child protection policy, ensured every contract and funding arrangement requires all services working in whole or part delivering services to children adopt a child protection policy, will review the policy three yearly and report through the DHB Annual Report.

4.3.5 Children's Worker Safety Checking

Waikato DHB will meet the safety checking requirements of the Vulnerable Children's' legislation within prescribed legislative and / or regulatory timeframes (1 July 2015).

Waikato DHB already police vets staff. This process is well established. There is also a process to identify all staff within the provider division who are within the 'core children's workforce' under the Vulnerable Children's Act. These staff will then undergo additional safety vetting and screening processes as they are recruited, and in time retrospectively for those staff members already employed.

Because of its centralised and standardised recruitment process Waikato DHB is able to institute a series of worker safety interview questions once these have been identified nationally. These questions would be asked during interviews and during reference checking.

4.4 Organisational Health

We need to make sure that we have the people, relationships, and processes that will enable us to achieve our outcomes, impacts, and outputs. We cannot be successful without well-qualified and motivated staff, sound management of resources and an effective working relationship between staff and stakeholders.

4.4.1 Governance

We have an established governance structure based on the requirements of the NZPHD Act 2000, through which the DHB functions. Governance plays a key role in determining what we need to do to maximise the impact on our outcomes.

Our Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population. The Board ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and our community. The normal composition of the board is 11 members, seven elected and four appointed by the Minister of Health. As required, the Board has two Māori members.

Three statutory (mandatory) advisory committees and three non-statutory committees have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. It includes both clinical and Māori members who contribute clinical and cultural experience and understanding to decision making.

The Board has not approved delegations to committees. All matters are recommended to the Board through the minutes of the relevant committee.

The public is welcome to attend meetings of the Board and its three statutory committees. However, for some items during a meeting the Board or committee may exclude the public. The Official Information Act states the grounds on which the public may be excluded. Such items are clearly noted on the agenda in question. Details of the meetings are publicly available on our website: http://www.waikatodhb.health.nz/board.

While responsibility for our DHB's overall performance rests with the Board, operational and management matters have been delegated to the chief executive. This delegation is made on such terms and conditions as the Board thinks fit. The chief executive is supported by his direct reports.

4.4.2 Providing health and disability services

We are responsible for the delivery of the majority of secondary and tertiary clinical services for the population of our district as the 'owner' of hospital and other specialist health services. The services are provided through Health Waikato (our provider division), across five hospital sites, two continuing care facilities, a mental health inpatient facility and 20 community bases. Our hospitals provide a range of inpatient and outpatient services and are located across the district:

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

Health Waikato is incurring some operational costs related to our major building programme. These relate to change management, decanting and demolition and we will continue to incur these costs as well as the increased interest, depreciation and capital cost associated with capital spend over the time frame of this plan. Once our redevelopment is complete we will exit the costs associated with the redevelopment. In addition we have an improvement programme to "right-size" the provider and bring them close to break even on national prices.

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

For further information about Health Waikato, including an overview of performance please see http://www.waikatodhb.health.nz/health_waikato .

4.4.3 Planning and Funding Health and Disability Services

The Planning and Funding Division of our DHB is responsible for planning and funding health and disability services across our district. The core responsibilities are:

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

While the Planning and Funding Division contracts services from Health Waikato they also contract services from a wide range of non-government organisation providers, as well as other DHBs who often provide more specialist services.

Planning and Funding is responsible for oversight of the total funding package for our DHB and linking on this with the Ministry of Health. Planning and Funding role incorporates ensuring equitable acceptable and effective spending of health funds and ensuring that all services funded are delivered in line with expectations. It acts for the DHB in local and

national technical and strategic forums working on the development of funding and pricing as well as service and purchasing frameworks.

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

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

4.5 Reporting And Consultation

4.5.1 Consultation with the Minister and the Ministry of Health

When making decisions, we follow an appropriate planning and consultation processes to avoid adverse financial, resource and clinical impacts on the affected population(s) and avoid unnecessary service instability. A well-managed process provides the confidence that:

- A robust process is followed;
- There are sufficient controls in place to avoid unnecessary service instability;
- The change is clinically appropriate and public confidence is managed.

There are a range of matters that we must consult / notify the Minister of Health, the National Health Board and Ministry of Health. These matters are:

- Proposed service changes;
- Acquisition of shares or other interests;
- Entry into joint ventures and / or collaborative or cooperative agreements / arrangements;
- Capital expenditure if required by policy and / or legislation;
- Otherwise as required by legislation, regulation or contract.

4.5.2 External Reporting

The Ministry of Health monitors our performance on behalf of the Minister. The mechanisms currently in place to achieve this are outlined in the following table.

Table: External Reporting Framework

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collections	Monthly
Risk reporting	Quarterly
Health target reporting	Quarterly
Crown funding agreement non-financial reporting	Quarterly
DHB Non-financial monitoring framework	Quarterly
Annual Report and audited accounts	Annual

MODULE FIVE: APPENDICES

- Glossary of Terms
- Output Class Definitions
- Output Class Revenue and Expenditure
- Output Measure Rationale
- Services funded but not provided by the DHB
- Accounting Policies

5.1 Glossary of Terms

Term	Description
Alliance Leadership Teams	The purpose of the Alliance Leadership Teams is to lead and guide our Alliances (with our primary care partners – Midlands Health Network, the National Hauora Coalition and Hauraki PHO) as they improve health outcomes for our population.
Catalyst Programme	This is a structured programme using lean methodologies to reduce cost through reducing waste and minimising variation. The approach is to use in-depth reviews which will include process review and benchmarking to identify opportunities and enable evidence based decision making for changes.
Crown Entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
HealthShare	A regional shared services agency jointly owned by Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato DHBs.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989).
Impact measures	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls.
Initiatives / activities and actions	What we do with our inputs to create outputs, impacts and other deliverables.
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs that will achieve the stated outcomes.
Intervention	An initiative, action or activity intended to enhance outcomes or otherwise benefit an agency or group.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes.
Map of	Is an electronic platform providing evidence-based clinical pathways to the health

Term	Description
Medicine	workforce which connect all the knowledge and services around a clinical condition.
Measure / indicator	A measure identifies the focus for measurement: it specifies what is to be measured.
NCHIP	National Child Health Information Programme – records and monitors children's health milestones from birth to 18 years
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve "outputs". E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance…etc. are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/) A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
Output classes	Are an aggregation of outputs. (Public Finance Act 1989). Outputs can be grouped if they are of a similar nature.
Outputs	Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Ownership	The Crown's core interests as 'owner' can be thought of as: Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown; Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future; Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (Refer http://www.ssc.govt.nz/glossary/).
Primary Health Organisation	Primary health organisations are funded by DHBs to support the provision of essential primary health care services through general practices to those people who are enrolled with the primary health organisations.
Priorities	Statements of medium term policy priorities.
Project Aroha	"Brand name" for a number of initiatives being run out through Te Puna Oranga (Māori Health Service) which focuses on smoke free whānau, breast feeding, immunisation, violence free and reducing Māori sudden unexplained death in infants rates
Project Energize	Project Energize is a project for Waikato primary schools to focus on children's physical activity and nutrition, to improve their overall health.
Regional collaboration	Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Our region is: Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti District Health, Taranaki DHB, Waikato DHB, Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network includes Taranaki DHB in addition to the Central Region DHBs.
Statement of Performance Expectations	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)

Term	Description
Strategy	See Ownership. (http://www.ssc.govt.nz/glossary/)
Sub regional collaboration	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalized with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (centralAlliance) and Canterbury and West Coast DHBs.
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.

5.2 Output Class Definitions

Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services;
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services;
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Rehabilitation and Support

Rehabilitation and support services are delivered following a ‘needs assessment’ process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.

On a continuum of care these services provide support for individuals.

5.3 Output Class Revenue and Expenditure

Total Cost and Revenue	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	1,291,109	1,321,395	1,351,096	1,381,079
Costs	1,288,882	1,318,940	1,348,695	1,378,711
Surplus / (deficit)	2,227	2,455	2,401	2,368

Prevention

Forecast Statement of Cost and Revenue for Prevention	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	29,289	29,976	30,650	31,330
Costs	23,253	23,795	24,332	24,873
Surplus / (deficit)	6,036	6,181	6,318	6,457

Early Detection and Management

Forecast Statement of Cost and Revenue for Early Detection and Management	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	248,290	254,114	259,826	265,592
Costs	232,419	237,840	243,205	248,618
Surplus / (deficit)	15,870	16,274	16,620	16,974

Intensive Assessment and Treatment

Forecast Statement of Cost and Revenue for Intensive Assessment and Treatment	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	875,408	895,943	916,081	936,410
Costs	899,735	920,718	941,489	962,443
Surplus / (deficit)	(24,327)	(24,775)	(25,408)	(26,032)

Rehabilitation and Support

Forecast Statement of Cost and Revenue for Rehabilitation and Support	**2015/16** **$000** **Budget**	**2016/17** **$000** **Budget**	**2017/18** **$000** **Budget**	**2018/19** **$000** **Budget**
Revenue	138,122	141,362	144,539	147,747
Costs	133,474	136,587	139,668	142,777
Surplus / (deficit)	4,648	4,775	4,871	4,970

The output class financial reporting for 2015/16 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code (purchase unit code mapping to output class as per data dictionary version 20). The out years are based on the same cost and revenue ratios being applied to total cost and revenue.

5.4 Output Measure Rationale

Measure	Rationale	Output class / Category	Dimension of Performance
Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services / Health Promotion and Education	Quantity
Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services / Health Promotion and Education	Quantity
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	Pregnancy is a period during which women are motivated to quit smoking, and evidence-based tobacco cessation programmes can significantly increase the likelihood of this. Reducing smoking in pregnancy would be well supported by New Zealanders, is easy to understand and leads to significant positive outcomes across the whole of life span	Prevention Services / Health Promotion and Education	Quantity
Percentage of eight month olds fully immunised	Immunisation can protect against harmful infections, which can cause serious complications, including death. It is one of the most effective, and cost-effective medical interventions to prevent disease	Prevention Services / Immunisation / Well Child	Quantity / Timeliness
Percentage of two year olds fully immunised			
Percentage of girls receiving the HPV dose three			
Seasonal influenza immunisation rates in the eligible population (65 years and over)		Prevention Services / Immunisation	Quantity
Percentage of infants exclusive or fully breast feed at lead maternity carer discharge and three months	Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden.	Prevention Services / Health Promotion and Education	Quantity / Timeliness
Percentage of infants receiving breast milk at six months			
The number of people participating in Green Prescription programmes	Research published in the New Zealand Medical Green Prescription is an inexpensive way of increasing activity. Research published in the British Medical Journal found that a Green Prescription can improve a patient's quality of life over 12 months, with no evidence of adverse effects. Research published in the British Medical Journal on the cost-effectiveness of physical activity in primary care stated that 'community walking, exercise and nutrition, and brief advice with exercise on prescription (Green Prescription) were the most cost-effective with respect to cost-utility.'	Early Detection and Management Services / Primary Healthcare	Quantity
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	Through Project Energize we can positively influence health behaviours in childhood, adolescence and adulthood. This can reduce the risk of many chronic conditions like cardiovascular disease and diabetes.	Prevention Services / Health Promotion and Education	Quantity
Percentage of total primary schools participating in Project Energize			
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services	Research shows that improving oral health in childhood and adolescence has benefits over a lifetime.	Early Detection and Management Services / Oral Health	Quantity
Percentage of pre-school and primary school children (0 – 12 years) who are overdue for their planned recall period			
Percentage of adolescents accessing DHB funded oral health services			
Percentage of people who are enrolled with a primary health	By increasing the percentage of people being checked for long-term conditions ensures these are identified	Early Detection and	Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
organisation and have had their cardiovascular risk assessed in the last five years	early and managed appropriately, and aid in the promotion and protection of good health and independence.	Management Services / Primary Healthcare	
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Cervical cancer is one of the most preventable of all cancers. Having regular cervical smears can reduce a woman's risk of developing cervical cancer by 90 percent	Prevention Services / Population Based Screening	Quantity
Percentage of eligible women (50-69) have a breast screen in the last 3 years	Breast screening is a proven way for finding breast cancers early to reduce the risk of dying of breast cancer	Prevention Services / Population Based Screening	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from their GP	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services / Health Promotion and Education	Quantity
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services / Well Child	Quantity
Acute rheumatic fever initial hospitalisation rate and number	Rheumatic fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.	Prevention Services / Well Child	Quantity
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services / Needs Assessment and Service Coordination	Quantity
Percentage of population enrolled with a primary health organisation	Advantages of enrolling are that your visits to the Doctor will be cheaper and you will have direct access to a range of services linked to the PHO.	Early Detection and Management Services / Primary Healthcare	Quantity
Needs assessment and service co-ordination waiting times for new assessments within 20 working days	Monitor the responsiveness and timeliness to NASC to service demand	Rehabilitation and Support Services / Age Related Residential Care Services	Quantity / Timeliness
Acute re-admission rate	Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity. An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability	Intensive Assessment and Treatment Services / Acute Services	Quality

Measure	Rationale	Output class / Category	Dimension of Performance
	services.		
Percentage of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	Specialist cancer treatment and symptom control is essential in reducing the impact of cancer	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quantity / Timeliness
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks			Quantity
Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of a subsequent Caesarean section and reduce the number of women who experience difficulties with their second and subsequent births as a consequence of a primary Caesarean section.	Intensive Assessment and Treatment Services / Elective Services	Quantity
Percentage of patients waiting longer than four months for their first specialist assessment	Patients have a much better chance of recovering and getting on with their lives where they are diagnosed and treated and returned home in a timely way.	Intensive Assessment and Treatment Services / Elective Services	Quantity / Timeliness
Improved access to elective surgery, health target, agreed discharge volumes	Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery should will improve access and reduce waiting times.	Intensive Assessment and Treatment Services / Elective Services	Quantity
Did-not-attend percentage for outpatient services	Reducing did not attends is a key objective in terms of removing waste in the system	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quantity
Inpatient Average Length of Stay (elective and acute)	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services / Elective Services and Acute Services	Quality
Percentage of young people aged 0 - 19 referred for non-urgent mental health services are seen within three weeks or eight weeks	Access and shorter waits are very important to patients. Earlier treatment in the progression of illness links to better outcomes as evidenced in international literature. Timeliness is also a key quality indicator in calls for improvement to the health care system.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Timeliness / Quality
Percentage of child and youth with a transition (discharge) plan	Maintaining and improving patient engagement through the use of transition/discharge plans will ensure that services are patient-centred and responsive, supporting patients' trust and confidence in services and the health and disability system. People that are better able to better manage their own health condition represent value for money because of the proven reduction in the demand for mental health services.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Quantity / Timeliness

Measure	Rationale	Output class / Category	Dimension of Performance
Rates of post-discharge community care	A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Service users leaving hospital after an admission with a formal discharge plan involving linkages with community services and supports are less likely to need early readmission. Research indicates that service users have increased vulnerability immediately following discharge, including higher risk for suicide.	Intensive Assessment and Treatment Services / Specialist Mental Health and Addiction Services	Quality
Number of first attendances at the Waikato DHB hospital palliative care outpatient service	It is important that people who have life threatening illness, along with their family and whanau, receive appropriate care and support to cope with their situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering.	Rehabilitation and Support Services / Palliative Care Services	Quantity
Improved wait times for diagnostic services	Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management.	Intensive Assessment and Treatment Services / Elective Services	Quantity / Timeliness
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	Timely turnaround of tests support clinical diagnosis and enable early intervention and treatment.	Early Detection and Management Services / Community Testing and Diagnosis	Quantity
Total number of pharmaceutical items dispensed in the community	Pharmaceuticals are an important resource in improving health outcomes.	Early Detection and Management Services / Pharmacy Services	Quantity

5.5 Services Funded but not provided by the DHB

Table: DHB funded services provided by other organisations

Personal Health Services	
Pharmaceuticals	• Subsidised pharmaceuticals dispensed by 80 pharmacies across our district.
Community Laboratories	• One private laboratory located in Hamilton undertaking all the testing, 38 collection sites (12 in Hamilton two in Huntly and two in Cambridge and one in every other town).
PHOs and GP services	• Three PHOs with approximately 80 general practices.
Medical / surgical inpatient and outpatient services and primary care inpatient services	• Included within this service area are arrangements with a private provider called USL for urology services, as well as with hospitals outside our district, and a number of smaller outpatient based agreements and primary care inpatient beds in six rural facilities.
Māori health	• Includes a range of community based services including whānau ora, healthy hapu, koroua and kuia services, and mobile Māori disease state management positions delivered by Māori providers.
Other personal health	• Range of services biggest spends are in the areas of: • dental • NGO maternity facilities • Project Energize • travel and accommodation • palliative care • haemophilia • primary care inpatient services • arthritis services.
Mental Health and Addiction Services	
Inpatient and residential service	• Includes 15 forensic inpatient beds purchased from Hauora Waikato and residential services funded on a fee for services basis.
Community and other service	• Included in this category are approximately 300 full time equivalent community based (mental health and/or alcohol and other drug) positions, together with residential services for mental health and addictions (including youth) funded on a capacity basis.
Health Of Older People Services	
Residential	• Included in this category is expenditure on hospital level, dementia and rest home services provided at 57 facilities ranging in size.
Other Services	• Included within this category are a range of community based and respite services including transitional care, day programmes, needs assessment and service co-ordination, home support and household management, respite and carer support services; as well as disability specific services such as orthotic services, disability information and rural stroke field worker services.

5.6 Notes to the Financial Statements

5.6.1 Significant accounting policies

Reporting entity

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

Waikato DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

The group financial statements of Waikato DHB for the year ended 30 June 2013 include a controlled subsidiary, Waikato Health Trust, Waikato DHB's interest in an associate (Urology Services Limited) and Waikato DHB's interest in a jointly controlled entity (HealthShare Limited). Waikato DHB's interest in its associate and joint venture are equity accounted. These companies are incorporated and domiciled in New Zealand.

Waikato DHB's activities are the purchasing and the delivering of health, disability services, and mental health services to the community within its district. Waikato DHB is a Public Benefit Entity, as defined under New Zealand International Accounting Standard (NZIAS) 1.

Statement of compliance

The financial statements have been prepared in accordance with the New Zealand Public Health and Disability Act 2000, the Crown Entities Act 2004, and Generally Accepted Accounting Practice in New Zealand (NZGAAP).

These financial statements have been prepared in accordance with, and comply with, the May 2013 iteration of the Tier 1 PBE accounting standards.

Basis of preparation

The financial statements have been presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, buildings, and forward foreign exchange contracts at fair value.

Non-current assets held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The preparation of financial statements under NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets, liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management under NZIFRS that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 30.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Associates

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

The financial statements include Waikato DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence begins until the date that significant influence ceases. When Waikato DHB's share of losses exceeds its interest in an associate, Waikato DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Waikato DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Joint ventures

Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement. The financial statements include Waikato DHB's interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases.

Transactions eliminated on consolidation

Unrealised gains arising from transactions with associates and joint ventures are eliminated to the extent of Waikato DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive income.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at the foreign exchange rate ruling at the date the fair value was determined.

Budget figures

The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable financial reporting standards as appropriate for Public Benefit Entities. Those standards are consistent with the accounting policies adopted by Waikato DHB for the preparation of these financial statements.

Financial instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest-bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments not at fair value through the statement of comprehensive income are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A non-derivative financial instrument is recognised if the Waikato DHB becomes a party to the contractual provisions of the instrument, and derecognised if the Waikato DHB's contractual rights to the cash flows from the financial assets expire or transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Purchases and sales of financial assets are accounted for at trade date, i.e. the date that the Waikato DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the Waikato DHB's obligations specified in the contract expire or are discharged or cancelled.

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts repayable on demand are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Accounting for finance income and expense is explained in a separate note.

Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

Derivative financial instruments

Derivative financial instruments comprise of foreign exchange and interest rate swap contracts to hedge exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Derivative financial instruments that do not qualify for hedge accounting are accounted for as trading instruments.

Derivative financial instruments are recognised initially at fair value and subsequent to initial recognition are stated at fair value. The gain or loss on remeasurement to fair value is recognised immediately in the statement of comprehensive income. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount received or paid to terminate the swap at the balance date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of foreign exchange contracts is their quoted market price at the balance date, being the present value of the quoted forward price.

Instruments at fair value through the statement of comprehensive income

An instrument is measured as at fair value through the statement of comprehensive income if it is held for trading or is designated as such upon initial recognition. Instruments are measured at fair value through the statement of comprehensive income. Upon initial recognition, attributable transaction costs are recognised in the statement of comprehensive income when incurred. Subsequent to initial recognition, changes to the fair value of financial instruments are recognised in the statement of comprehensive income.

Investments in equity securities

Investments in equity securities are classified as available-for-sale, except for investments in equity securities of subsidiaries, associates and joint ventures which are measured at cost.

The fair value of equity investments classified as available-for-sale is their quoted bid price at the balance date.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Trade and other payables

Trade and other payables are stated at amortised cost using the effective interest rate. Creditors and payables are non-interest bearing and normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

Hedging

Cash flow hedges

Where a derivative financial instrument is designated as a hedge of the variability in cash flows of a recognised asset or liability, or a highly probable forecast transaction, the effective part of any gain or loss on the derivative financial instrument is recognised directly in equity. When the forecast transaction subsequently results in the recognition of a non-financial asset or liability, or the forecast transaction becomes a firm commitment, the associated cumulative gain or loss is removed from equity and included in the initial cost or other carrying amount of the non-financial asset or liability. If a hedge of a forecast transaction subsequently results in the recognition of a financial asset or liability, the associated gains and losses that were recognised directly in equity are reclassified into the statement of comprehensive income in the same period or periods during which the asset acquired or liability assumed affects the statement of comprehensive income (i.e. when interest income or expense is recognised). For cash flow hedges, other than those covered by the preceding two policy statements, the associated cumulative gain or loss is removed from equity and recognised in the statement of comprehensive income in the same period or periods during

which the hedged forecast transaction affects the statement of comprehensive income. The ineffective part of any gain or loss is recognised immediately in the statement of comprehensive income.

When a hedging instrument expires or is sold, terminated or exercised, or the entity revokes designation of the hedge relationship but the hedged forecast transaction is still expected to occur, the cumulative gain or loss at that point remains in equity and is recognised in accordance with the above policy when the transaction occurs. If the hedged transaction is no longer expected to take place, the cumulative unrealised gain or loss recognised in equity is recognised immediately in the statement of comprehensive income.

Hedge of monetary assets and liabilities

Where a derivative financial instrument is used to hedge the foreign exchange exposure of a recognised monetary asset or liability, no hedge accounting is applied and any gain or loss on the hedging instrument is recognised in the statement of comprehensive income.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- Freehold land
- Freehold buildings
- Plant, equipment and vehicles
- Work in progress.

Owned assets

Except for land and buildings and the assets vested from the Hospital and Health Service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, any costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amounts are not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive income. Any decrease in value relating to a class of land and buildings is debited directly to the revaluation reserve, to the extent that it

reverses previous surpluses and is otherwise recognised as an expense in the statement of comprehensive income.

Additions to property, plant and equipment between valuations are recorded at cost.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Health Waikato Limited (a Hospital and Health Service company) vested in Waikato DHB on 1 January 2001. The assets were transferred to Waikato DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Waikato DHB has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where Waikato DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Property, plant and equipment held under finance leases and leased out under operating leases are classified as investment property and stated at fair value. Property, plant and equipment leased under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Waikato DHB. All other costs are recognised in the statement of comprehensive income as an expense incurred.

Depreciation

Depreciation is charged to the statement of comprehensive income using the straight-line method. Land is not depreciated. Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
Buildings		
Structure	3 to 78 years	1-33%
Fit out	2 to 71 years	1-50%
Plant and equipment	2 to 20 years	5-50%

The residual value of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion, and then depreciated.

Intangible assets

Research and development

Expenditure on research activities, undertaken with the prospect of gaining new scientific or technical knowledge and understanding, is recognised in the statement of comprehensive income as an expense incurred. Expenditure on development activities, whereby research findings are applied to a plan or design for the production of new or substantially improved products and processes, is capitalised if the product or process is technically and operationally feasible and Waikato DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour, and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of comprehensive income as an expense incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Other intangibles

Other intangible assets acquired by Waikato DHB are stated at cost less accumulated amortisation and impairment losses.

Subsequent costs

Subsequent costs on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is recognised in the statement of comprehensive income as an expense incurred.

Amortisation

Amortisation is charged to the statement of comprehensive income on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	1 to 10 years	10 – 100%

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is based on weighted average cost. Work in progress includes the cost of direct materials, direct labour and an appropriate share of overheads.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

Impairment

The carrying amounts of assets other than investment property, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any

indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive income.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance date.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive income.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on numbers of days overdue, and taking into account the historical loss experience in portfolios with a similar amount of days overdue.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

The estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit, value in use is based on depreciated replacement cost. For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive income.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of comprehensive income over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Defined benefit plan

The net obligation in respect of defined benefit pension plans is calculated separately for each plan by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any planned assets is deducted. The discount rate is the yield at the balance date on New Zealand government bonds that have maturity dates approximating to the terms of the obligations. The calculation is performed by a qualified actuary using the projected unit credit method. All actuarial gains and losses are recognised in the statement of comprehensive income.

Where the defined benefit scheme is a multi-employer scheme with insufficient information to use defined benefit accounting then defined contribution accounting will be used.

Long service leave, sabbatical leave and retirement gratuities

The net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance date.

Annual leave, sick leave and continuing medical education leave

Annual leave, sick leave and continuing medical education leave are short-term obligations and are calculated on an actual basis at the amount expected to pay. The obligation is accrued for paid absences when the obligation relates to employees' past services and accumulates.

Other Liabilities

Provisions

A provision is recognised when there is a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years and up to a specified maximum amount. At the end of the two year period, the DHB pays a premium to ACC for

the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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 government bonds at balance date with terms to maturity that match the estimated future cash outflows.

Income tax

Waikato DHB is exempt from income tax under section CB3 of the Income Tax Act 2007.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

The majority of revenue is via a Crown Funding Agreement between Ministry of Health (MoH) and Waikato DHB. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the revenue equally throughout the year.

Revenue and expenses relating to service contracts

Waikato DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Waikato DHB, with the agreement of Ministry of Health, may be required to expend it on specific services in subsequent years.

Goods sold and services rendered

Revenue from goods sold is recognised when the significant risks and rewards of ownership of the goods has been transferred and where there is either no continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold. Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow and

the payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied.

Rental income

Rental income from investment property is recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of comprehensive income over the lease term as an integral part of the total lease expense.

Finance lease payments

Lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis. The interest expense component of finance lease payments is recognised in the statement of comprehensive income using the effective interest rate method.

Financing costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, and gains and losses on hedging instruments that are recognised in the statement of comprehensive income.

Non-current assets held for sale and discontinued operations

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRS. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of comprehensive income, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

A discontinued operation is a component of the business that represents a separate major line of business or geographical area of operations.

Classification as a discontinued operation occurs upon disposal or when the operation meets the criteria to be classified as held for sale, if earlier.

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are ultimately controlled by the same party or parties both before and after the business combination, and that control is not transitory.

The book value measurement method is applied to all common control transactions.

Standards not early adopted

The following standards have not been early adopted.

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year end 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

New standards issued and not yet effective and not yet adopted

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Waikato DHB will apply these updated standards in preparing its 30 June 2016 financial statements. Waikato DHB expects there will be minimal or no change in applying these updated accounting standards.

Cost of Service Reports

The cost of service statements represents the cost of providing the outputs less the revenue.

Cost Allocation

The net cost of service for each significant activity is arrived at using the cost allocation system outlined below.

Cost Allocation Policy

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.

Criteria for Direct and Indirect Costs

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

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.