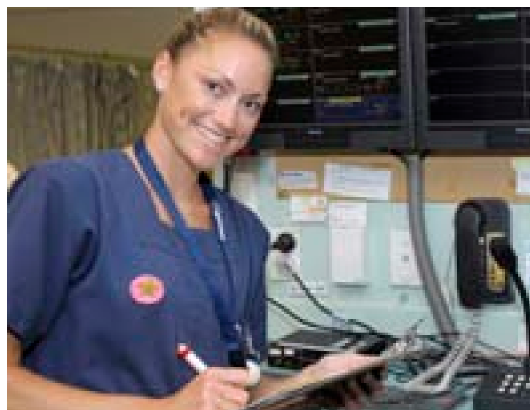
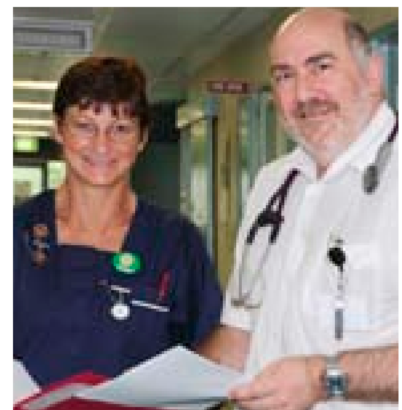
Waikato District Health Board

Statement of Intent 2010/11





Waikato District Health Board

Waikato District Health Board
Statement of Intent

2010/11 – 2012/13

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1.0 OVERVIEW

This Statement of Intent (SOI) is intended to outline for Parliament and the general public Waikato DHB performance during 2010/11. It contains non-financial information and financial forecast information for 2010/11 to 2012/13. The SOI provides an overview of some of the services delivered along with objectives and performance targets which have been set for the period. Due to the vast range of services delivered by Waikato DHB, only selected non-financial performance measures are included in our SOI.

The Waikato DHB priorities[1] for 2010/11 are:

1. financials
2. quality improvement
3. workforce
4. chronic conditions
5. redevelopment
6. rural services

Strong financial performance is the top priority during the 2010/11 year. We are planning a surplus of $8 million. To achieve this result we plan to save $12.9 million by becoming more efficient and reducing costs. This will enable us to focus on our core functions:

- to improve the health of our population
- to reduce or eliminate inequalities in health

Quality improvement will also be high on the agenda. During 2010/11 we will continue to build on the patient safety initiative, plus focus our attention on process improvement, hospital productivity and elective services. The positive impacts of quality improvement will flow through to our patients, staff and the public and will enable us to maintain a sharp organisational focus on our core functions. We are planning to increase productivity and to improve the quality of the services we fund and deliver. Our productivity measure for 2010/11 is planned to be 21.2 case weight discharges / accrued full time equivalents (comparable figures for 2009/10 and 2008/09 are 20.8[2] and 19.4).

There is a need to make better use of the available health workforce. While DHBs can achieve much individually, many changes require national action. A key workforce priority for 2010/11 is clinical leadership. We will be implementing a new management structure within Waikato Hospital which supports clinicians in the management of their services.

We will continue to work with primary health organisations and other key stakeholders to reduce the incidence and impact of chronic conditions. Tackling chronic conditions will lead to the single biggest improvement we can make in terms of reducing health inequalities for Māori, Pacific people and people who live in areas of low socio-economic status.

Strong financial performance is critical to allow us to meet the costs associated with campus redevelopment, which will continue for the at least the next 15 years. Form will follow function, as more important than the physical build is how we will work in the new buildings. We will for example implement new patient flow initiatives to

[1] See section 3.2.3 for further information
[2] Adjusted to include growth in mental health & addictions and oral health

maximise the benefits gained from increasing the Emergency Department foot print from 1,888m² to 4,200m² from February 2011.

There is increasing pressure on clinical sustainability in rural areas with the impact of declining patient numbers and workforce supply. Clinical sustainability will be the rural services focus in 2010/11.

To enable planned activities there will be decisions made about how and where services are provided. This is likely to bring changes.

The Government wants better, sooner, more convenient health care for all New Zealanders. Waikato DHB has made significant investments in services to improve the health of our population over the last few years, many of these related to the health targets. A focus for 2010/11 will be to ensure the maximum impact is achieved from these investments, rather than adding further funding.

Signature (Graeme Milne Board Chair)	Signature (Sally Christie Deputy Chair)

Date: 30 June 2010

2.0 NATURE AND SCOPE OF FUNCTIONS

Waikato District Health Board is one of 21 District Health Boards throughout New Zealand. District Health Boards (DHBs) were set up under the New Zealand Public Health and Disability Act 2000. Waikato DHB is responsible for the provision, or funding the provision of, the majority of the public health and disability services in our district. The role of a DHB is complex and covers the key areas of planning, funding, promotion, provision and monitoring.

Waikato DHB has a focus on our population. Waikato DHB is responsible for working within allocated resources to improve, promote and protect the health of the population of our district and to promote the independence of people with disabilities. Waikato DHB needs to consider all needs and services including prevention, early intervention, treatment and support services, and how these services can be provided to best meet the needs of the population within the funding provided.

Waikato DHB receives funding from Government to undertake its' roles and functions[3]. The amount of funding is determined by the size of the district's population, as well as the populations' age, gender, ethnicity and socio-economic status characteristics. The funding covers health and disability services that the provider arm provides directly to our population, or services provided indirectly through other providers (such as another DHB, primary health organisations, or a non-government organisation). The Ministry of Health also has a role in the planning and funding of some services[4].

Waikato DHB is responsible for monitoring and evaluating service delivery, including audits of the services we fund.

2.1 Functions of District Health Boards

For the purpose of pursuing its objectives, Waikato DHB has the following functions:

a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement
b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities
c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes (a) and (b)
d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
f) to provide relevant information to Māori for the purposes (d) and (e)
g) to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services
h) to promote the reduction of adverse social and environmental effects on the health of people and communities

[3] A list of services funded by Waikato DHB is located in appendix 3 of this document
[4] Particularly for public health and disability support services

i) to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services
j) to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector
k) to provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders
l) to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004
m) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes
n) to perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it

To manage any tension Waikato DHBs may experience in our dual roles as funders and providers of services, we have established three permanent core advisory committees:

1. a Community and Public Health Advisory Committee (CPHAC) to advise the Board on the health needs of the Waikato DHB population and the priorities and funding required to address those needs (recognising both resource constraints and the requirements of the New Zealand Health and Disability Strategies)
2. a Disability Support Advisory Committee (DSAC) to advise the board on issues facing people with disabilities and how these can best be managed by Waikato DHB
3. a Health Waikato Advisory Committee (HWAC) to advise the Board on the operating and financial performance of the Waikato DHB's hospital and health service provider, and on strategic issues relating to the provision of those services

The committees (CPHAC, DSAC and HWAC) are advisory only although the board may specify and delegate authority to committees to act on specific matters as appropriate. The public are welcome to observe the meetings of the Board and statutory committees. The meetings are usually held monthly (Board, CPHAC and HWAC) or quarterly (DSAC) and details of the meetings are publicly available on our website: http://www.waikatodhb.govt.nz/page/pageid/2145838840 . The Board and committees may deal with some meeting matters in a public excluded session as provided for in the NZPHD Act 2000.

Waikato DHB has been involved in the establishment of primary health organisations (PHOs) in our district under the Primary Health Care Strategy introduced by the Ministry of Health. PHOs provide primary health care services to their enrolled populations and are funded by DHBs; PHOs are not public entities.

DHBs are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. The community is able to be involved in Waikato DHB planning processes through consultation on documents such as the District Strategic Plan. Waikato DHB has a variety of Community Health Forums and advisory groups which provide advice and input into our decision-making processes.

Waikato DHB works in a co-operative and collaborative manner where appropriate to ensure the best service delivery for our populations.

3.0 STRATEGIC CONTEXT

Health has been defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[5]. Good health enables people to participate fully in society.

Different cultures have different interpretations of health. However, the same view is not necessarily held by all members of a particular culture. For Māori the word Hauora has a broader meaning than physical well-being. It spans the full spectrum of wellness through to poor health and death. It commonly encompasses and is about the assessment and treatment of taha hinengaro, taha wairua, taha tinana and taha whānau[6]. For many Pacific people spiritual well-being is essential to health.

Many factors combine together to affect the health of individuals and communities. These factors are often referred to as the determinants of health and are[7]:

- Age, sex and heredity factors
- Individual lifestyle factors
- Social and community influences
- Living and working conditions
- General socioeconomic, cultural and environmental conditions

These determinants have considerable impacts on health for example higher income is linked to better health; low education levels are linked with poor health; and safe water and clean air contribute to good health. Factors such as access to and the use of health services often have less of an impact. However, appropriate health and disability support services are important, particularly in the treatment of established disease.

3.1 Treaty of Waitangi

Waikato DHB are committed to the principles of the Treaty of Waitangi, in particular Māori well-being, partnership with Māori and Māori participation in health and disability services development, planning, delivery and monitoring. In accordance with the DHB's responsibilities under the NZPH&D Act 2000, Waikato DHB is committed to:

- improving health outcomes for Māori
- reducing inequalities for Māori

3.2 Strategic Direction

3.2.1 National

The Government wants better, sooner, more convenient health care for all New Zealanders.

The key priorities from the Minister of Health (outlined in the Ministers letter of expectations for District Health Boards and their subsidiary entities for the 2010/11 year) are listed below:

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[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

[6] Mental, spiritual, physical and family dimensions

[7] Source: Dahlgren and Whitehead (1991)

- delivery of agreed financial results
- improving service and reducing waiting times, specifically:
  - increasing elective surgical volumes year on year
  - improving emergency department waiting times
  - improving cancer treatment waiting times
- next steps in the Primary Health Care Strategy, specifically:
  - work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and specify these in your district annual plan
  - provide these services at no cost to patients
  - actively investigate and facilitate the opportunities that exist in your district to consolidate PHOs where appropriate, acknowledging existing provider networks
- clinical leadership
- regional co-operation
- more unified system

Improving performance across the sector is fundamental to the Government's goal of better, sooner, more convenient health care to all New Zealanders. The Ministry of Health monitors our performance on behalf of the Minister. The mechanisms currently in place to achieve this include:

- health targets
- performance improvement actions
- DHB non-financial monitoring framework

For 2010/11 the Ministers six health targets[8] are:

1. shorter stays in emergency departments
2. improved access to elective surgery
3. shorter waits for cancer treatment
4. increased immunisation
5. better help for smokers to quit
6. better diabetes and cardiovascular services.

The first three health targets are focused on patient waiting times in public hospitals. The remaining health targets are focused on investing in the health of our children, preventing ill health, and effective prevention through primary health care services.

Having a specific focus on these targets will not only impact the chosen areas, but is expected to bring broader benefits such as relieving pressure and lifting performance across the health sector. The health targets are assessed annually to ensure they are relevant and align with the health priorities of the time.

DHBs are required to respond to the Governments request to all Crown Entities to develop performance improvement actions[9] (PIAs) as part of “Improving the Business of Government: Delivering Better, Smarter Public Health Services for Less”. PIAs are a new reporting requirement for DHBs. They are intended to reflect the vital few actions that will have a material impact on performance, over the next one to five years, to achieve focussed delivery on Government policy priorities and maximum value for money (efficiency, effectiveness) across DHB spending.

[8] See appendix 1
[9] See appendix 2

The DHB non-financial monitoring framework is a key tool to provide assurance that DHBs deliver in terms of the legislative requirements, and in terms of Government priorities, "to the extent they are reasonably achievable within the funds provided" (NZPH&D Act 2000 S3(2).

The monitoring framework for 2010/11 aims to ensure the Ministry of Health can provide the Minister of Health, and other key stakeholders, with assurance that DHBs:

- give effect to the government's goals, strategies, and priorities
- that nationwide consistency is achieved where required
- that legislative and regulatory and operational requirements are met
- that risks (financial and non-financial) are effectively managed
- that a balance is struck between cost, and volume which maintains quality

It is intended that the monitoring framework will enable stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, but with the balance of measures focused on government priorities.

Our progress against the health targets, PIAs and the non-financial framework will be reported at least quarterly. Our progress against the health targets will be reported quarterly on the Ministry of Health website, our website and in other media. Our progress against the PIAs and non-financial monitoring framework is reported to the Ministry of Health, our Board committees and is available to the public as part of the committee agendas.

3.2.2 Regional

We are part of the Midland DHB region which is:

- Bay of Plenty DHB
- Lakes DHB
- Tairawhiti DHB
- Taranaki DHB
- Waikato DHB

The Midland DHBs are currently developing a clinical services plan (CSP) for the Midland region. This will be reflected in the development of strategic, annual and other plans developed by Waikato DHB (and the Midland DHBs).

<u>2010/11</u>

The Midland region is currently implementing two vulnerable services plans in the areas of obstetrics / gynaecology and rural primary care. These services were identified as initial focus areas based on work that was completed in early 2009.

An obstetrics / gynaecology clinical network has been established to support capacity to work regionally to support the services. While little progress has been made to date on implementing the action plan for obstetrics / gynaecology it will be a key focus for the obstetrics / gynaecology network once clinical leadership of the network has been established.

Rural primary care issues are less amenable to regional solutions. Rural primary care vulnerable services action plans have consequently been progressed at individual DHB level by Lakes DHB, Tairawhiti DHB and Waikato DHB, focussing on supporting rural primary care to maintain service coverage.

A draft CSP identifying 3 – 4 vulnerable services will be prepared by 1 July 2010. Development of actions to address the vulnerabilities identified in these areas will progress over the course of 2010/11. This process will review the prior work that was completed in early 2009 identifying rural primary care and obstetrics / gynaecology as vulnerable services and will determine if these services need to be further addressed by the CSP.

It is expected that a draft Midland region CSP will be submitted to the National Health Board by 30 September 2010.

2011/12 and beyond
The Midland region will develop a 10 year plan for regionally led, collaborative community and hospital services in the region, taking a whole-of-system approach. It will take a long-term (20 year) view of health needs across the population and will be matched to future clinical service provision and infrastructure requirements.

The plan will examine services that are currently vulnerable (or may become so) because of workforce, demand growth or funding issues. It will include an assessment of the status quo financial situation of Midland DHBs, likely cost growth and changes required to "live within our means" regionally. It will include a five – 10 year financial forecast.

The Ministry of Health's Role Delineation Model will be used to inform the development of future service configuration. The final plan will include both primary and hospital services and provide a regional roadmap to enable DHBs in the Midland region to make critical strategic decisions about the future delivery of specialist health and disability support services, for example, in relation to:

- the distribution of 24/7 acute and elective secondary services,
- the distribution of tertiary services
- future capital investment decisions
- changes to models of care, levels of care, or locus of care required to improve quality and live within the available resources

3.2.3 Local

Waikato DHBs strategic direction is based around our vision of:

Waikato District Health Board will improve the health, independence and quality of life for the communities it serves by addressing the needs of the population and reducing health disparities.

For 2010/11 our activities will be structured around the following priority areas:

- financials
- quality improvement
- workforce
- chronic conditions
- redevelopment
- rural services

Although these priorities may appear to differ from the health and population priorities in the Waikato DHB District Strategic Plan (DSP) 2006-2015[10], this difference is mostly in language and groupings. For example, the health priorities in the DSP

[10] Available from http://www.waikatodhb.govt.nz/file/fileid/7089

relating to heart disease and stroke, cancer, diabetes and smoking related lung disease are grouped under the chronic conditions priority. In terms of the population priorities outlined in our DSP the biggest positive impact for those groups can be made by addressing chronic conditions.

Priorities like financials, quality improvement, workforce, redevelopment and rural services cut across all the DSP health and population priorities.

The DSP 2006-2015 was reviewed by the Board in 2008 in light of the Waikato DHB Health Needs Analysis (HNA) 2008. Given the high degree of consistency between the priorities identified in the DSP 2006-2015 and the HNA 2008 it was agreed that the DSP 2006-2015 be considered "fit for purpose" and it has been adopted for the period 2009-2011.

4.0 OPERATING ENVIRONMENT

Outlined in this section are a number of factors that have an impact on the health sector as a whole. Also in this section is some detail around key factors that inform the decisions made by Waikato DHB (detailed information is available in the Waikato DHB Health Needs Analysis and Assessment 2008[11]).

4.1 Health Sector Wide Factors[12]

Factor	Implications
Urban growth	Requirement for ongoing investment in services, workforce and facility development in urban areas
Rural decline	Increasing pressure on clinical sustainability due to declining patient numbers and workforce supply
Increasing ethnic diversity	Demand for greater flexibility and a range of culturally responsive services
Evolving family structure	Decreased access to informal care and increased demand for support services
Ageing population	• The nature of required services is likely to shift toward an emphasis on chronic conditions and toward increasing complexity • Funding will need to increase, or be redistributed between service areas. The health care expenditure on services for those aged 65 years and over will increase
Growth in the number of people living with chronic conditions	Acute services will increasingly accommodate patients whose needs are more complicated. New care models to focus on managing conditions and preventing acute exacerbations through the use of more proactively planned care in a primary / community –based setting and the promotion of patient or whānau- led care. This will mean impacts on workforce availability, investment in information technology and primary/community-based infrastructures
Increased incidence of multiple complex symptoms and co-morbidities	Care is likely to require greater use of interconnected multidisciplinary teams. Providers will need to co-ordinate services and communicate more efficiently with each other
Greater chance of chronic conditions linked to lifestyle choices	National decisions will have to be made on the appropriate levels of investment into interventions which help prevent the onset and progression of these conditions as well as interventions which promote healthier lifestyles
New technologies and models of care	People will expect access to new technologies. This will require new funding or robust prioritisation processes (including disinvestment and reallocation decisions) or current services may need to be reconfigured. New technologies and models of care may be more efficient, but their introduction usually requires upfront investment in infrastructure and development. There are likely to be increased disparities between publicly funded services and those funded by private insurance or directly by patients, in terms of which new technologies are more likely to be available.
A decrease in the rate of funding growth (after a recent period of increases)	There will be a need to: • Increase efficiencies within existing services • Redistribute existing funding • Find ways to leverage resources and staff with other sectors • Find better ways of prioritising resources and providing care to those who need it most
Inequalities in health status continue, with potential for disparities to worsen	There will be a need to: • Effectively and appropriately design services • Maintain an appropriate skill set within the workforce, and ensure a focus on cultural responsiveness • Determine the most appropriate resource distribution within the health sector and across government
International demand and an ageing workforce Decreased hours / availability as a result of: • Regulated maximum	International competition for health workers. places increasing pressure on organisations to offer competitive wages. There will be a need to make better use of the workforce we have available and look for alternatives such as: • Invest in technology to support new ways of working (i.e.

[11] Available from the Waikato DHB website
[12] Adapted from Ministry of Health document – final draft Trends in Service Design and New Models of Care A Review

working hours • Changing lifestyle preferences	telemedicine) • Regional and national collaboration • Employment of supervised but unregulated staff • Making greater use of patients' own personal resources (i.e. self-management, expert / lay support and whānau / family care
Super-specialisation of some medical professions	The pool of generalist professionals will become smaller, at a time when demands for general skills will be increasing. Staff development will be affected (i.e. training).
Rural workforce shortages	There will be a need to consider reconfiguration or clustering of services to provide clinical sustainability. Investment in telemedicine, information technology and cross-organisational arrangements will be required.
More accessible information for patients and clinicians	The way information is accessed will change for both patients and health workers.
Increased communication options and speed for patients and clinicians	The way patients and health workers communicate will change particularly with the increasing use of secure electronic interactions (voice, video or e-mail)
Continued growth in research and knowledge	Ongoing need for guidelines and decision support for clinicians to assist the assimilation of research into practice.
Increased understanding of need and service impacts	Analysis of appropriate information will be necessary to identify the people most in need as well as to support quality improvement and research.
Increasing expectations of the health sector e.g. patients will be better informed, expectations of highly personalised services	• Patients will have higher expectations of health professionals. They will be better placed to take more of a lead in their own care. • There must be a balance between the needs of the individual and the needs of the broader population. • Health is likely to remain high on the political agenda. There will be implications for the workforce (likely to require greater regulation to ensure safe services).

4.2 Waikato DHB Factors

4.2.1 Geographic Boundaries

Waikato DHB covers 7.9% of New Zealand, from northern Coromandel to close to Mt Ruapehu in the south, and from Raglan on the west coast to Waihi on the east coast. It takes in the city of Hamilton and towns such as, Cambridge, Huntly, Matamata, Kawhia, Morrinsville, Ngaruawahia, Otorohanga, Taumarunui, Te Kuiti, Te Awamutu, Thames and Tokoroa.

The geographic boundaries of Waikato DHB cover the following council areas:

1. Thames-Coromandel District Council
2. Hauraki District Council
3. Hamilton City Council
4. Waikato Ditrict Council
5. Waipa District Council
6. Matamata District Council
7. South Waikato District Council
8. Otorohanga District Council
9. Waitomo District Council
10. Ruapehu District Council (part of)

Waikato DHB covers a large rural area as well as having a major metropolitan city (Hamilton). It has only one main urban area made up of three zones: Hamilton, Cambridge and Te Awamutu. Approximately 40% of the DHB population live in Hamilton.

4.2.2 Population

In 2010/11 the Waikato DHB population[13] is projected to be 365,730 of which, 21.87% (79,970) identify as Māori, 2.48% (9,080) identify Pacific and 75.65% (276,680) identify as Other[14].

Detailed information on the Waikato DHB population is in the Waikato DHB Health Needs Assessment and Analysis (HNA) 2008, which is available on: http://www.waikatodhb.govt.nz/page/pageid/2145840843/Health_Needs_Assessment
Key points of interest regarding the Waikato DHB population are:

- The proportion of the population in the 65+ age group is expected to increase by 64.5% from 49,000 to 80,600 by the year 2026
- The proportion of the population in the 85+ age group is expected to more than double by 2026 (118% growth)
- The 25 -64 year old age group currently makes up approximately 50.26% of the Waikato DHB population, this percentage will drop to 47.86% by 2026
- The child and youth age group (0-24) currently makes up approximately 36.25% of the Waikato DHB population, this percentage will drop to 32.01% by 2026
- The Māori population is growing at a slightly faster rate than the Pacific and Others and by 2026 Māori are projected to be 23.3% of the population
- The Waikato DHB district is more rural than New Zealand as a whole
- Based on the 2006 census 21.7% of the Waikato DHB population live in rural areas
- The faster growth rate for males over the past few years is set to be more in line with female growth rates
- There will continue to be four or five thousand more females than males in the population
- Waikato DHB has a larger proportion of people living in high deprivation areas[15] (24.1%) than in low deprivation areas (15%)[16]. The comparable figures for New Zealand as a whole are 19.8% living in high deprivation areas and 20.5% living in low deprivation areas

4.2.3 Health Profile

Identifying and understanding the health profile of the Waikato DHB population means we are able to make better decisions on the provision of services that contribute to achieving our objectives. The Waikato DHB HNA is a key mechanism in this process.

Key points of interest from the Waikato DHB HNA in terms of the health profile of the population are:

<u>Māori Health</u>
Mortality

- Waikato Māori population aged 45 to 64+years are more than twice at risk of mortality from chronic conditions, demonstrating that Māori die at a younger age than Other ethnic group.

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[13] Based on Statistics NZ projected population figures for Ministry of Health population based funding formula
[14] Describes the population who are non-Maori and non-Pacific
[15] Defined as deprivation decile 9 and 10 (NZDep 2006)
[16] Defined as deprivation decile 1 and 2 (NZDep 2006)

- Māori aged 25-44 years are ten times more at risk of mortality to cerebrovascular disease when compared with Other ethic group.
- the rate of mortality to chronic obstructive pulmonary disease among Waikato Māori aged 45-64 years was six times higher than Other ethnic group in 2003-2004.
- around 67% of Māori deaths from hanging/suffocation/strangulations in 2004 occurred in 15-24 year olds.
- approximately 78% of Māori deaths from chronic conditions were concentrated in the highest NZ Deprivation quintile 4 and 5.

Morbidity

- Over 58% of bronchus and lung cancers registered for Māori were in the 45-64 age groups and almost all the remainder (40%) in the 65+ age groups for 1999-2005.
- Most hospitalisations for the chronic conditions in Māori were among 45-64+ age groups and Māori living in NZDeprivation quintiles 4 and 5.
- Ethnic comparison of dialysis showed a significantly high rate among Māori (59% in 2006) and a possible explanation could be the epidemic of Type II diabetes particularly among Māori population.
- Māori aged 25-44 and 15-24 made up most of the hospitalisation for schizophrenia, in 2000 to 2006.
- Around 58% of hospitalisation for depressive episode was among Māori aged 25-44 year olds in 2006. The biggest volume of hospitalisation was among 35-44 year olds.
- Māori children are at much higher risk of hospitalisation for dental conditions than children from Other ethnic group.

Pacific Health

- Pacific People are hospitalised at an even younger age than Māori. In 2006, around 44% of the hospitalisation was in the 25-44 age group and 33% in the 45-64 age group.
- The top five leading causes of hospitalisation among Pacific People were:
  - Colon cancer
  - Diffuse non-Hodgkin's lymphoma
  - Breast cancer
  - Secondary malignant neoplasm of other site
  - Lung cancer
- The age standardised rate and age specific rate of hospitalisation among 45-64 year olds for diabetes increased slightly from 337.33 in 2005 to 405.84 in 2006. The age standardised rate in the Waikato Pacific people was within the national age standardised rate of 597.62 per 100,000 in 2006.
- The age specific rate of hospitalisation among Pacific People 45-64 age groups increased slightly to 1570.2 in 2006, highest since 2000. Waikato age specific rate was within the national rate of 1388.8 per 100,000 people in 2006.
- The age specific rate among Pacific People aged 65+ years decreased from 1344.1 in 2005 to 1025.6 in 2006. Waikato age specific rate among this age groups was considerably lower than the national rate of 3259.8 per 100,000 in 2006.

4.3 Link to Decision-making

Variables such as population size, age, ethnicity, rurality, gender, socio-economic status and the health profile impact the level, nature, types and variety of health services demand, and subsequent service provision. These variables have a significant impact on how Waikato DHB functions. A knowledge and understanding of these demographic variables are therefore essential for health services development and delivery, as it allows for planning and targeted service provision.

The work undertaken in the Waikato DHB HNA helps identify and describe these variables, which in turn inform the strategic direction of Waikato DHB. This direction is articulated through the District Strategic Plan and in particular through the strategic priorities.

Changes in any of the demographic variables have the potential to impact on demand for and provision of health services. For example, where there is a relatively large population of various ethnic groups, such as in the Waikato DHB district, ethnicity becomes increasingly important, as various ethnic groups exhibit diverse perceptions, norms, values, attitudes and practices towards health.

5.0 PERFORMANCE INTENTIONS

This section includes background information about the Waikato DHB approach to performance reporting. Also included in this section are the statements of service performance for each of the four output classes we have used to aggregate our outputs.

5.1 Measuring Health Status

Health status is difficult to measure, especially if a broad view of health is assumed as in the World Health Organisation definition presented in section 3.0. A more limited measure of health status, life expectancy at birth[17], is used to compare countries and examine trends in health status. High level outcome indicators like life expectancy are seldom directly attributable to the activities of one specific agency alone. External factors frequently drive changes in outcome indicators and multiple agencies may also affect the same outcomes. Therefore, identifying the direct impact on high level outcome indicators caused by Waikato DHB is very difficult to quantify.

Life expectancy is calculated from time to time by Statistics New Zealand. At the time of preparing the most recent Waikato DHB HNA (2008) the most current result is outlined in the following table.

Sex	Māori	Non-Māori	Total
Male	69.0	77.2	76.3
Female	73.2	81.9	81.1

Overall, in New Zealand, life expectancy has been slowly increasing. Females have a longer life expectancy at birth than males. Non-Māori also have a longer life expectancy at birth than Māori.

We will continue to monitor life expectancy at birth through our regular Health Needs Assessment and Analysis processes (updates take place every 3 years).

A number of mechanisms have been developed to measure the overall burden of disease[18]. These include Years of Life Lost (YLL), Years Lived with Disability (YLD), quality adjusted life years (QALYS) and disability adjusted life years (DALYS). These mechanisms are currently not used by Waikato DHB as we do not have the internal capacity. In the current environment the focus of investment is frontline health services and it is therefore unlikely Waikato DHB will be able to invest in building the capacity to use these mechanisms effectively. Investing in building or having this capacity at 21 DHBs does not appear to be an efficient use of resources.

5.2 Waikato DHB Enterprise Reporting Framework

The current iteration of our performance framework is entitled Enterprise Reporting and consists of two parts:

- performance reporting (narrative indicators)

[17] Life expectancy at birth is an estimation of the average number of years that children born now can expect to live if current mortality rates persist for the whole of their lives.
[18] Disease burden is the impact of a health problem in an area measured by financial cost, mortality, morbidity, or other indicators

- key performance indicator reporting (numerical indicators)

The Enterprise Reporting framework continues to be refined and enhanced. Through this framework we can measure whether our activities are effective and efficient. This enables us, on an on ongoing basis, to:

- chart the progress we are making
- make adjustments when they are needed
- report on progress
- track effectiveness
- make informed decisions on service delivery, capability investments and resource allocations
- define what results matter the most to us in terms of our performance

As our Enterprise Reporting framework continues to evolve, we will be aiming to focus on impact measures rather than input or output measures. However, in the short-term we may not be able to present impact measures for a number of areas and so output or input measures are used.

In developing the framework, we focused firstly on what mattered most (i.e. national priorities[19]). We are taking a step by step approach, which enables us to focusing national priorities, while working towards a system that will provide information on all key aspects of performance.

The health targets, performance improvement actions and the DHB non-financial monitoring framework indicators are integrated into our Enterprise Reporting framework. They sit beside indicators of local importance and are structured under the following priority areas[20]:

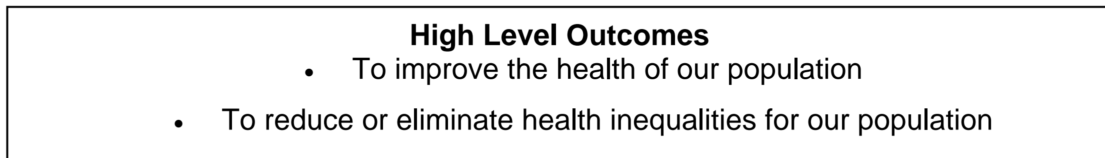
1. financials
2. quality improvement
3. workforce
4. chronic conditions
5. redevelopment
6. rural services

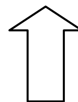
All the indicators presented in the current iterations of our district annual plan (DAP) and our statement of intent (SOI) are included within the Enterprise Reporting framework. Monthly Enterprise Reporting updates are provided to our Executive Action Group (EAG), our Chief Executive Officer and our Board.

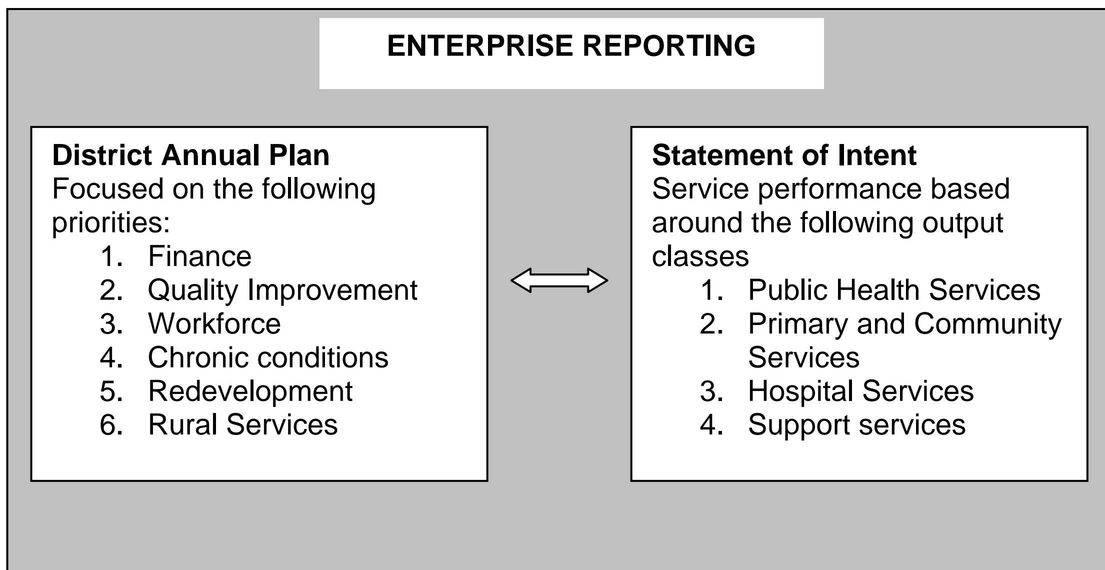
The diagram on the following page shows the linkage from our feeder plans to our district annual plan and statement of intent (which form the basis of our Enterprise Reporting framework) to our high level outcomes[21].

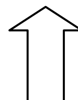
[19] Health targets, performance improvement actions and indicators in the DHB non-financial monitoring framework
[20] These priorities are the basis of our annual planning process (further information is available in our district annual plan 2010/11)
[21] Link directly to our key functions

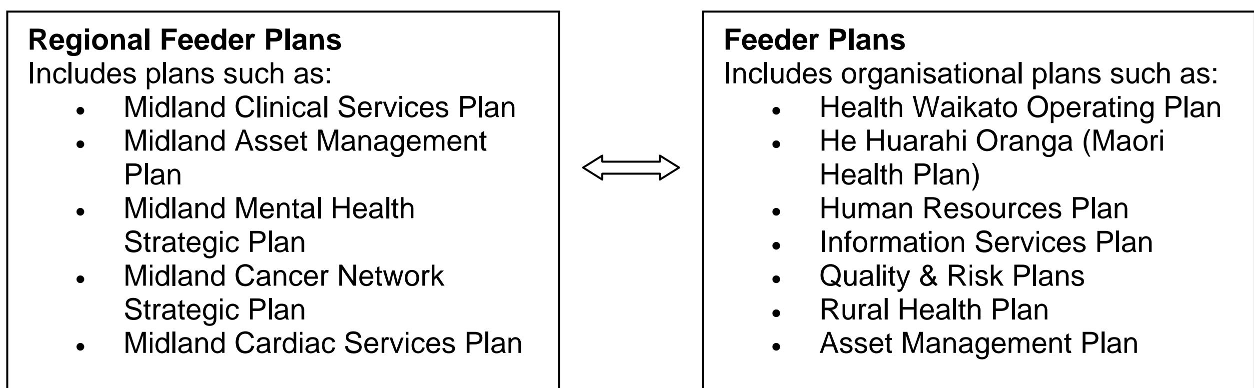
Diagram: Performance Linkages











5.3 Statement of Forecast Service Performance

Section 142 of the Crown Entities Act 2004 requires DHBs to provide measures and forecast standards of output delivery performance. The actual results against these measures and standards will be presented in the Waikato DHB Annual Report 2010/11. The measures presented in the Statement of Forecast Service Performance Measures are non-financial measures only.

DHBs must provide these measures and standards of output delivery performance under aggregated output class. There are four output classes for 2010/11, and they are defined below.

5.3.1 Output Class Definitions

1. Public Health Services - 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 the curative services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public Health 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, individual health protections services such as immunisation and screening services.

2. Primary and Community Health Services – comprise services that 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.

3. Hospital Services - comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. 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

4. Support Services - comprise services that 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.

For each of the four output classes we have identified a number of measures and targets. These measures and targets do not cover all the services provided by Waikato DHB under the output classes, but instead cover key items identified through our Enterprise Reporting Framework.

Other services not mentioned in any detail will continue to be planned, funded and provided to a high standard. Although measures and targets for these services are not included in this section, Waikato DHB does report quarterly to the Ministry of Health on our performance in relation to a number of these services. The quarterly reporting ensures that our progress in these services is documented and improvements are tracked; these reports can be accessed on the Ministry of Health website (www.moh.govt.nz).

The statement of forecast service performance contains different types of measures. There are:

- output measures – related to final goods and services (supplied to someone external to Waikato DHB)
- impact measures – attributed to Waikato DHB outputs. These represent near-term results expected from the outputs we deliver.

In the discussions about 'What will we do to achieve' relating to the output or impact measures a number of services and activities are identified. These are not necessarily all the services provided that impact this measure. A full list of services provided is outlined in appendix 3.

Information on forecasts costs and revenue for each for the four output classes is available in appendix 5.

5.4 Statement of Forecast Service Performance for Public Health Services

Public health services are the domain of many organisations across the Waikato:
- Ministry of Health, principally as a funder of public health services, and also a regulator and planner
- Population Health Service, as a provider of services
- Waikato DHB, in both funding and provision
- Primary Health Organisations, mainly in the area of provision of primary health care services, but with some public health functions (mostly health promotion)
- A significant array of private and non-government organisations, including Māori and Pacific providers
- Regional Sports Trusts
- Local and regional government

The Ministry of Health provides direct funding for our Population Health Service who work in the following areas:
- Health promotion (including tobacco control, sexual health, preventing alcohol and drug related harm, healthy physical activity)
- Health protection (e.g. air quality, waste treatment and disposal, regulatory services[22])
- Population-based screening programmes (breast, cervical and antenatal HIV, national immunisation register and mobile immunisation service, refugee and new migrant screening)
- Emergency management

Other public health activities directed to be funded by the Ministry of Health include family violence, Healthy Eating Health Action[23] and emergency management. We have prioritised funding for Project Energize, which is a public health initiative delivered in a school setting.

Public health services are "the ambulance at the top of the cliff" as opposed to personal health service delivery generally "at the bottom of the cliff". Programmes are planned and delivered so that health inequalities between populations are addressed. A number of groups within the Waikato provide public health services; with Population Health Service being the Waikato DHB public health service provider and delivers a significant amount of Waikato DHBs population-based programmes.

5.4.1 Key Measures for Public Health Service Output Class

The key public health service measures and targets selected for inclusion in the SOI are:
- Population screening (specifically breast screening)
- Immunisation (specifically two year-old immunisations)
- Immunisation (specifically influenza vaccine for people aged 65 years or over)
- Breast feeding

[22] For example controlled purchase operations for sale of tobacco and liquor and food safety
[23] Includes funding for leadership, communications, breastfeeding, Maori and Pacific community action plans and some evaluation projects

Diagram: Public health services intervention logic

If we invest in	And undertake	Then we produce	Then we will achieve	And contribute to
→	→	→	→	
Population Screening	Breast Screening Services	An increase breast screening rate	Early detection of cancerous or pre-cancerous conditions	**Improved health status**
Immunisation	Immunisation Services	An increase in the immunisation rate for: • Under two year olds • Over 65 year olds (influenza vaccine)	Increased level of protection against communicable diseases in the population Reduced number of preventable hospitalisation	
Health Promotion	Peer counselling programmes (breast feeding) Professional development for primary health sector staff (breast feeding)	An increase in the breast feeding rate at six weeks, three months and six months	Health benefits for infants, mother and family/whānau	**Reduced inequalities**

Population screening – specifically breast screening

Rationale for inclusion

- The aim of breast screening is to find very small cancers before a lump can be found on the breast. Early treatment has the best chance of success.

What are we seeking to achieve?

We are seeking to increase the coverage of the Breast Screening Aotearoa programmes for women aged 45 – 69 years.

What will we do to achieve this?

Breast Screen Midland[24] (BSM) provides the following services:

- Health promotion service throughout the Midland region, enabling women to access the screening services through the provision of information, education and recruitment
- Regional Coordination Centre - provides identification, recruitment, invitation and booking services for Breast Screen Midland, including components in the Waikato and the Bay of Plenty. Also complementing the service is the provision of local and regional data management and monitoring.
- Screening mammography - at both fixed sites throughout the region and also via the services of a mobile unit staffed and managed by Waikato DHB
- Assessment and diagnosis of recalled screened clients

Output Performance Measure	Baseline[25]	Target 2010/11
Percentage of women aged 45-69 years (by ethnicity) who have had a breast screen in the last the 24 months ending June 2011	Māori 33.0% Pacific 39.7% Other 49.7%	Māori 41% Pacific 48% Other 70%

[24] Covering Bay of Plenty DHB, Lakes DHB and Waikato DHB
[25] As at June 2008

***Immunisation - specifically two year-old immunisations*[26]**

Rationale for inclusion

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

What are we seeking to achieve?

The national immunisation goal is 95% of children fully immunised at two years of age by ethnicity by July 2012. We will be reporting on this target quarterly throughout 2010/11.

What will we do to achieve this?

Provision of or funding provision of the following:

- To monitor the performance of the mobile immunisation service
- Hospital based immunisation service to deliver immunisations in emergency departments, outpatient and inpatient settings
- Work with all primary health organisations to improve coverage against their national performance programme target
- Percentage increase set with primary health organisations every 6 months
- Appropriate learnings to be shared with the DHBs in the Midland Region
- Bulk fund 100% of 2 year old immunisations for Midland Network enrolled patients for 6 months to enable reconfigured models of care focused on achievement of health target
- Health TV advertisements at Waikato and Thames Hospitals
- Ongoing promotions regarding the mobile and opportunistic immunisation service

Impact Performance Measure	Baseline[27]	Target 2010/11
An increase in the percentage of two year olds fully immunised by July 2011	Māori 66.4% Pacific 56.5% Total 73.6%	Māori - 87% Pacific - 82% Total 90% Other - 92%

Immunisation - specifically influenza vaccine for people aged 65 years or over

Rationale for inclusion

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

What are we seeking to achieve?

To increase the number of people aged 65 or over who have been vaccinated against influenza.

What will we do to achieve this?

- Hospital based opportunistic immunisation service
- Out reach immunisation service
- General practice immunisation services
- National social marketing programmes

[26] This target is calculated based on whether children turning two in the relevant quarter are fully immunised by their second birthday. The measure does not reflect increased immunisation levels if the child is not fully immunised by their birth-date.

[27] As at June 2008

Impact Performance Measure	Baseline[28]	Target 2010/11
An increase in the percentage over 65 year olds immunised against influenza by July 2011	Total 62.65%	Total 63 %

Breast feeding

Rationale for inclusion

Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. 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.

What are we seeking to achieve?

Increase the proportion of infants exclusively and fully breastfed

What will we do to achieve this?

- implement and provide ongoing support for peer counselling programmes within Māori and Pacific communities
- provide professional development for primary health sector staff and other community based health workers in the area of breastfeeding to support their work and baby friendly community initiatives
- implement antenatal education pilots in conjunction with Māori and Pacific health service providers
- develop and deliver a training programme for early childhood education provider staff working across the Midland DHB's

Impact Performance Measure	Baseline[29]	Target 2010/11[30]
Increasing breast feeding rates	6 weeks Māori 56.4% Pacific 59.0% Other 72.6% All 67.5% 3 months Māori 44.6% Pacific 58.0% Other 60.1% All 55.8% 6 months Māori 19.5% Pacific 25.0% Other 30.1% All 26.9%	6 weeks Māori 58.0% Pacific 60.5% Other 73.5% All 69.0% 3 months Māori 46.0% Pacific 58.0% Other 60.1% All 57.0% 6 months Māori 21.0% Pacific 27.0% Other 30.1% All 27.0%

5.4. 2 Medium Term Intentions

The medium term focus in relation to public health services will be:

- reducing inequalities
- improving population well-being
- reducing the risk of avoidable disease
- foster a culture of innovation
- recruit, retain and develop a skilled workforce
- develop and strengthen regional collaboration

[28] As at September 2009
[29] 2008 Plunket Breast Feeding Rate
[30] Planned targets for 2010/11 are the same as planned for 2009/10 following Ministry of Health advice

In terms of the measures outlined in this section we will:

- continue to increase the coverage of the Breast Screening Aotearoa programmes for women aged 45 – 69 years particularly with a focus on reducing inequalities
- continue to increase our immunisation rates for two year olds (to meet the national target of 95% of two year olds fully immunised)
- continue to increase our the rate of over 65 year old who have had an influenza vaccination

Prior to the commencement of each year significant analysis and discussion is undertaken to set appropriate targets.

5.5 Statement of Forecast Service Performance for Primary and Community Health Services

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups. Primary and Community Health Services are the domain of many organisations across the Waikato:

- Waikato DHB, in both funding and provision
- PHOs, mainly in the area of provision of primary health care services
- A significant array of private and non-government organisations, including Māori and Pacific providers

There are currently four PHOs in the Waikato DHB district. They are:

- Waikato Primary Health (Pinnacle)
- Te Toi Ora PHO Coalition
- Hauraki PHO
- North Waikato PHO

Table: Overall PHO enrolments as at April 2010

Enrolled in a PHO	2010 Popn Projection	%
354,135	363,980	97.3%

Table: PHO enrolments as at April 2010 by ethnicity

Ethnicity	Enrolled in a PHO	2010 Popn Projection	%
Māori	69,874	79,330	88.1%
Pacific	8,259	8,990	91.9%
Other	276,002	275,660	100.1%

Table: PHO enrolments as at April 2010 by NZDep06

Dep Decile	Enrolled in a PHO	2006 Census Count Population	%
Decile 9 & 10	76,140	81,759	93.1%
Decile 1 - 8	277,995	257,442	108.0%

5.5.1 Key Measures for Primary and Community Health Services Output Class

The key primary and community health services measures and targets selected for inclusion in the SOI are:

- better diabetes and cardiovascular disease services
- better help for smokers to quit
- increased utilisation of Waikato DHB funded dental services by adolescents

Primary and community services intervention logic

If we invest in	And undertake	Then we produce	Then we will achieve	And contribute to
→	→	→	→	
Chronic Condition Management	Diabetes free annual checks	Increase in free annual checks for diabetes	Contribution to the proportion of those people diagnosed with diabetes staying healthier and reducing the impact of complications and unplanned admissions to hospital.	**Improved health status**
	Diabetes management	Increase in people with good diabetes management		**Reduced inequalities**
	CVD risk assessment	Increase in people who have had their CVD risk assessed in the last 5 years	Those most in need of advice and intervention identified	
	To routinely ask about smoking status and then provide brief advice and offer quit support to current smokers	Increase in smokers who have been provided with advice and help to quit	An increase in the population who do not smoke	
Oral Health	Adolescent dental treatment services	Increased utilisation of Waikato DHB funded dental services by adolescents	Better adolescent oral health and the learning of good oral health habits	

Better diabetes and cardiovascular disease services

Rationale for inclusion

Chronic conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need.

What are we seeking to achieve?

1. To increase the percentage of the eligible adult population who have had their cardiovascular disease (CVD) risk assessed in the last five years
2. To increase the number (and percentage) of people with diabetes who attend free annual checks
3. To increase the number (and percentage) of people with diabetes who have satisfactory or better diabetes management (HBA1c = 8.0% or less)

What will we do to achieve this?

The services that match to measures outlined in the table below are provided by PHO. Actions Waikato DHB plan to undertake to contribute to achieving better diabetes and CVD services include:

- Implementation of the appropriate actions outlined in the Cardiac Servics Plan for the Midland DHB region
- Implementation of the Waikato DHB approach to chronic disease management including linkages with PHOs
- Increase in numbers of diabetes free annual checks through General Practice during 2010/11
- Bulk fund 100% of diabetes free annual checks for Midland Network enrolled patients for 6 months (to December 2010) to enable reconfigured models of care focused on achievement of health target
- Continued funding of mobile nursing service

Output Performance Measure	**Baseline[31]**	**Target 2010/11**
Increase in the percentage of people in all population groups: Cardiovascular Disease Risk Assessment	Māori 54.6% Pacific 51.3% Other 68.2% Total 65.6%	Māori 67% Pacific 63% Other 79% Total 76%
An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks	Māori 42% Pacific 53% Other 52% Total 51%	Māori 44% Pacific 38% Other 55% Total 52%
Impact Performance Measure		
An increase in the and percentage of people in all population groups on the diabetes register who have good diabetes management (HBA1c = 8.0% or less)	Māori 55% Pacific 55% Other 76% Total 71%	Māori 65% Pacific 65% Other 79%) Total 76%

Better help for smokers to quit

Rationale for inclusion

Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

Including this measure and target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

What are we seeking to achieve?

Patients attending primary care to be provided with advice and help to quit by July 2011.

What will we do to achieve this?

The measures outlined in the table below are linked to PHO performance. Actions Waikato DHB plan to undertake to contribute to achieving better help for smokers to quit include:

- Staff education on the need to provide advice and help to quit to patients who attend primary care and are smokers
- Implementation of PHO plans for cessation activities in primary care settings
- Engage with primary care sector regarding systems to capture primary health section of this target

[31] Results as at July 2009

- Learnings from work to increase the number of hospitalised smokers offered advice and help to quit is shared with primary care as appropriate
- Implement smoking status recording indicator as part of the Waikato DHB PHO quality indicator programme

Output Performance Measure	Baseline[32]	Target 2010/11
Patients attending primary care smokers provided with advice and help to quit by July 2011	New measure for 2010/11	80%

Increased utilisation of Waikato DHB funded dental services by adolescents[33]

Rationale for inclusion

Research shows that improving oral health in childhood and adolescence has benefits over a lifetime. This information will enable Waikato DHB and the Ministry of Health to evaluate the effectiveness of adolescent oral health service utilisation.

What are we seeking to achieve?

An increase in the percentage of adolescent utilising Waikato DHB funded dental services.

What will we do to achieve this?

- launch the Community Oral Health Service
- implement new oral health information system and supporting infrastructure

Output Performance Measure	Baseline[34]	Target 2010/11
Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years	60.2%	70%

5.5.2 Medium Term Intentions

The medium term focus in relation to primary and community health services will be:

- reducing the impact of chronic conditions
- reducing inequalities
- implementing better, sooner, more convenient primary care services for our population

In terms of the measures outlined in this section we will:

- Continue to increase the number of people with diabetes who have a free annual check
- Continue to increase the number of people with good diabetes management
- Continue to increase the number of people who've had a CVD risk assessment
- Providers routinely asking about smoking status and offering brief advice about quitting to smokers
- Continue to increase the utilisation of Waikato DHB funded oral health services by adolescents

Prior to the commencement of each year significant analysis and discussion is undertaken to set appropriate targets.

[32] For the 2008 calendar year
[33] In this context an adolescent is defined as year 9 up to and including age 17 years
[34] As at June 2008

5.6 Statement of Forecast Service Performance for Hospital Services

Health Waikato is the DHB's main provider of hospital and health services. It has seven divisions across five hospital sites, two maternity and continuing care facilities, a mental health facility and 21 community bases offering a comprehensive range of primary, secondary and tertiary health services.

Health Waikato is our main provider of hospital and health services with an annual budget of more than $606 million and 4740 staff. It has seven divisions across five hospital sites, two maternity and continuing care facilities, a mental health facility and 21 community bases offering a comprehensive range of primary, secondary and tertiary health services.

Services provided within Health Waikato are:

- Waikato Hospital
  - critical care
  - surgery
  - medicine
  - oncology
  - child and adolescent health
  - women's health
- Rural and Community Services
- Mental Health & Addictions
- Older Persons & Rehabilitation
- Population Health/Public Health

Our hospitals provide a range of inpatient and outpatient services to the people of the Waikato DHB district. As well as a range of acute[35] and elective[36] services. The seven campuses Health Waikato has are of varying sizes and functions located across the district:

- Matariki (Te Awamutu) – continuing care and primary maternity facility
- Rhoda Read (Morrinsville) - continuing care and primary maternity facility
- Taumarunui – rural hospital
- Te Kuiti – rural hospital
- Thames – rural hospital
- Tokoroa – rural hospital
- Waikato Hospital (Hamilton) –secondary and tertiary teaching hospital and Henry Rongomau Bennett Centre (mental health service)

Health Waikato, through Waikato Hospital, will maintain its preferred tertiary provider status to the Midland region.

For 2010/11 we will increase our volume of elective surgery discharges. To complement this, we intend to increase internal capacity by better utilisation of the surgical facilities at Thames hospital until the Waikato Clinical Centre is completed in 2013. Some specialised surgical procedure work will however, continue to be outsourced. We will also review all outsourced contractual arrangements to ensure they fully meet the needs of the DHB.

[35] Acute services are for illnesses that have an abrupt onset. It is usually of short duration, rapidly progressive, and in need of urgent care.
[36] Elective services (booked surgery) is for patient who do not require immediate hospital treatment

In 2010/11 we will be repatriating some of our outsourced electives (we had $11.5 million of outsourced electives). Over previous years we significantly increased our outsourced electives with the intention of doing so for a number of years whilst we increased internal capacity. We will be looking to repatriate 50% of outsourced electives.

In managing Elective Services Health Waikato will focus on the following areas:

- Patient Flow Management – we will comply with required standards on Elective Services Patient Flow Indicators (ESPIs). These demonstrate that Waikato DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching their commitments to capacity, and meeting the 6 month timeframe for provision of assessment and treatment
- Level of Service – we will ensure that we provide the amount of elective operations, procedures and assessments agreed to in our District Annual Plan
- Order of Service – we are committed to making sure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given

In terms of regional capacity, the Midland region is progressing the development of a regional Elective Surgical Services Plan for inclusion within the Midland DHB Regional Clinical Services Plan to enable critical strategic decisions to be made about 24/7 acute and elective secondary services. The regional Elective Surgical Services plan will encourage sharing of resources and expertise. The initial steps of this work involve an analysis of:

- comparative access levels
- referral pathways
- the role of clinical networks
- regional reporting
- the mix of elective delivery standard intervention rates

5.6.1 Key Measures for Hospital Services Output Class

The key hospital services measures and targets selected for inclusion in the SOI are:

- improved access to elective surgery
- shorter waits in emergency department
- shorter waits for cancer treatment
- better help for smokers to quit
- inpatient average length of stay
- Improved health status for people discharged from mental health inpatient services

Hospital services intervention logic

If we invest in	And undertake	Then we produce	Then we will achieve	And contribute to
Hospital inpatient and outpatient services	Elective services	More elective procedures	Reduction in level of illness and disability in the community	**Improved health status**
	ED services	Shorter waits in ED	Improved experiences for patients	
	Cancer services	Reduction in treatment times	Peoples ability to function is increased	**Reduced inequalities**
			Safer, high quality services	
	To routinely ask about smoking status and then provide brief advice and offer quit support to current smokers	Increase in smokers who have been provided with advice and help to quit		
	Acute services	Improved throughput		
	Mental Health and Addiction inpatient services	Improvement in HoNOS[37] scores	Improved mental health Improved experiences for patients	

Improved access to elective surgery

Rationale for inclusion

The government wants the public health system to deliver better, sooner, more convenient healthcare for all New Zealanders.

The growth in elective surgical discharges did not keep up with population growth over the 2000/01 – 2007/08 period. The Minister has set an expectation that the annual increase in elective surgical discharges will improve.

What are we seeking to achieve?

The Government direction is that the number of elective surgical discharges provided nationally needs to increase each year.

The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients.

What will we do to achieve this?

- Leverage Thames Hospital theatre and bed capacity
- Rationalise outsourced contracts
- Consolidate outsourced contracts
- Implement Non-acute service management structure
- Implement elective surgical short stay ward model of care
- Re-organise and develop bed footprint at Waikato hospital to maximise use of facility
- Increasing out of hours use of theatre

[37] Health of the Nation Outcome Scales

Output Performance Measure	Baseline	Target 2010/11
To increase the number of government funded elective surgical discharges in for Waikato DHB domiciled patients	Government funded elective surgical discharges in for Waikato DHB domiciled patients planned to be 11,732 in 2009/10	Volume of government funded elective surgical discharges in for Waikato DHB domiciled patients is 12,285

Shorter waits in emergency department[38]

Rationale for inclusion

Emergency Department (ED) length of stay is an important measure of service quality in DHBs, because:

- EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients
- long stays in emergency departments are linked to overcrowding of the ED
- the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.

What are we seeking to achieve?

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

What will we do to achieve this?

- Implement ED 6 hour target operational improvement project, initiatives include:
  - Establishment of the ED short stay facility (an 8 bedded facility replacing the old observation unit)
  - Implementation of a bed manager based in ED (new bed management policy also implemented at the same time)
  - Working with the Radiology Department about timeliness to CT's and ultrasound.
  - Working with the attendant service to look at extra attendant resource in the evening.
  - Reporting of the 6 hr target breeches and visibility of the LOS screen throughout the hospital (coupled with education around this)
  - Working with specialities to identify any potential improvements from breeches
  - Development of standard operating procedures
  - Social worker resource for the department
- Internal communications campaign (we are all in this together)
- Implement capacity and patient flow management initiatives
- To increase ED footprint from 1,888m² to 4,200m²
- To implement 101 Acute Beds Project

Output Performance Measure	Baseline[39]	Target 2010/11
95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	67%	95%

[38] National definition of this target covers Waikato Hospital and Thames Hospital Emergency Departments only
[39] As at September 2009

Shorter waits for cancer treatment

Rationale for inclusion

Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is, however, restricted by the lack of routinely collected information on common treatment. In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients. This is justifiable, because radiotherapy is of proven effectiveness in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes of treatment.

What are we seeking to achieve?

Everyone needing radiation treatment will have it within four weeks of first specialist assessment by December 2010.

What will we do to achieve this?

- Meet the 4 week target before December 2010 by reviewing all processes and implementing changes agreed by clinical staff
- Replacement of linear accelerator unit
- Implement recommendations from the Midland lung cancer service and patient mapping recommendations within available resources
- Complete service and patient mapping of colorectal cancer and implement service improvements within available resources:
- Continue to focus on improving colonoscopy capacity and capability
- Work with the national bowel cancer team

Output Performance Measure	Baseline[40]	Target 2010/11
Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	100%	100%

Better help for smokers to quit

Rationale for inclusion

Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

Including this measure and target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

What are we seeking to achieve?

90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011 (and 95 percent by July 2012)

[40] As at September 2009

What will we do to achieve this?

- Staff education on the need to provide advice and help to quit to hospitalised smokers and patients who attend primary care and are smokers
- Job descriptions of clinical nurse and midwifery managers to include specific key performance indicators around the health target indicator for hospitalised smokers
- Implementation of PHO plans for cessation activities in primary care settings
- Engage with primary care sector regarding systems to capture primary health section of this target
- Learnings from work to increase the number of hospitalised smokers offered advice and help to quit is shared with primary care as appropriate
- Implement smoking status recording indicator as part of the Waikato DHB PHO quality indicator programme
- Health TV advertisements at Waikato and Thames Hospitals

Output Performance Measure	Baseline[41]	Target 2010/11
Hospitalised smokers provided with advice and help to quit by July 2011	39%	90%

Inpatient Average Length of Stay[42]

Rationale for inclusion

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

It should be noted that situations are conceivable where improvements to services could lengthen inpatient average length of stay (ALOS). In particular, treating increasing numbers of patients as day cases or outpatients, or moving less complex services into primary care setting, will raise the complexity of hospital casemix and could legitimately raise inpatient ALOS. For this reason, it is important to consider ALOS in conjunction with other measures of hospital (and system) performance, such as day surgery rates.

One complication for measurement of ALOS is that current government policy is for greater lengths of stay for new mothers after delivery. For this reason, maternity patients are excluded from the main measure, but ALOS for maternity admissions is nevertheless calculated as a subsidiary measure for information only.

The measure described here is for standardised ALOS. That is, the ALOS of each DHB is adjusted to account for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector.

What are we seeking to achieve?

- to reduce average length of stay for elective and arranged inpatients.

[41] As at September 2009
[42] Average length of stay is a widely accepted measure of hospital throughput and productivity

- to reduce average length of stay for acute inpatients

What will we do to achieve this?

- implement non-acute service management structure using centralisation, simplification and standardisation principles (impacts elective and arranged inpatients ALOS)
- monitor all non-acute service improvement initiatives (impacts elective and arranged inpatients ALOS)
- implement capacity and patient flow management initiatives (impacts acute inpatients ALOS)
- implement surgical and procedure operational management improvement initiatives (impacts acute inpatients ALOS)

Impact Performance Measure	Baseline[43]	Target 2010/11
To reduce elective and arranged inpatient length of stay	4.66 days	4.1 days
To reduce acute inpatients length of stay	4.60 days	4.3 days

Improved health status for people discharged from mental health inpatient services[44]

Rationale for inclusion

The Health of the Nation Outcome Scales (HoNOS) is a set of scales used to measure changes in mental health. The HoNOS is completed when a person is admitted to the inpatient unit and than again at the time of discharge. A decreased HoNOS on discharge means that treatment provided during admission has resulted in an improvement in mental health.

What are we seeking to achieve?

Improved HoNOS scores for people discharged from mental health inpatient services

What will we do to achieve this?

- train staff
- develop monthly reporting template
- 50% of people discharged from mental health inpatient services have completed HoNOS pairs (i.e. admission and discharge) by December 2010
- 80% of people discharged from mental health inpatient services have completed HoNOS pairs (i.e. admission and discharge) by July 2011

Impact Performance Measure	Baseline	Target 2010/11[45]
Improved HoNOS scores for people discharged from mental health inpatient services	New measure	80% of people with HoNOS admission and discharged scores show at least a 50% decrease in score on discharge

5.6.2 Medium Term Intentions

The medium term focus in relation to hospital services will be:

- hospital productivity
- patient safety
- elective surgery volumes
- workforce and organisational development

[43] As at 2008/09
[44] Applies to Health Waikato services only
[45] To be reported 6 monthly (December 2010 and July 2011)

In terms of the measures outlined in this section we will:

- Continue to increase elective surgery volumes
- Meet the national target of 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
- Meet the national target of everyone needing radiation treatment will have this and within four weeks
- Hospital staff routinely asking about smoking status and offering brief advice about quitting to smokers
- Reduce inpatient average length of stay
- Continue improving our the health status of mental health and addiction service users

Prior to the commencement of each year significant analysis and discussion is undertaken to set appropriate targets.

5.7 Statement of Forecast Service Performance for Support Services

Waikato DHB aims to have a fully inclusive community, where people are supported to live with independence and can participate in their communities.

5.7.1 Health of Older People

Waikato Integrated Services for the Elderly (AgeWISE), strategy was developed in 2001 in order to address the needs of older people in the Waikato DHB district. AgeWISE is the vehicle used by the Waikato DHB for the delivery against the Government's Health of Older People Strategy. AgeWISE was developed to be predominately community orientated with a focus on health rather than illness to promote independence in ageing.

AgeWISE is a 10-year strategy which aims to effectively co-ordinate services for all older people in a sustainable way. The AgeWISE network is the 'vehicle' for service development, education, workforce development, training, and projects and best practice to occur. Key elements of the integrated approach are:

- services are older person focused
- the wellness model is promoted
- services are co-ordinated and responsive to needs
- family, whānau and carer needs are also considered, where appropriate
- there is information sharing and a smooth transition between services
- planning and funding arrangements support integration

Within Health Waikato the Older Person's Model of Care provides the framework for the integration of services to older people as part of our Building Programme.

Phase 1 of the AgeWISE strategy has been completed and now Waikato DHB implementing Phase 2 of the strategy. Phase 1 concentrated on establishing key district wide relationships, re-engineering referral processes and addressing gaps in the primary / secondary interface. Phase 2 of the strategy involves developing and implementing longer-term goals that achieve health improvements and innovative care within the community and primary sector.

5.7.2 Other Support Services

The services provided for people with disabilities are designed around the New Zealand Disability Strategy. Waikato DHB aims to have a fully inclusive community, where people with disabilities can live in a society that highly values them and continually enhances their full participation.

5.7.3 Palliative Care

As the Waikato DHB population grows and ages, with an increasing incidence of cancer and growth in chronic life-threatening diseases, there will be increasing demands on the health system. Palliative care services tend to be associated with the needs of people with cancer. Large proportions of the population, however, have chronic illnesses, which over significant periods of time may include symptoms requiring palliative care. The number of referrals to palliative care for non-malignant conditions is increasing. Delivering palliative care services is a challenge in the Waikato as Waikato DHB spans a large geographical area and encompasses a diverse mix of rural, remote and urban areas.

The Waikato DHB palliative care goal is to ensure that all providers of palliative care in the Waikato DHB work together with the community to ensure that the New Zealand Palliative Care Strategy is implemented in the most optimal way for the Waikato district. This is to ensure that all people with palliative care needs and their family / whānau have access to essential palliative care services, provided in a co-ordinated and culturally appropriate way.

5.7.1 Key Measures for Support Services Output Class

The key support services measures and targets selected for inclusion in the SOI are:

- home based support services
- aged residential care paid bed days[46]
- short-term respite care packages for older people

Support services intervention logic

If we invest in	And undertake	Then we produce	Then we will achieve	And contribute to
→	→	→	→	
Support services	Home based support	A number of hours of home based support	Older people able to live in their own home longer	**Improved health status**
	Aged residential care	A number of aged residential care - paid bed pays	Older get services to match their needs	**Reduced inequalities**
	Vitamin D supplementation for residents of DHB funded aged residential care	Implementation of vitamin D supplementation service	Increase in the number of residents on high dose vitamin D supplementation Reduction in the number of falls by aged residential care residents Prevention of unnecessary admissions to hospital	

Home based support services

Rationale for inclusion

Home support services give older people the ability to make choices in later life about where they want to live, and to receive the support to do so.

This will enable Waikato DHB contribute to the vision of "Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes", which is presented in the Health of Older Peoples Strategy[47] (2002).

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[46] Based on Waikato DHB paid long-term care bed days. Does not include private payers or other services provided by short-term programmes

[47] Ministry of Health

What are we seeking to achieve?
To enable older to people to live in their own home for longer

What will we do to achieve this?
Waikato DHB will continue to fund services that enable older people to be supported to live in their own homes.

Output Performance Measure	Baseline	Target 2010/11
Number of home support service hours funded	227,620 hours funded over the 2009 calendar year	Maintain at least 227,620 hours of home based support funded

Aged residential care paid bed days

Rationale for inclusion
The Waikato DHB population is ageing and there is projected to be significant increases in the population aged 65 and over and the population aged 85 and over. It will be important to ensure the ongoing development of health services and systems to meet the anticipated health needs caused by this projected population growth. Residential care is a part of the continuum of care for older people.

Residential care includes the following types of long-term care provided in a rest home or hospital:

- rest home care
- continuing care (hospital)
- dementia care
- specialised hospital care (psychogeriatric care)

Short-term respite care and convalescent care may be provided in these facilities, but do not involve income and asset testing. Long-term residential care does not include independent living in a retirement village.

What are we seeking to achieve?
To ensure that there are sufficient contracted care beds available to people assessed as requiring long-term residential care.

What will we do to achieve this?
Waikato DHB is responsible for funding residential care services for older people under the Social Security Act 1964. We have a contracts with rest homes or hospital owners ("providers") to provide long - term residential care ("contracted care services") to residents who are eligible for government funding through the residential care subsidy.

Only rest homes or hospitals that have achieved Certification under the Health and Disability Services (Safety) Act 2001 and comply with the Health and Disability Sector Standards 2001 can have a contract with DHBs.

Output Performance Measure	Baseline	Target 2010/11
Number of aged residential care – paid bed days provided	Rest home care • 15,144 bed days Continuing care (hospital) • 217,956 bed days Dementia care • 73,531 bed days	Maintain at least the following number of aged residential care – paid bed days provided: Rest home care • 15,144 bed days Continuing care (hospital) • 217,956 bed days Dementia care • 73,531 bed days

	Psychogeriatric care • 351,542 bed days Total • 658,173 bed days (for the 2009 calendar year)	Psychogeriatric care • 351,542 bed days Total • 658,173 bed days

Vitamin D supplementation for residents of DHB funded aged residential care

Rationale for inclusion

People aged over 65 have low serum levels of Vitamin D. This is associated with loss of muscle strength / mass and hip, fractures. Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce the risks of falls. Approximately one-third of people aged over 65 years fall each year. These falls can result in considerable poor health. Of those people that fall:

- 22 - 60% suffer injuries
- 10 – 15% suffer serious injuries
- 2 - 5% suffer fractures
- 0.2 – 5 % suffer hip fractures

Vitamin D supplementation is a low cost and effective treatment to reduce falls which are common in older people and cause considerable morbidity. Use of vitamin D supplements for residents of aged residential care may reduce falls and consequential impacts on both the resident and the health system (i.e. reduction in mobility and admission to hospital).

Falls resulting in fractures are more common in aged residential care and hospital, with about 10 – 20% leading to fracture

What are we seeking to achieve?

- increase in the number of residents on high dose vitamin D supplementation
- reduction in the number of falls by aged residential care residents
- prevention of unnecessary admissions to hospital

What will we do to achieve this?

Implementation of vitamin D supplementation service in conjunction with Accident Compensation Corporation (ACC).

Output Performance Measure	Baseline	Target 2010/11
Increase in the number of residents on high dose vitamin D supplementation	23% of aged residential care residents in the Waikato DHB district are on vitamin D supplementation	75% of aged residential care residents in the Waikato DHB district prescribed vitamin D supplements

5.7.2 Medium Term Intentions

The medium term focus in relation to support services will be:

- services are older person focused
- the wellness model is promoted
- services are co-ordinated and responsive to needs
- family, whānau and carer needs are also considered, where appropriate
- there is information sharing and a smooth transition between services
- planning and funding arrangements support integration

In terms of the measures outlined in this section we will:

- continue to monitor home based support service hours provided
- continue to monitor aged residential care – paid bed days

- continue to monitor uptake of short-term respite care packages for older people
- continue to monitor vitamin D supplementation service with the expectation that we see a decrease in the percentage of people in aged residential care admitted to Waikato Hospital for fractures as the result of falls[48]

Prior to the commencement of each year significant analysis and discussion is undertaken to set appropriate targets.

[48] Evidence suggests that supplementing older adults in residential care with Vitamin D reduces the risk of falling by approximately 28% and subsequently reduces the risk of fracture and hospital admission

6.0 MANAGING IN A CHANGEABLE OPERATING ENVIRONMENT

The environment we face has changed significantly in recent times and is continuing to do so. Our success over the next few years will depend on our ability to adapt to the changing circumstances and continue to improve the health status of our communities and reduce inequalities in health.

Outlined below are some key changes that will have impacts in 2010/11.

6.1 Better, sooner, more convenient primary care

Both Waikato DHB and the primary health organisations (PHOs) across the district are committed to working together to progress the goal of better, sooner, more convenient primary care.

We have worked (and will continue to work) with PHOs and have implemented initiatives[49] to reduce barriers to access for patients.

We have participated in the development of two primary care business cases:

1. Midland Network
2. National Māori PHO Coalition

Lakes, Tairawhiti, Taranaki and Waikato DHBs have worked collectively with the Midland Network and the National Māori PHO Coalition to ensure that the 'increased immunisation' and 'better help for smokers to quit' national health targets are accorded priority in their respective primary care business cases.

No specific agreement regarding extended after hours and nurse-walk in clinics for integrated family health clinics (IFHCs) and Whānau Ora centres have been reached with either primary care partner at this stage, but we anticipate that as part of agreeing to implementation of both business cases, that these two components would be core to an alliance arrangement. This will be negotiated on a case-by-case basis as each rollout of an IFHC or Whānau Ora Centre occurs.

6.1.2 Midland Network

Four Midland DHBs[50] have been involved in the Midland Network Expression of Interest (EoI) for Better, Sooner, More Convenient Primary Care. The DHBs are working with the Midland Network towards agreed strategic and operational governance arrangements, including the establishment of governance arrangements for the Commissioning Board and Clinical Governance Groups.

The following clinical service areas have been discussed with the Midland Network and are all deemed as being able to contribute to better, sooner, more convenient health care for patients:

- Primary referred radiology[51] - patients will be able to access free CTUs (Cat scans for kidney stones) directly on referral from their general practitioners

[49] For example DVT

[50] Lakes DHB, Tairawhiti DHB, Taranaki DHB and Waikato DHB

[51] Clear consistent regional access will need to be agreed between primary care the DHBs

(GPs), where otherwise they would be referred for first specialist assessment and then CT. For Waikato DHB access to general radiology will also be increased, with funding to be available for approximately 2400 additional primary referred radiology investigations, at a cost of $0.4 million, which represents a funding increase of about 10%

- Primary referred neurology diagnostics - we propose to make direct access to EEGs (electroencephalograms) and EMGs (Electromyographs) tests available on GP referral according to agreed criteria
- Teledermatology (for diagnosis of lesions including melanoma) - will be provided by dermatologists reviewing a high quality digital image rather than patients seeing a dermatologist face to face at an outpatient clinic. The image will be recorded at a facility in Hamilton City rather than requiring attendance at Waikato hospital. If this approach is found to be successful it could be extended with images being recorded at other locations across the district. Waiting times will be shorter and less specialist time is needed in the model so around twice as many patients can be seen as the price per event is lower
- Co-locations of district nursing within IFHC - two district nurses will work from Northcare from 1 July 2010 and one from the IFHC in Whitianga (when built). Basic principles will mean shared patient notes (access to Medtech for district nurses), agreed referral criteria and business processes. Reconfiguring the roles of primary care nurses (practices nurses and district nurses) will ensure patients get one point of access through general practice and get the most appropriate nurse for the job. The transition to this model is already supported by nurses and general practitioners as well as Waikato PHO and Health Waikato, community services. It has been consulted fully in Te Kuiti and Raglan as part of pilots for those areas. A further pilot is also to be commenced shortly for South Waikato.
- Waikato DHB will provide six months (July 2010 – December 2010) worth of upfront funding to enable an improvement in coverage for the two year old immunisation target, the diabetes annual review target. The same process will be used to enable an improvement in coverage for influenza vaccinations for over 65 year olds.
- Outpatients - up to 1000 follow-up appointments with hospital specialists will be transferred to primary care. Waikato DHB will fund the patient co-payment for these appointments to ensure that there will be no cost to patients for these appointments.

6.1.3 National Māori PHO Coalition

Three Midland DHBs[52] are part of National Māori PHO Coalition EoI business case. At a high level, the DHBs are prepared to give high level qualified support for some components of the EoI business cases. This is subject to Board approval. None of the work received to date encompasses specific improvement targets, costings and financial analysis, timing and implementation considerations, and in most cases, further work is required to distil the various components of what is being proposed in each of the individual DHB areas. All of these elements are essential elements to make an informed decision. We commit to keep working with the Coalition to narrow down what the components of each of the business cases are and then work on them collectively. We will work towards agreed strategic and operational governance arrangements.

[52] Tairawhiti DHB, Taranaki DHB and Waikato DHB

Conversations have not as yet begun with respect to DHB governance arrangements with the Maori coalition.

6.1.4 Primary Health Organisation (PHO) Reconfiguration Plans

PHO reconfiguration plans are due to Waikato DHB on the 30 June 2010. High level summary information on progress relating to our four PHOs is outlined below:

1. Waikato Primary Health – looking to merge with three other PHOs across the Midland region to create a regional organisation called the Midland Network, with a membership of approximately 463,000
2. At this stage the three[53] other PHOs in the Waikato DHB district have not flagged any specific intentions to merge. One of these PHOs[54] is part of the National Maori PHO Coalition business case process

6.2 Service Changes

We will be engaging in four significant areas of work in 2010/11 which may result in service changes. Any service change will be undertaken within the requirements in the Service Coverage Schedule (SCS) and the Operational Policy Framework (OPF).

For each identified service change Waikato DHB may need to:

- provide evidence of the benefits the change will deliver
- signal whether the change is directly linked to delivery within a lower future funding path
- identify if the change is associated with regional clinical services planning

The four areas of work are:

1. Long term workforce issues particularly in rural areas of Waikato DHB are impacting on clinical sustainability. Where services appear to be compromised through workforce issues we have options to reduce local service provision and resourced bed numbers at our rural hospitals to better match occupancy and clinical workforce availability.
2. Our primary birthing services on the Rhoda Read (Morrinsville) and Matariki (Te Awamutu) sites require review. The review will assess clinical safety and sustainability as well as cost effectiveness
3. During 2010/11 services of low clinical value will be identified within Health Waikato with a view to stopping or changing them.
4. Provision of better, sooner more convenient primary care

6.3 Managing Risk

Waikato DHBs approach to risk management divides the risks into 5 categories:

- patient safety
- operational
- financial
- reputation
- workforce safety

The approach utilises a risk assessment tool which examines consequence, control evaluation, risk exposure, likelihood and residual risk.

[53] North Waikato PHO, Toiora PHO Coalition and Hauraki PHO
[54] Toiora PHO Coalition

Waikato DHB produces an annual Risk Plan, which is an integral component of the District Annual Plan and meets the Ministry of Health's risk management requirements, reporting requirements and certification standards.

7.0 ORGANISATIONAL HEALTH AND CAPABILITY

In this section capability refers to the resources Waikato DHB needs to efficiently deliver the outputs required to achieve our planned activities and contribute to the Governments desire for better, sooner, more convenient health care for all New Zealanders. These resources include access to leadership, people, culture, relationships, processes and technology, physical assets and structures.

7.1 Financial Management

Like other DHBs, Waikato DHB has to operate in financially responsible manner and we have a variety of demands on how we prioritise our spending. We are committed to delivering value for money as part of our ongoing activities.

We are planning an overall surplus of $8 million in 2010/11, with surpluses of $4 million and $2 million in 2011/12 and 2012/13 respectively. This is consistent with our long term financial model, which tracks the financial performance required to achieve the DHB's long term capital intentions.

One of the impacts of the global financial situation is a significantly lower rate in the growth of national funding for the public health sector. While there will be lower funding increase than the health sector is used to, our Government base funding for 2010/11 is $971.7 million (an increase of 4.2%), which is above the national average (3.61%) and is the equal third highest percentage increase received by any DHB.

It is evident additional constraint and productivity gains must be attained in order to enable our long term plans. As part of this all services across the DHB will need to reduce the overall rate of cost increase and make savings in 2010/11 of $12.9 million.

7.2 Workforce

The central part of our capability is our people. Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located.

Waikato DHB has a responsibility to view the health workforce in its entirety – including the primary and private sector – because all contribute to the health and well-being of the Waikato DHB population. For this reason, Waikato DHB has led the development of a sector wide workforce plan. As the largest health employer in the Waikato, the DHB has a role to find ways of sharing its capability with others in the sector.

Waikato DHB employs almost 6,000 people[55] (includes full-time and part-time staff) across a range of activities and at a number of different sites. The following table shows Waikato DHB full time equivalents by staff types by ethnicity as at December 2009.

[55] Total full time equivalents as at 22 December 2009 was 4838.8

Ethnic Group	Medical	Nursing	Allied & Technical	Support[56]	Management & Administration
Māori	1	125	61	32	70
NZ European / Māori	15	87	35	26	54
Other	570.43	1791.26	716.97	233.63	844.51
Not identified	33	57	14	5	31
Total	619.43	2060.26	826.97	296.63	999.51

For the July – September 2009 quarter, Waikato DHBs staff turnover rate[57] was 2.35. The average rate across all 21 DHBs for the quarter was 2.41. When compared against the six other 'large[58]' DHBs our turnover rate is the fifth highest.

In terms of workplace illnesses or injuries[59] for the July – September 2009 quarter, Waikato DHBs rate was 2.74. The average across all 21 DHBs was 8.03. When compared against the six other 'large' DHBs our workplace illness or injury rate was the lowest.

As outlined in our District Annual Plan for the 2010/11 year, our key workforce priorities are:

- Clinical leadership – Waikato DHB is improving clinical leadership along the lines set out in "In Good Hands" . This improvement is based on ensuring that the roles of clinicians in leadership are both clear and meaningful. We will be implementing a new management structure within Waikato Hospital that builds capacity and performance and which supports clinicians in the management of their services. Examples of clinical leadership initiatives which will continue during 2010/11 include:
  - Board of Clinical Governance
  - Chief Medical Advisor regular Board slot
  - Regular clinical presentations to the Health Waikato Advisory Committee
  - Establishment of Clinical Practice Improvement Structures and Activities as part of a Waikato DHB Clinical Governance Framework' project
  - Clinical Reference Group (participating in the development of a Midland Region Clinical Services Plan)
  - Participation in the Waikato DHB building and relating process redevelopment
  - Clinical Advisory Group participation in development of the mental health and addictions funding plan (the role of this group may change in 2010/11 to enable a wider scope to aid in development of phase 2 of this work)
- Run a staff engagement survey using a nationally agreed provider
- Producing short to medium term workforce models and staffing plans for each area
- Complete initiatives in the workforce plans that focus on productivity and workforce flexibility
- Standardise workplace practises including increasing use of electronic workflow solutions as well as process improvement.
- Strengthen the links between leadership development initiatives and active demonstration of leadership potential

[56] Includes job types like orderlies, kitchen hands
[57] Staff turnover rate measures resignations during the quarter as a percentage of total workforce headcount
[58] Auckland, Canterbury, Capital & Coast, Counties Manukau, Otago, Waikato, Waitemata
[59] Measured by the number of work-related illnesses or injuries leading to time off, per one million hours worked by hospital employees

- Focus on recruitment and attraction initiatives

7.2.1 Good Employer obligations

As a good employer, Waikato DHB is committed to the fair and proper treatment of employees in all aspects of their employment including:

- good and safe working conditions
- an equal employment opportunities programme
- the impartial selection of suitably qualified people
- and recognition of:
  - the aims and aspirations of Māori
  - the employment requirements of Māori
  - the need for involvement of Māori as employees
  - opportunities to enhance the abilities of individual employees
  - the aims, aspirations, employment requirements and cultural differences of ethnic and minority groups
  - employment requirements of women
  - employment requirements of people with disabilities

7.3 Technology

We will continue making a strong level of investment in information systems. This addresses the need to replace legacy systems that do not meet the demands of the new health care environment, and support service and campus redevelopment on the Waikato Hospital campus.

Some initiatives planned are at a regional level, meeting requirements from several regional plans; others are directed at primary-secondary services interactions. Each major project is subject to finalisation through its own business case process.

In addition to work that is part of the DHB's capital plan, we undertake many changes to systems and processes every year to keep operational systems up to date and respond to business changes. The level of such change in 2010/11 will have to be lower than last year to achieve the major projects planned for this year.

Our 'must do' information communications technology projects from our Information Systems Strategic Plan (ISSP) planned for 2010/11 are:

- Laboratory System Replacement implementation
- Pharmacy Systems Planning, Scoping and Analysis
- Integrated Oral Health Information System
- Midland Connected Health implementation
- Waikato and Regional Clinical Systems Planning studies
- Unified Communications Implementation
- Regional Chronic Care Management Information System (CCM-IS)
- Acute Services Management
- Supply Chain/ procurement
- Enterprise Reporting Phase 3
- IS Security Strengthening
- Disaster Recovery Planning
- Inter-RAI
- Patient Information data quality improvements
- Corporate Records / Public Records Act implementation

We are prepared to take a regional and /or national role in ICT developments in co-operation with the Midland DHBs, the National Health Board, and Shared Services Establishment Board.

7.3.1 Improving our services through the technology

In 2010/11 we will also undertake a major project to upgrade or replace the voice services platforms. This will involve modernisation to digital equipment, rationalisation of technology deployment and service delivery, and the provision of some new services such as texting of appointment reminders. Work undertaken in this financial year will provide the platform for a call centre initiative in 2011/12.

7.4 Property / Physical Assets

The building and related process redevelopment at the Waikato Hospital campus is a major undertaking with "plans" over the next 15 years or more to complete a rebuild of the campus. These "plans" entail a capital investment of over $500 million. Provision has been made for rural facilities but no investment will occur until a long-term sustainable model for delivering services is agreed.

Form will follow function as more important than the physical build is how we will work in the new buildings. The physical build will allow for growth (although there are no plans to increase bed numbers). The 2010/11 year will be quieter from a planning, design and approval perspective but will be busier from a construction perspective.

Four buildings under construction:

1. a new 4200m² Emergency Department – scheduled for opening February 2011
2. four wards (101 beds in total) being constructed over the Emergency Department – known as Acute Services, scheduled for opening the third quarter of 2011.
3. Waikato Clinical Centre (day surgery, radiology, outpatients, operating and interventional suites) has commenced. These facilities are due to be commissioned in two stages – mid 2012 and early 2013.
4. a new 34 bed Intensive Care: High Dependency Unit – scheduled for commissioning first quarter 2013.

Two further projects are awaiting Ministry of Health approval and if approved will be initiated by September 2010.

- A new 113 bed rehabilitation hub, incorporating the clinical services of
  - over 65 years assessment treatment and rehabilitation
  - psycho-geriatric
  - stroke unit
  - general rehabilitation over 65 years
- 200 vehicle carpark in Pembroke Street

Other Waikato Hospital campus projects either in design or construction phases are

- forensic mental health – upgrading of inpatient facilities - due for completion third quarter of 2010
- upgrading of pathology laboratory – design being completed and construction start is currently programmed for the beginning of the 4th quarter of 2010

- refurbishment of a building to accommodate all renal ambulatory services – design being completed.

Development of the Toward2020 business case is currently underway and will deliver the framework for campus redevelopment beyond that already approved. The business case is due in September 2010. It will incorporate new ward blocks, replacing the existing Menzies Building and the relocation of services remaining in old buildings such as pharmacy and kitchens. Clinical staff as business owners work alongside the dedicated project managers.

Significant work has been undertaken to improve the oral health of children within our district. This has involved the development of an oral health business case which outlined a change in service delivery including the building of a number of new dental clinics and an increase in the mobile clinic fleet (over a number of years). There is a total capital investment of $9.75 million to fund this work.

7.5 Collaboration

Waikato DHB participates in a large number of national, regional and local collaborative and co-operative initiatives. Waikato DHB continues to take a lead role in promoting and participating in both intrasectoral and intersectoral collaborations. It is important to recognise that this activity is an evolving and changing landscape with new activities being added and activities being removed once completed. Waikato DHB is committed to collaboration with the Ministry, National Health Board (NHB), District Health Board New Zealand (DHBNZ), primary health organisations, non-government organisations, government agencies, local government and other service providers in order to achieve specific outcomes.

For Waikato DHB collaboration reflects the fact that working together with other groups on targeted areas often brings better outcomes than those groups working in isolation in the same area. A number of the health determinants are outside the direct control of the health sector and therefore, it is prudent for Waikato DHB to work with intersectoral agencies in the district. This can take many forms including advice, advocacy, and information provision.

7.5.1 National

We are fully supportive of the national savings work across the sector and are committed to participating in initiatives as appropriate. We encourage the National Health Board and shared service agency to take a firm approach in driving efficiency and effectiveness gains through its' activities. During 2010/11 we will work with all DHBs and agencies on:

- national service location
- high cost treatment
- low clinical value services
- procurement
- support services

7.5.2 Regional

We are part of the Midland DHB region which is:

- Bay of Plenty DHB
- Lakes DHB
- Tairawhiti DHB
- Taranaki DHB

- Waikato DHB

The Midland DHBs will be progressing a number of initiatives during 2010/11 including[60]:

- Completion of a Midland Region Clinical Services Plan (inclusive of a regional electives plan)
- Midland Regional Trauma System in place and building functional capacity
- A single nursing clinical procedure manual across the Midland DHBs
- Midland Regional Mental Health Network
- HealthShare
- Midland Cancer Network
- Midland Renal Network
- Midland Chronic Care and Disease Management Project
- Midland chronic care and disease management information system programme
- Midland service plan implementation
- Considering a business case for a Midland Region connected health network

7.5.3 Intersectoral Collaboration

There are many examples of Waikato DHB working with organisations outside the 'traditional health sector'. Examples include:

- Vibrant Living Project
- Project Energize
- Long-term Community Council Plans
- Hamilton City Social Well-being Strategy
- Strengthening Families
- Accident Compensation Corporation and DHB relationship

Waikato DHB recognises it is not able to achieve the objectives of improving health and reducing inequalities on its own. So we work with other agencies (for example Ministry of Education, 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.

The aims of this collaboration include:

- keeping people well
- assist those people who are not currently accessing health services and need to be using health services, to be proactively using the health system

7.6 Hospital Productivity

We are facing a lower funding growth path, therefore we will need to raise productivity (especially hospital productivity) and look at how we can provide more for each dollar spent.

Health Waikato has developed a set of targets[61] to increase productivity. These relate to standardisation of processes but require a specific focus on:

- improving theatre productivity

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[60] Further information is available on http://www.waikatodhb.govt.nz/page/pageid/2145849563/Midland_Regional_Services

[61] Outlined in our District Annual Plan (average length of stay target is included in the Statement of Service Performance)

- improving day surgery rates
- reducing did not attends
- reducing acute readmission rates
- reducing average length of stay

The key measure of productivity is case weight discharges (CWD) / accrued full time equivalents (FTEs). Our productivity measure for 2010/11 is planned to be 21.2 CWDs /accrued FTEs (comparable figures for 2009/10 and 2008/09 are 20.8[62] and 19.4).

[62] Adjusted to include growth in mental health and addictions and oral health

8.0 FINANCIAL PERFORMANCE

8.1 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.

Waikato DHB is a Public Benefit Entity, as defined under New Zealand International Accounting Standard (NZIAS) 1.

The consolidated financial statements of Waikato DHB group for the year ended 30 June 2010 comprise Waikato DHB parent (referred to as "Waikato DHB") and Waikato DHB group's interest in associate (Urology Services Limited) and jointly controlled entity (HealthShare Limited).

The Waikato Health Trust, which has been deemed a member of the group under an interpretation of FRS37, has not been consolidated on the basis of materiality. The Trustees act independently in accordance with their fiduciary duties and trust law.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Waikato DHB's activities are the purchasing and the delivering of health and disability services and mental health services in a variety of ways to the community.

8.2 Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for Public Benefit Entities.

8.3 Basis of preparation

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), land and buildings and investment property.

The preparation of financial statements under NZIFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and 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 25.

8.4 Basis for consolidation

8.4.1 Associates

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

The consolidated 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.

8.4.2 Joint ventures

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

8.4.3 Transactions eliminated on consolidation

Intragroup balances, any unrealised gains and losses, and income and expenses arising from intragroup transactions are eliminated in preparing the consolidated financial statements. 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.

8.5 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 financial performance.

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 foreign exchange rates ruling at the dates the fair value was determined.

8.6 Budget figures

The budget figures are those approved in the District Annual Plan and included in the Statement of Intent tabled in Parliament. 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.

8.7 Financial instruments

8.7.1 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 statement of financial performance 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 are 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.

8.7.2 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 financial performance. 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.

8.7.3 Instruments at fair value through statement of financial performance

An instrument is measured as at fair value through statement of financial performance if it is held for trading or is designated as such upon initial recognition. Instruments are measured at fair value through statement of financial performance if the Waikato DHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in the statement of financial performance when incurred. Subsequent to initial recognition, financial instruments at fair value through statement of financial performance are measured at fair value, and changes therein are recognised in profit or loss.

8.7.4 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.

8.7.5 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.

8.7.6 Trade and other payables

Trade and other payables are stated at amortised cost using the effective interest rate.

8.8 Hedging

8.8.1 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 non-financial 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 a financial liability, the associated gains and losses that were recognised directly in equity are reclassified into the statement of financial performance in the same period or periods during which the asset acquired or liability assumed affects the statement of financial performance (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 financial performance in the same period or periods during which the hedged forecast transaction affects the statement of financial performance. The ineffective part of any gain or loss is recognised immediately in the statement of financial performance.

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 financial performance.

8.8.2 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 financial performance.

8.9 Property, plant and equipment

8.9.1 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.

8.9.2 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, where relevant, the 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 amount is 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 financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.

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.

8.9.3 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 parent 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.

8.9.4 Disposal of Property, Plant and Equipment

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

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

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

8.9.5 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.

8.9.6 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 financial performance as an expense incurred.

8.9.7 Depreciation

Depreciation is charged to the statement of financial performance 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.

8.10 Intangible assets

8.10.1 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 financial performance 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 financial performance as an expense incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

8.10.2 Other intangibles

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

8.10.3 Subsequent expenditure

Subsequent expenditure 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 expensed as incurred.

8.10.4 Amortisation

Amortisation is charged to the statement of financial performance 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	2 to 3 years	33 – 50%

8.11 Investments properties

Investment properties are properties held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. An external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, values the portfolio every 12 months. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the statement of financial performance. Rental income from investment property is accounted for as described in the accounting policy on rental income (see below).

When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the statement of financial performance.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When Waikato DHB begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

A property interest under an operating lease is classified and accounted for as an investment property on a property-by-property basis when held to earn rentals or for capital appreciation or both. Any such property interest under an operating lease classified as an investment property is carried at fair value. Lease payments are accounted for as described in the accounting policy on operating lease payments and finance lease payments (see below).

8.11.1 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.

8.11.2 Inventories held for distribution

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

8.12 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 financial performance.

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 financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance 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 financial performance.

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.

8.12.1 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.

8.12.2 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 financial performance.

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.

8.13 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 financial performance over the period of the borrowings on an effective interest basis.

8.14 Employee benefits

8.14.1 Defined contribution plans

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

8.14.2 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 plan 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.

When the benefits of a plan are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of financial performance on a straight-line basis over the average period until the benefits become vested. To the extent that the benefits vest immediately, the expense is recognised immediately in the statement of financial performance.

All actuarial gains and losses as at 1 July 2006, the date of transition to NZIFRSs, were recognised. Likewise, all actuarial gains and losses that arise subsequent to the transition date in calculating the obligation in respect of a plan are recognised in the statement of financial performance.

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.

8.14.3 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.

8.14.4 Annual leave, conference leave, sick leave and 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 both relates to employees' past services and it accumulates.

8.15 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.

8.16 Income tax

Waikato DHB is exempt from income tax under section CB3 of the Income Tax Act 1994.

8.17 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.

8.18 Revenue

8.18.1 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 appropriation equally throughout the year.

8.18.2 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 the MOH, may be required to expend it on specific services in subsequent years.

8.18.3 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.

8.18.4 Rental income

Rental income from investment property is recognised in the statement of financial performance 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.

8.19 Expenses

8.19.1 Operating lease payments

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

8.19.2 Finance lease payments

Minimum 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 financial performance using the effective interest rate method.

8.19.3 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 financial performance.

8.19.4 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 financial performance, 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.

8.20 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.

8.21 Capital Expenditure

New capital expenditure projects budgeted for the three-year planning period is as follows:

Table: New capital expenditure

New Capital Expenditure	2010/11 $M	2011/12 $M	2012/13 $M
Under $20,000	2	2	2
Over $20,000 (excluding campus reconfiguration)	25	16	29
Campus Redevelopment	119	85	63
Contingency	1	1	1
Total Capital Expenditure	147	104	95

The new capital expenditure plans includes projects totalling $52.9 million covering the financial years 2010-11 to 2012-13 that have not been approved by the Minister. We understand that approval of the District Annual Plan is not approval of any particular business case. Some business cases will still be subject to a separate approval process that includes Ministry of Health, National Health Board and Treasury officials prior to a recommendations being made to the Minister of Health. The Board also requires management to obtain final approval in accordance with delegations prior to purchase or construction commencing.

We have developed a formal asset management plan in accordance with Ministry of Health requirements. Our capital expenditure plan and asset management plan are based upon the information prepared as a part of the Service and Campus Reconfiguration business case, and updated for any material new data that has become available such as the ability to invest in some additional information technology and clinical assets during the planning period.

8.21.1 Capital Financing

Table: Capital Financing

Capital Financing	2010/11 $M	2011/12 $M	2012/13 $M
Internal Financing			
Surplus/(deficit)	8	4	2
Depreciation	32	36	51
Other - includes cash reserves	19	4	13
External Financing			
CHFA debt	93	61	1
Equity Injection	0	0	30
Total Capital Financing	152	106	98

8.22 Financial Statements

We have an objective of strong financial performance. We have met this objective for several years with better than break-even net results being achieved. We have set a target surplus of $8 million (1% of revenue in 2010/11) for campus redevelopment. A smaller surplus will simply push out the already 20 year development timeframe and means the organisation will be unable to maintain a continuous design and project management team.

The total redevelopment costs are $593 million and we must generate the cash to pay for it – directly or via loan servicing. We have some loan facilities but we intend to internally fund the redevelopment without seeking further external funding – this is to avoid reliance on central sources of capital and to maximise control of the programmes progress.

We have produced a long term financial plan over the next 20 years to fit with redevelopment that models the surpluses required to deliver the programme in that time.

Importantly, financial planning includes funding not being diverted from services into buildings. The plan includes all demographic funding going into new or additional services, in the same proportions it has historically. That is 60% to Health Waikato and 40% to NGOs. The extra service funding going into Health Waikato will be to pay for the additional services, which will in turn be physically enabled by the redevelopment.

We also have revenue banking of $52.3 million, which is included in revenue and equity from 2011-12 on the following planned schedule:

- 2011-12 $6 million revenue
- 2012-13 $16.3 million revenue and $30 million equity

In prior years, the revenue allocation under the population based funding formula has being adjusted, at our request to reduce current revenue and increase future revenue. This has an overall neutral impact over the period of the redevelopment as all funds that are retained are guaranteed by the Crown to be redistributed back to us for the provision of capacity to provide service delivery in subsequent years. The $52.3 million is to meet the increased cost of the redevelopment which delivers increased capacity. It therefore ensures a sustainable approach to managing the organisation in a way that maximises the future health and wellbeing of the districts population.

Included in plan are new debt arrangements of $55.7 million. These are:

- $40 million is conversion of equity repaid in prior years converted to Crown debt.
- $9.8 million funding for oral health business case.
- $6.7 million funding for mental health business case

Table: Statement of Planned Comprehensive Income

Forecast Statement of Comprehensive Income	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
REVENUE					
Government and Crown Agency	969,386	1,049,414	1,079,455	1,121,983	1,175,203
Non-Government	24,887	18,834	27,617	24,112	24,963
TOTAL REVENUE	994,273	1,068,248	1,107,072	1,146,095	1,200,166
EXPENSES					
Personnel	378,082	402,309	427,136	428,980	443,223
Outsourced Services	48,299	47,000	35,505	40,319	45,958
Clinical Supplies and Patient Costs	103,799	106,357	111,331	109,522	112,373
Infrastructure & Non-clinical Supplies	72,870	66,179	63,190	70,573	69,384
Interest	2,649	3,012	5,750	11,249	14,142
Depreciation	22,742	24,510	32,086	36,248	51,135
Capital Charge	12,432	13,804	13,502	13,547	13,612
Payments to Non-health Board Providers	354,989	386,413	410,550	431,339	448,219
TOTAL EXPENSES	995,862	1,049,584	1,099,050	1,141,777	1,198,046
Share of profit of Assoictaes and Joint venture	4	-	-	-	-
SURPLUS/(DEFICIT)	(1,585)	18,664	8,023	4,318	2,120
OTHER COMPREHENSIVE INCOME					
Property Plant & Equipment revaluation	33	8	-	-	-
TOTAL COMPREHENSIVE INCOME	(1,552)	18,672	8,023	4,318	2,120

Table: Statement of Planned Movements in Equity

Forecast Statement of Movements in Equity	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
Crown equity at start of period	144,053	140,393	156,871	162,700	164,824
Surplus/(Deficit) for the period	(1,585)	18,664	8,023	4,318	2,120
Increase in Revaluation Reserve	33	8	-	-	-
Equity Injection from Crown	-	-	-	-	-
Distributions to Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in Equity	86	-	-	-	30,000
Crown equity at end of period	140,393	156,871	162,700	164,824	194,750

Table: Summary – Planned Financial Information

Summary	2008/09 $M ACTUAL	2009/10 $M FORECAST	2010/11 $M PLANNED	2011/12 $M PLANNED	2012/13 $M PLANNED
Revenue	994	1,068	1,107	1,146	1,200
Net Surplus/(Deficit)	(2)	19	8	4	2
Total Fixed Assets	295	343	458	527	571
Net Assets	140	157	163	165	195
Term Borrowings and Liabilities	56	103	196	258	259

Table: Statement of Planned Financial Position

Forecast Statement of Financial Position	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
CROWN EQUITY	140,393	156,871	162,700	164,824	194,750
CURRENT ASSETS:					
Bank balances, deposits and cash	3,709	19	20	20	19
Receivables	31,856	32,652	33,479	34,148	35,002
Inventory	7,281	7,537	7,725	7,880	8,077
	42,846	40,208	41,224	42,048	43,098
CURRENT LIABILITIES:					
Short Term Loans	5,107	3,013	-	-	-
Payables and Accruals	82,678	66,429	85,741	89,631	102,189
Payroll Accruals	53,040	54,101	55,026	56,127	57,531
	140,825	123,543	140,767	145,758	159,720
Net Working Capital	(97,979)	(83,335)	(99,543)	(103,710)	(116,622)
NON CURRENT ASSETS:					
Fixed Assets	294,531	342,933	458,391	526,433	570,682
Investments	107	107	107	107	107
	294,638	343,040	458,498	526,540	570,789
NON CURRENT LIABILITIES:					
Payroll Liabilities	15,409	15,777	16,155	16,465	16,861
Term Loans	40,857	87,057	180,101	241,542	242,557
	56,266	102,834	196,256	258,007	259,418
NET ASSETS	140,393	156,871	162,700	164,824	194,750

Table: Statement of Planned Cashflows

Forecast Statement of Cashflows	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
OPERATING CASHFLOWS					
Cash was provided from Crown Agencies and other income sources	999,095	1,066,663	1,105,098	1,144,371	1,198,239
Cash was disbursed to employees, suppliers and payment of finance charges	(943,271)	(1,040,229)	(1,046,577)	(1,100,482)	(1,132,876)
	55,824	26,434	58,521	43,889	65,363
INVESTING CASHFLOWS					
Cash was provided from assets and equity	2,364	884	1,187	1,154	1,199
Cash was disbursed to purchase of assets and investments	(58,320)	(72,912)	(147,544)	(104,291)	(95,384)
	(55,956)	(72,028)	(146,357)	(103,137)	(94,185)
FINANCING CASHFLOWS					
Cash was provided from proceeds of borrowings and equity movements	2,015	41,904	87,837	59,248	28,821
Cash was disbursed to repayment of borrowings	-	-	-	-	-
	2,015	41,904	87,837	59,248	28,821
Net increase/(decrease) in cash held	1,883	(3,690)	1	-	(1)
Add Opening cash balance	1,826	3,709	19	20	20
CLOSING CASH BALANCE	3,709	19	20	20	19
Made up from:					
Bank balances, deposits and cash	3,709	19	20	20	19

Appendix 1: Health Targets

Health Target	Indicator	Waikato DHB Target 2010/11
Shorter stays in Emergency Departments (ED)	95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours	95%
Improved access to elective surgery	For 2010/11 the target increase has been set at an extra 2000 surgical discharges	Target for volume of government funded elective surgical discharges for Waikato DHB domiciled patients is 12,285
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	100%
Increased immunisation	90 per cent of two year olds are fully immunised by July 2011; and 95 per cent by July 2012	2 year olds fully immunised Total 90% Māori 87% Pacific 82% Other 92%
Better help for smokers to quit	90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011; and 95 per cent by July 2012 80 per cent of patients attending primary care will be provided with advice and help to quit by July 2011; 90 per cent by July 2012; and 95 percent by July 2013	90% 80%
Better diabetes and cardiovascular services	increased percent of the eligible adult population will have had their CVD risk assessed in the last five years increased percent of people with diabetes will attend free annual checks increased percent of people with diabetes will have satisfactory or better diabetes management.	CVD risk assessment Māori 67% Pacific 63% Other 79% Total 76% Accessing free annual checks Māori 44% Pacific 38% Other 55% Total 52% Good diabetes management Māori 65% Pacific 65% Other 79% Total 76%

Appendix 2: Performance Improvement Actions (PIAs)

Name	Savings / Impact
Achieve financial security	$3.4 million
Improve productivity and quality	$5.0 million
Enhance regional cooperation	Yet to be determined

Appendix 3: Services

Non Provider arm services (Non government organisations and other DHBs)

Capability (to be assigned to output classes)

Inequalities Funding
Outcome Based Purchasing & Service Development
Information Technology & Administration
Personal Health Projects
Quality Improvement Initiatives
Quality Improvements
Workforce Development
Regional Advocacy Service for Consumer Complaints
Pharmaceutical Review Services

Hospital (Output Class)

Anaesthetist Fee Group
Family Information Service
Inpatient Dental treatment
Outpatient Dental treatment
Emergency Dept - Level 2, 3,4,5,6
Emergency Care Co-ordination
First Specialist Assessment (Tertiary)
IVF Programme
ISCI Addition
Donor Insemination
AIH Simple
AIH + stimulation
Donor Egg Addition
Frozen Embryo Replacement
Surgical Retrieval of Sperm
Sperm Freezing
Annual Storage of Sperm
Cancelled Cycle
Incomplete Cycle
IVF standard second cycle
Blastocyst addition
Pre-implantation Genetic Diagnosis
ATR Inpatient
ATR Outpatient – Clinics
ATR Outpatient – domiciliary assessments & education sessions
ATR Inpatient – Mental Health Services for Elderly
General Internal Medical Services - Inpatient Services (DRGs)
General Medicine - 1st attendance
General Medicine - Subsequent attendance
Adult Acute Assessments
Medical Non-contact First Specialist Assessment - Any health specialty
Inpatient Services (DRGs)
Cardiology - 1st attendance
Cardiology - Subsequent attendance
Cardiac Education and Management
Specialist Paediatric Cardiac - Inpatient Services (DRGs)
Specialist Paediatric Cardiac - 1st Attendance
Specialist Paediatric Cardiac - Subsequent Attendance
Spinal Cord Stimulators - implant only
Dermatology - 1st attendance
Dermatology - Subsequent attendance
Dermatology - UV Treatment
Endocrinology & Diabetic - Inpatient Services (DRGs)
Endocrinology - 1st attendance
Endocrinology - Subsequent attendance
Diabetes - 1st attendance
Diabetes - Subsequent attendance
Specialist Paediatric Endocrinology - 1st attendance
Specialist Paediatric Endocrinology - Subsequent attendance
High Risk Type I Diabetes Support for up to 18 year olds
Gastroenterology - Inpatient Services (DRGs)
Gastroenterology - 1st attendance
Gastroenterology - Subsequent attendance
Gastroenterology - ERCP
Gastroenterology - Colonoscopy
Gastroenterology - Gastroscopy
Gastroenterology - Motility investigations
Haematology - Inpatient Services (DRGs)
Haematology - 1st attendance

Haematology - Subsequent attendance
Haemophilia - Case Management
MUD Donor Marrow Fee
Haematology - Blood transfusions
MUDs Risk Pool includes IRF MUDS adjustment
IV Chemotherapy -cancer- haematology (non paediatric)
Oral Chemotherapy Oversight - cancer - haematology (non paediatric)
National Leukaemia and Blood Foundation service
Specialist Paediatric Haematology
Infectious Diseases (incl Venereology) - Inpatient Services (DRGs)
Infectious Diseases (incl HIV/Aids) - Subsequent attendance
HIV/AIDS Viral Load Testing
Neurology - Inpatient Services (DRGs)
Neurology - 1st attendance
Neurology - Subsequent attendance
Neurology - Botulinum toxin therapy
Neurology - metabolic - Subsequent attendance
Neurology - Metabolic - Ambulatory
Specialist Paediatric Neurology
Specialist Paediatric Neurology Outpatient 1st attendance
Specialist Paediatric Neurology Outpatient - Subsequent attendance
Oncology - Inpatient Services (DRGs)
Oncology - 1st attendance
Oncology - Subsequent attendance
Oncology - Radiotherapy
Oncology - Stereotactic radiosurgery
Oncology - Stereotactic radiotherapy
Specialist Paediatric Oncology
Specialist Paediatric Oncology - Outpatient 1st attendance
Specialist Paediatric Oncology - Outpatient subsequent attendance
IV Chemotherapy - cancer - Specialist paediatric oncology
Paediatric Medical Service (Inpatient)
Paediatric Medical Outpatient - 1st attendance
Paediatric Medical Outpatient - Subsequent attendance
Paediatric Acute Assessments
Paediatric community programme
Renal Medicine - Inpatient Services (DRGs)
Renal Medicine - 1st attendance
Renal Medicine - Subsequent attendance
Renal Medicine - Recurrent home based CAPD
Renal Medicine - CAPD Training
Renal Medicine - In centre Haemodialysis
Pre-renal Replacement Therapy Programme
Respiratory - Inpatient Services (DRGs)
Respiratory - 1st attendance
Respiratory - Subsequent attendance
Respiratory Education and Management
Sleep apnoea assessment - Respiratory
Sleep apnoea - long term treatment
Specialist Paediatric Respiratory - 1st Attendance
Specialist Paediatric Respiratory - Follow up
Rheumatology (incl Immunology) - Inpatient Services (DRGs)
Rheumatology (incl immunology) - 1st attendance
Rheumatology (incl immunology) - Subsequent attendance
Immunology (excludes rheumatology) - 1st attendance
Immunology (excludes Rheumatology) - Subsequent attendance
Rheumatology daypatients at QE Hospital
Rheumatology inpatients at Queen Elizabeth Hospital
QE weekend supported accommodation
Clinical Genetics - 1st attendance
Clinical Genetics - Subsequent attendance
Clinical Genetic testing
Genetics Services - Midland
Subacute Extended Care - Inpatient beds
Co-existing disorders (mental health & addiction) - Nursing and/or allied health staff
Children & Young People Community Services (Other Clinical FTEs)
Includes sub units:
Needs Assessment & Service Co-ordination – Child & Youth
Specialist Maternal Mental Health Service
Infant, child, adolescent & youth community mental health services - Senior medical staff
Infant, child, adolescent & youth community mental health services - Nursing/allied health staff
Acute Inpatient Beds
Clinical Rehabilitation/Sub-Acute/Extended Care Inpatient Beds
Child and Youth Inpatient Beds
Detoxification – Medical Inpatient
Blood transfusions - Any health specialty
Bronchoscopy - Any health specialty
Cystoscopy - Any health specialty

Gastroscopy - Any health specialty.
ERCP - Any health specialty
Colonoscopy - Any health specialty
IV Chemotherapy - cancer - Any health specialty
Sleep apnoea assessment - Any health specialty
Oral Chemotherapy Oversight - cancer - Any health specialty
Blood & Blood Products to Private Hospitals and primary providers
Coroner Deaths not requiring Post Mortem
Pain Specialist assessment
Pain Specialist Appointment - Follow-up
Pain comprehensive assessment (triple assessment)
Pain Residential Management Programme
Pain Psycho-social assessment
Pharmaceutical Cancer Treatments
Pharmaceutical Cancer Treatments Exceptional Circumstances
Inpatients in Level 2 Rural Hospitals (Rural Inpatients)
General Surgery - Inpatient Services (DRGs)
General Surgery (incl Vascular Surgery) - 1st attendance
General Surgery (incl Vascular Surgery) - Subsequent attendance
General Surgery (excl vascular surgery) - 1st attendance
General Surgery (excl vascular surgery) - Subsequent attendance
Minor Operations
Breast Op Proc - 1st Attendance
Breast Op Proc - Subsequent Attendance
Surgical non contact First Specialist Assessment - Any health specialty
Cardiothoracic - Inpatient Services (DRGs)
Cardiothoracic - 1st attendance
Cardiothoracic - Subsequent attendance
Ear, Nose and Throat - Inpatient Services (DRGs)
Ear Nose and Throat - 1st attendance
Ear Nose and Throat - Subsequent attendance
ENT Minor operations
Otoneurology Clinic
Multifaceted Specialist Clinics
Gynaecology - Inpatient Services (DRGs)
Gynaecology - 1st attendance
Gynaecology - Subsequent attendance
Termination of Pregnancy - 1st trimester
Gynaecology Minor Procedure - High Cost
Termination of Pregnancy - 2nd trimester
Neurosurgery - Inpatient Services (DRGs)
Neurosurgery - 1st attendance
Neurosurgery - Subsequent attendance
Ophthalmology - Inpatient Services (DRGs)
Ophthalmology - 1st attendance
Ophthalmology - Subsequent attendance
Minor Eye Procedures
Eye - Argon Laser
Orthopaedics - Inpatient Services (DRGs)
Orthopaedics - 1st attendance
Orthopaedics - Subsequent attendance
Fracture Clinic - 1st attendance
Fracture Clinic - Subsequent attendance
Gait Laboratory
Spinal - 1st attendance
Spinal - Subsequent attendance
Paediatric Surgical Services
Primary & Community
Paediatric Surgery Outpatient - 1st attendance
Paediatric Surgery Outpatient - subsequent attendance
Plastic & Burns - Inpatient Services (DRGs)
Plastics (incl Burns and Maxillofacial) - 1st attendance
Plastics (incl Burns and Maxillofacial) - Subsequent attendance
Pulsed Dye Laser Treatment - Initial Assessments
Pulsed Dye Laser Treatment - treatments
Urology - Inpatient Services (DRGs)
Urology - 1st attendance
Urology - Subsequent attendance
Urology - Cystoscopy
Urology - Lithotripsy
Urodynamics
Vascular Surgery - Inpatient Services (DRGs)
Vascular Surgery Outpatient - 1st attendance
Vascular Surgery Outpatient - Subseq attend
Patient Travel & Accommodation Assistance
Patient transport - non emergency and inpatient transfers
Air ambulance - emergency
DHB non-specialist antenatal consults
DHB non-specialist postnatal consults
First Obstetric Consults
Subsequent Obstetric Consults
Amniocentesis
Chorion villis sampling
Rhesus Clinics - multidisciplinary clinics
Specialist neonates
Maternity inpatient (DRGs)
Maternity non-LMC Services

Dietetics
Occupational Therapy
Orthoptist
Physiotherapy
Podiatry
Speech Therapy
Psychologist Services - Non Mental Health
GMS: GP Services - Capitation
Hospital at Home - Cystic Fibrosis Drugs
Targeted Activities
General Medical Services FFS
Practice Nurse Subsidy FFS
Free GP Annual Diabetes Check Review
Management Services - Quality Management
Rural Payment Subsidy fee
Rural Workforce Retention Subsidy
Rural Reasonable Roster Funding Subsidy
Community Based Services
Advocacy / Peer Support Family / Whanau (Child)
Educator Development Co-ordinator Services
Community Asthma Services
Refugee Primary Health Services
Hospital
Hospital-Retail
X-Ray Diagnostic Service
Diagnostic Imaging Fee Group
Specialist Fee Group
Community Pharmacy Services
Community Radiology
Laboratory Fee Groups
Community Laboratory
Refugees and Asylum Seekers - lab tests
Non-Schedule Community Laboratory Tests
Hospital Dispensing of Pharmaceuticals
Community referred tests - cardiology
Community referred tests - neurology
Community referred tests - audiology
Community referred tests - endocrinology
Community referred tests - respiratory
Lab Tests and Pharms for Sexual Health Services
Adolescent dental services
Oral Health Services in Exceptional Circumstances
Emergency Dental Care for Low Income Adults
Oral Health Regional Co-ordination Services
Provision of Oral Health Services for Adolescents
Special Dental Services for Children and Adolescents
Administration of Adolescent Dental Services
Community Services - home oxygen
Transitional care: Facility Based Level 1
Transitional care: Facility Based Level 2
Transitional care: Home-Based Level 3
Diabetes Education and Care
Diabetes - Fundus Screening
Local Diabetes Teams
Mobile Maori Nursing Disease
Koroua and Kuia Support Services
Support Services for Mothers & their Pepi
Diabetes Management - Maori
Primary Health Care & Community Nursing Service
Maori Health Development
Maori Primary Health
Whanau Ora - Maori Community Health Services
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Service for Profoundly Hearing Impaired - Non-clinical staff
Planned Adult Respite
Activity Based Recovery Support Services - Non-clinical staff
Vocational Support Services - Non clinical staff
Housing and Recovery Services Day time/ Awake Night support
Housing and Recovery Services Day time/Responsive Night support
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Mental health (new PUC name to be inserted)
Community Alcohol & Drug Services (Other Clinical FTEs)
Community Alcohol & Drug Services (Non-Clinical FTEs)
Mental health (new PUC name to be inserted)
Community based alcohol and other drug services
Community based alcohol and other drug services
Intensive alcohol and other drug service with accommodation
Managed withdrawal- home/community

Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff
Child, adolescent and youth community alcohol and drug services with accommodation
Child, Adolescent and& Youth Community - accommodation - Nursing and allied staff
Child, Adolescent and& Youth Community - accommodation - Non-clinical staff
Mental health
Community Forensic mental health service
Prison mental health
Court liaison
Child, adolescent and youth mental health community care with an accommodation component
Infant, child, adolescent, and youth package of care
Nurse Led Outpatient Clinics
General Medicine
Base Pharmacy Services
ECP Services
Special Foods Services

Exceptional Circumstances Services A (Pharmaceuticals on the Pharmaceutical schedule)
Exceptional Circumstances Services B (Pharmaceuticals on the Pharmaceutical schedule)
Class B Controlled Drug Services
Monitored Therapy Medicine Services
Complex Medicine Services
Aseptic Pharmacy Services
NRT Services
Unused Medicines
Medicines Use review and Adherence Support Services
Pharmacist Health Education Services
Glivec & MS Treatments
First contact services – access
Care Plus Services
First contact services – interim
PHO General Medical Services for Casual Patients
PHO Projects
Management fee

PHCS MH initiatives and innovations
Rural Premium Services
Services to improve access – access
Services to improve access – interim
Very Low Cost Access - Individual Practice
Very Low Cost Access - Whole PHO
Non-VLCA for under 6 year olds
Generalist Primary Care (SAMO/INP)
Sexual Health - First Contact
Sexual Health - Follow Up
Family Planning Services
Sexual Health & School Based Clinic Evaluation
Free Sexual and Reproductive Health Service
Pregnancy and Parenting Education
Labour and delivery in a Primary Maternity Facility
Postnatal stay in a primary maternity facility (mother)
Labour, delivery and postnatal stay in a primary facility

<u>Public Health</u>
New Well Child Framework
Vision Hearing Screening
School Health Services
Outreach Immunisation Services
Youth Sexual Health
Child Protection
Immunisation FFS
Health Promotion
Immunisation projects and programmes set up.

HPV Whanau Engagement
Specialist Immunisations
Disability Information and Advisory Services (DIAS)
DIAS National Contracts
Information and Advisory
HIV Registry
CAPD Registry
Advocacy

Immunisation
Outreach Immunisation Services provided by PHOs
Health promotion – interim
Health promotion – access
Health Promotion DHB Support
Physical Environment
Tobacco Control
Delivery Funding

<u>Support</u>
Social Work

Prosthetic Eyes

Short Term Respite Care for Medically Fragile Children
Family Options for Chronically ill Children
Management Services - CMI
Non Provider Arm Hospital Beds for the Chronically Medically Ill – CMI patients
Palliative Clinical Care
Community Services - professional nursing services
Community Services - stomal services
Community Services - continence service
Community Services - Home help
Community Services - meals on wheels
Community Services - personal care
Community Services - orthotics
DIAS National Contracts
Orthotics
Contact Lens Benefit

Accredited Equipment Assessments
Aged Continuing Care
Accredited visitor service
Home Based Support - Household management
Home Based Support - Personal Care
Day Care
Carer Support
Ageing in Place - Bed Day
Assistive Technology
Residential (Aged - Dementia)
Residential (Aged - Rest Home)
Aged Continuing Care - Specialist
Needs Assessment
Service Coordination
Respite Care
Orthotics
Rural Travel

Geriatric- Early Intervention, Preventative, Comprehensive Assessment
Community Health Services and Support
Supply & Maintenance of Hearing Aids
Palliative Care - Community Services
Service Coordination Services
Planned Adult Respite - Non-clinical staff
Adult Community Support Services - Nursing & allied health staff
Adult Community Support Services - Non-clinical staff
Consumer resource and information service - Peer support
Residential Treatment – Alcohol and Drug Service
Residential Care Loan Money

Provider arm services

Children & Young Peoples Death Register/Review
Outcome Based Purchasing & Service Development
Hospital
Inpatient Dental treatment
Outpatient Dental treatment
Emergency Dept - Level 2
Emergency Dept - Level 3
Emergency Dept - Level 6
Emergency Care Co-ordination
ATR Inpatient
ATR Outpatient – Clinics
ATR Outpatient – domiciliary assessments & education sessions
General Internal Medical Services - Inpatient Services (DRGs)
General Medicine - 1st attendance
General Medicine - Subsequent attendance
Emergency Medical Services - Inpatient Services (DRGs)
Cardiology - Inpatient Services (DRGs)
Cardiology - 1st attendance
Cardiology - Subsequent attendance
Cardiac Education and Management
Dermatology - Inpatient Services (DRGs)
Dermatology - 1st attendance
Dermatology - Subsequent attendance
Dermatology - UV Treatment
Endocrinology & Diabetic - Inpatient Services (DRGs)
Endocrinology - 1st attendance
Endocrinology - Subsequent attendance
Diabetes - 1st attendance

Capability (to be assigned to output classes)
CHF initiative
Quality Improvement Initiatives
Change Management
Quality Improvements

Diabetes - Subsequent attendance
High Risk Type I Diabetes Support
Gastroenterology - Inpatient Services (DRGs)
Gastroenterology - 1st attendance
Gastroenterology - Subsequent attendance
Gastroenterology - Motility investigations
Haematology - Inpatient Services (DRGs)
Haematology - 1st attendance
Haematology - Subsequent attendance
MUD Donor Marrow Fee
IV Chemotherapy -cancer- haematology (non paediatric)
Infectious Diseases (incl HIV/Aids) - 1st attendance
Infectious Diseases (incl HIV/Aids) - Subsequent attendance
HIV/AIDS Viral Load Testing
Neurology - Inpatient Services (DRGs)
Neurology - 1st attendance
Neurology - Subsequent attendance
Neurology - Botulinum toxin therapy
Oncology - Inpatient Services (DRGs)
Oncology - 1st attendance
Oncology - Subsequent attendance
Oncology - Radiotherapy
HDR Brachytherapy
HDR Brachytherapy Old Code
Paediatric Medical Service (Inpatient)

Research and Development
Workforce Development

Paediatric Medical Outpatient - 1st attendance
Paediatric Medical Outpatient - Subsequent attendance
Enuresis Programme
Renal Medicine - Inpatient Services (DRGs)
Renal Medicine - 1st attendance
Renal Medicine - Subsequent attendance
Renal Medicine - Recurrent home based CAPD
Renal Medicine - CAPD Training
Renal Medicine - Recurrent home based Haemodialysis
Renal Medicine - Haemodialysis Training
Renal Medicine - In centre Haemodialysis
Pre-renal Replacement Therapy Programme
Respiratory - Inpatient Services (DRGs)
Respiratory - 1st attendance
Respiratory - Subsequent attendance
Respiratory Education and Management
Respiratory - Bronchoscopy
Sleep apnoea - long term treatment
Rheumatology (incl Immunology) - Inpatient Services (DRGs)
Rheumatology (incl immunology) - 1st attendance
Rheumatology (incl immunology) - Subsequent attendance

Palliative Medical Services - Inpatient Services (DRGs)
Patient Flow Improvement Project - Surgical
Dual Diagnosis - Mental Health and Alcohol & Drug
Community Mental Health Service (Senior Medical FTEs)
Includes sub units:
MHCS06B1: Needs Assessment & Service Co-ordination
MHCS06B2: Crisis Intervention
MHCS06B4: Community Day Hospital Programme
MHCS06B5: Early Intervention for people
General Hospital Liaison Service
Children & Young People Community Services (Other Clinical FTEs)
Includes sub units:
Needs Assessment & Service Co-ordination – Child & Youth
Children & Young People Community Services (Senior Medical FTEs)
Includes sub units:
Needs Assessment & Service Co-ordination – Child & Youth
Specialist Psychotherapy Service
Community Forensic Service
Community Service - Older People
Early Intervention Alcohol & Drug Service
Refugee Mental Health Service
Specialist Maternal Mental Health Service
Methadone Treatment – Specialist
Dual Diagnosis with Intellectual Disability
Older Persons Day Hospital Programme
Child and Youth Acute Care Packages
Acute Inpatient Beds
Older People Inpatient Beds
Clinical Rehabilitation/Sub-Acute/Extended Care Inpatient Beds
Long Term Secure Forensic
Medium Secure Forensic
Minimum Secure Forensic
Intensive Care Inpatient Beds
Detoxification – Medical Inpatient
Blood transfusions - Any health specialty
Bronchoscopy - Any health specialty
Cystoscopy - Any health specialty
Gastroscopy - Any health specialty.
ERCP - Any health specialty
Colonoscopy - Any health specialty
IV Chemotherapy - cancer - Any health specialty
Sleep apnoea assessment - Any health specialty
Pain Specialist assessment
Pain Specialist Appointment - Follow-up
Inpatients in Level 2 Rural Hospitals (Rural Inpatients)
General Surgery - Inpatient Services (DRGs)
General Surgery (excl vascular surgery) - 1st attendance
General Surgery (excl vascular surgery) - Subsequent attendance
Minor Operations
Breast Op Proc - 1st Attendance
Breast Op Proc - Subsequent Attendance
Anaesthesia Services - Inpatient Services (DRGs)
Cardiothoracic - Inpatient Services (DRGs)
Cardiothoracic - 1st attendance
Cardiothoracic - Subsequent attendance
Ear, Nose and Throat - Inpatient Services (DRGs)
Ear Nose and Throat - 1st attendance
Ear Nose and Throat - Subsequent attendance
Multifaceted Specialist Clinics
Gynaecology - Inpatient Services (DRGs)
Gynaecology - 1st attendance
Gynaecology - Subsequent attendance
Termination of Pregnancy - 1st trimester
Gynaecology Minor Procedure - High Cost
Neurosurgery - Inpatient Services (DRGs)
Neurosurgery - 1st attendance
Neurosurgery - Subsequent attendance
Ophthalmology - Inpatient Services (DRGs)
Ophthalmology - 1st attendance
Ophthalmology - Subsequent attendance
Minor Eye Procedures
Eye - Argon Laser
Additional ophthalmology consults and treatments
Orthopaedics - Inpatient Services (DRGs)
Orthopaedics - 1st attendance
Orthopaedics - Subsequent attendance
Fracture Clinic - 1st attendance
Fracture Clinic - Subsequent attendance
Paediatric Surgical Services
Paediatric Surgery Outpatient - 1st attendance
Paediatric Surgery Outpatient - subsequent attendance
Plastic & Burns - Inpatient Services (DRGs)
Plastics (incl Burns and Maxillofacial) - 1st attendance
Plastics (incl Burns and Maxillofacial) - Subsequent attendance
Urology - Inpatient Services (DRGs)

Vascular Surgery - Inpatient Services (DRGs)
Vascular Surgery Outpatient - 1st attendance
Vascular Surgery Outpatient - Subseq attend
Patient Travel & Accommodation Assistance
Patient transport - non emergency and inpatient transfers

Primary & community

Dietetics
Occupational Therapy
Orthoptist
Physiotherapy
Podiatry
Speech Therapy
Child Health Nurse Educator
Community Radiology
Laboratory Fee Groups
Community Laboratory
Community referred tests - cardiology
Community referred tests - audiology
Community referred tests - endocrinology
Community referred tests - respiratory
School dental services
Oral Health Regional Co-ordination Services
Community Services - home oxygen
Thrombolysis Project
Service Integration and Health Information Projects
Diabetes Education and Care
Diabetes - Fundus Screening

Public Health

New Well Child Framework
School Health Services

Support

Social Work
Non Provider Arm Hospital Beds for the Chronically Medically Ill – CMI patients

First Obstetric Consults
Subsequent Obstetric Consults
Amniocentesis
Chorion villis sampling
Foetal medicine / anomalies clinics - multidisciplinary clinics

Diabetes Screening Initiative
Care and Review
Community Alcohol & Drug Services (Other Clinical FTEs)
Community Alcohol & Drug Services (Senior Medical Clinical FTEs)
Detoxification - Home/Community
Community Mental Health Service (Other Clinical FTE)
Includes sub units:

- Needs Assessment & Service Co-ordination
- MHCS06A2: Crisis Intervention
- MHCS06A4: Community Day Hospital Programme
- MHCS06A5: Early Intervention for people

Prison/Court Liaison

Advocacy/Peer Support – Consumers
Includes sub-units as follows:

- MHCS21.1 Adults
- MHCS21.2 Older Adults
- MHCS21.4 Forensic Services

Outreach Immunisation Services
Family Violence Project Coordination
Immunisation projects and programmes set up.

Community Services - professional nursing services
Community Services - stomal services

Specialist neonates
Additional Maternity Project
Maternity inpatient (DRGs)
Maternity inpatient (DRGs)

- MHCS21.7 Child & Youth
- MHCS21.8 Alcohol & Drug

Maori Advisory Services
Methadone Treatment – General Practitioner
Children and Youth Alcohol and Drug Community Services (Other Clinical FTEs)
Specialist eating disorders residential service - Nursing and/or allied health staff
Nurse Led Outpatient Clinics
GP Drug Advisory
Sexual Health - First Contact
Sexual Health - Follow Up
Pregnancy and Parenting Education
Labour and delivery in a Primary Maternity Facility
Postnatal stay in a primary maternity facility (mother)
Labour, delivery and postnatal stay in a primary facility
Postnatal early intervention
Neonatal home care
Maternity LMC antenatal services
Communicable Diseases
Nutrition
Physical Environment

Community Services - continence service
Community Services - Home help
Community Services - personal care

Community Services - orthotics
Ageing In Place - Community Support
Environmental Support
Geriatric- Early Intervention, Preventative,
Comprehensive Assessment
Palliative Care - Outpatient Services
Residential Co-ordination Service
Other Residential Support
Activity-Based Rehabilitation Service/Day
Activity and Living Skills (Non-Clinical FTEs)
Adult Planned Respite
Adult Crisis Respite
Child and Youth Planned Respite

Other (unassigned)
General Medicine Premium/Discount
PET Scanning
PHO Projects

Appendix 4:

Table: Planned Financial Targets and Measures DHB Provider (Health Waikato)

DHB Provider Forecast Statement of Financial Performance	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
REVENUE					
Government and Crown Agency	581,159	633,981	644,242	670,446	704,978
Non-Government	24,724	18,684	27,577	24,112	24,963
TOTAL REVENUE	605,883	652,665	671,819	694,558	729,941
EXPENSES					
Personnel	376,573	400,813	425,501	427,315	441,513
Outsourced Services	48,138	46,666	35,079	39,886	45,512
Clinical Supplies and Patient Costs	110,819	113,412	120,067	120,510	131,942
Infrastructure & Non-clinical Supplies	102,892	99,944	104,837	119,652	127,705
Internal Recharges	(1,637)	(2,289)	(2,213)	(2,256)	(2,312)
TOTAL EXPENSES	636,785	658,546	683,271	705,107	744,360
SURPLUS/(DEFICIT)	(30,902)	(5,881)	(11,452)	(10,549)	(14,419)

Table: Planned Financial Targets and Measures DHB Governance

DHB Governance Forecast Statement of Financial Performance	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
REVENUE					
Government and Crown Agency	5,017	5,057	5,058	5,159	5,289
Non-Government	167	150	40	-	-
TOTAL REVENUE	5,184	5,207	5,098	5,159	5,289
EXPENSES					
Personnel	1,509	1,496	1,635	1,665	1,710
Outsourced Services	161	334	426	433	446
Clinical Supplies and Patient Costs	-	-	-	-	-
Infrastructure & Non-clinical Supplies	781	506	955	977	999
Internal Recharges	1,637	2,289	2,213	2,256	2,312
TOTAL EXPENSES	4,088	4,625	5,229	5,331	5,467
SURPLUS/(DEFICIT)	1,096	582	(131)	(172)	(178)

Table: Planned Financial Targets and Measures DHB Funding

DHB Funding Forecast Statement of Financial Performance	2008/09 $000 ACTUAL	2009/10 $000 FORECAST	2010/11 $000 PLANNED	2011/12 $000 PLANNED	2012/13 $000 PLANNED
REVENUE					
Government and Crown Agency	908,617	983,978	1,016,770	1,056,879	1,108,706
TOTAL REVENUE	908,617	983,978	1,016,770	1,056,879	1,108,706
EXPENSES					
Governance Administration	4,939	5,048	5,048	5,148	5,277
Personal Health	682,842	752,469	760,439	801,997	848,018
Mental Health	95,012	103,959	114,335	116,279	118,255
Disability Support	90,484	98,539	110,644	112,524	114,438
Public Health	2,091	-	428	562	571
Maori Services	5,028	-	6,271	5,330	5,430
TOTAL EXPENSES	880,396	960,015	997,165	1,041,840	1,091,989
SURPLUS/(DEFICIT)	28,221	23,963	19,605	15,039	16,717

Appendix 5: Forecast Statements of Cost and Revenue for Output Classes

Forecast Statement of Cost and Revenue for Public Health	2010/11 $000 Budget	2011/12 $000 Budget	2012/13 $000 Budget
Revenue	31,045	32,179	33,712
Costs	24,206	25,181	26,466
Surplus/(deficit)	6,839	6,998	7,246
Forecast Statement of Cost and Revenue for Primary & Community	2010/11 $000 Budget	2011/12 $000 Budget	2012/13 $000 Budget
Revenue	300,168	311,131	325,956
Costs	308,932	321,379	337,772
Surplus/(deficit)	(8,764)	(10,249)	(11,816)
Forecast Statement of Cost and Revenue for Hospital	2010/11 $000 Budget	2011/12 $000 Budget	2012/13 $000 Budget
Revenue	602,214	624,208	653,951
Costs	599,704	623,867	655,688
Surplus/(deficit)	2,510	341	(1,737)
Forecast Statement of Cost and Revenue for Support	2010/11 $000 Budget	2011/12 $000 Budget	2012/13 $000 Budget
Revenue	134,848	139,773	146,433
Costs	127,410	132,544	139,304
Surplus/(deficit)	7,438	7,229	7,129

Output class Financial reporting - This financial reporting is a new requirement by the Ministry of Health. We do not have any currency with this new reporting view and cannot explain the results being calculated as they do not relate to our current services/management type reporting structures. The output class financial reporting for 2010-11 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 15). The out years are based on the same cost and revenue ratios being applied to total cost and revenue