Waikato District Health Board

2021-22 ANNUAL PLAN

INCORPORATING THE
2021/22 STATEMENT OF PERFORMANCE EXPECTATIONS

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Contents

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Mihi

Ka tuwhera te tatau pounamu o te Ao
E takoto te whāriki o te Atua ki mua i a tātou
He hōnore, he korōria ki te Atua
He maungārongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Ka huri te kei o te waka ki te Kingi a Tūheitia me te whare Kāhui Ariki whānau whānui tonu
Mā te Atua e tiaki, e manaaki i a rātou
Me ngā whakaaro tonu ki ngā mate o te wā takoto mai, moe mai koutou, haere, haere, haere
Kāti, rātou ki a rātou, tātou ki a tātou
Nō reira, he korowai rau whero o te whare Waiora o Waikato
Haere mai, Haere mai, Nau mai.

Minister's letter of expectations to Waikato DHB

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

10 FEB 2021

Dame Karen Poutasi
Commissioner
Waikato District Health Board
Karen.Poutasi@waikatodhb.health.nz

Tēnā koe Dame Karen

Letter of Expectations for district health boards and subsidiary entities for 2021/22

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2021/22. As a DHB Commissioner you are accountable to me for meeting these expectations.

This government acknowledges the progress made to rebuild our health system, but there is still more to do. It is clear that COVID-19 will be placing a range of pressures on our health system for some time. We are well placed to continue to respond to resurgence as needed and to lock-in new ways of operating based on our COVID-19 response so that we retain and embed new and innovative approaches where possible.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the health system during 2021/22. Additional information will be provided when it becomes available.

As you know the Government has accepted the high-level direction of travel of the Health and Disability System Review (HDSR) and during this next phase we will roll out our plan to improve the public health system to ensure it delivers high quality services, improved equity for our vulnerable populations and supports better outcomes for all New Zealanders.

There will be uncertainty ahead, but I expect that this will not stop you from driving forward and continuing to deliver the improvements already underway. It is important that the sector continues to function at its best to provide health and disability services for New Zealanders while system changes are being confirmed and implemented. I also expect that you will begin to work together on further enhancements. The work we do now will ensure we have the right models of care to support longer term sustainability and to maximise outcomes through robust investment in primary and community care.

The priorities this Government has previously outlined to guide DHB planning will remain of critical importance for the coming year. Our wellbeing and equity system priorities together with a focus on giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 and improvements to DHB sustainability, continue to provide a solid framework for planning and articulating the work DHBs are doing:

- giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- improving sustainability
- improving child wellbeing
- improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry

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- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

I would like you to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

I expect all DHBs to deliver breakeven results by the end of 2021/22 and your annual plan will not be supported without this commitment. Strong fiscal management is critical to support our collective ability to invest more in new models of care and in primary care and population prevention approaches.

It is also imperative that the health system maintains and continues to strengthen our health capital planning, investment and delivery and as Commissioner you must have clear oversight of the DHB's annual plan to ensure it is sustainable, person centred and reflects Government expectations, including breakeven financial targets.

As you will be aware the Government will be implementing recommendations from the Health and Disability system review. This work will be undertaken alongside the work laid out in this letter. I expect that all DHB's will continue to provide the highest quality services to their populations while any changes are implemented across the system.

A number of DHBs will benefit from expert support across a range of areas and I understand that Chairs are working on an exemplars group. I expect you to seek the support of your colleagues and the Ministry where you need a lift in capability or support to navigate specific challenges.

This Government has provided specific sustainability funding for DHB led improvement projects. I expect to see tangible outcomes being delivered and implemented with this funding and reports on the impact it is having.

You will be aware that pay parity for workforces in the DHB-funded sectors is an issue. This is also an issue in other parts of the State sector, and it is important that a whole-of-Government approach is taken. This Government's position will be developed at a central agency level and I expect you to contribute to and act consistently with this approach. There are complex matters that need careful consideration, including whether DHB funding has flowed equitably to employees in the past and how this would be protected in the future.

I expect all DHBs to increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MECA. I want to be clear that full implementation of CCDM includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place.

DHBs are responsible for the health outcomes for your population and it is important that DHBs and the Ministry continue to work together, and with primary and community providers, to ensure we have a strong and equitable public health system delivering better health outcomes for our most vulnerable populations who have long-standing health inequities.

Please ensure any approaches to a service reconfiguration support improved access to care and equity, and are financially sound. As you are aware any shifts or additions in workforce / FTE must be considered as a service change and follow service change processes. DHBs

must remain focused and prepared for increased pressure and ensure systems are in place to ensure COVID-19 innovations are used to avoid pressure building up on existing services.

DHBs are expected to support and contribute to the Ministry's National Asset Management Programme (NAMP), which will be used to assist the Capital Investment Committee and Ministers to make more informed decision on DHB capital expenditure. I expect DHBs to develop their own Asset Management Policy and Strategy and align their asset management practices with the Ministry of Health district health board sector Asset Management Framework.

Unlike previous years I have strong expectations that the annual planning process will be completed on time and as Commissioner it is your responsibility to meet all deadlines for this process. I expect a strong first draft annual plan will be provided to the Ministry for review in early March so that a robust final plan that meets all expectations will be able to be agreed with me as early as possible post Budget 21. If timelines are not met and robust and appropriate plans are not delivered I will not be able to sign them off for the year.

Please note that I do not require you to refresh your Statement of Intent for 2021/22.

We face complex challenges that require collective approaches and I am looking forward to working with you as we continue our efforts to improve outcomes for New Zealanders.

Thank you for the work you have been doing to provide strong governance within our health system. I remind you that in everything you do you are part of the system.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Cc Dr Kevin Snee
Chief Executive
Waikato District Health Board

Minister's 2021/22 letter to Waikato DHB

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Dame Karen Poutasi
Commissioner
Waikato District Health Board
Karen.Poutasi@waikatodhb.health.nz

30 September 2021

Tenā koe Dame Karen

Waikato District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Waikato District Health Board's (DHB's) 2021/21 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Keeping COVID-19 out of communities.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health (the Ministry), including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Please ensure that a copy of this letter is attached to any copies of your signed plan made available to the public.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dr Kevin Snee
Chief Executive

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Strategic intentions, priorities and outcomes

Introduction

The 2021/22 Waikato District Health Board (DHB) Annual Plan (the plan) meets the requirements set out in Section 38 of the New Zealand Public Health and Disability Act, The Public Finance Act and sections 100 and 141 of the Crown Entities Act 2004.

Detailed planning and reporting components of the plan, including Waikato DHB's Statement of Performance Expectations and System Level Measure Improvement Plan are contained in the appendices.

The plan sets out the DHB's goals and objectives and what it intends to achieve, in terms of improving the health of the population it serves over the coming year. It outlines our strong focus on health equity and access, financial and clinical sustainability, and evidence based pathways for chronic disease management.

Areas of strategic focus for the coming three years include implementing Te Korowai Waiora, Waikato Health System Plan through locality development and reconfiguring models of care including a review of resourcing to support these models.

National (key strategies, health system review impact)

Waikato DHB is committed to a number of key national health strategies and plans that will help to achieve the vision that "All New Zealanders live well, stay well, get well." The key national documents that guide our direction at a regional and local level include:

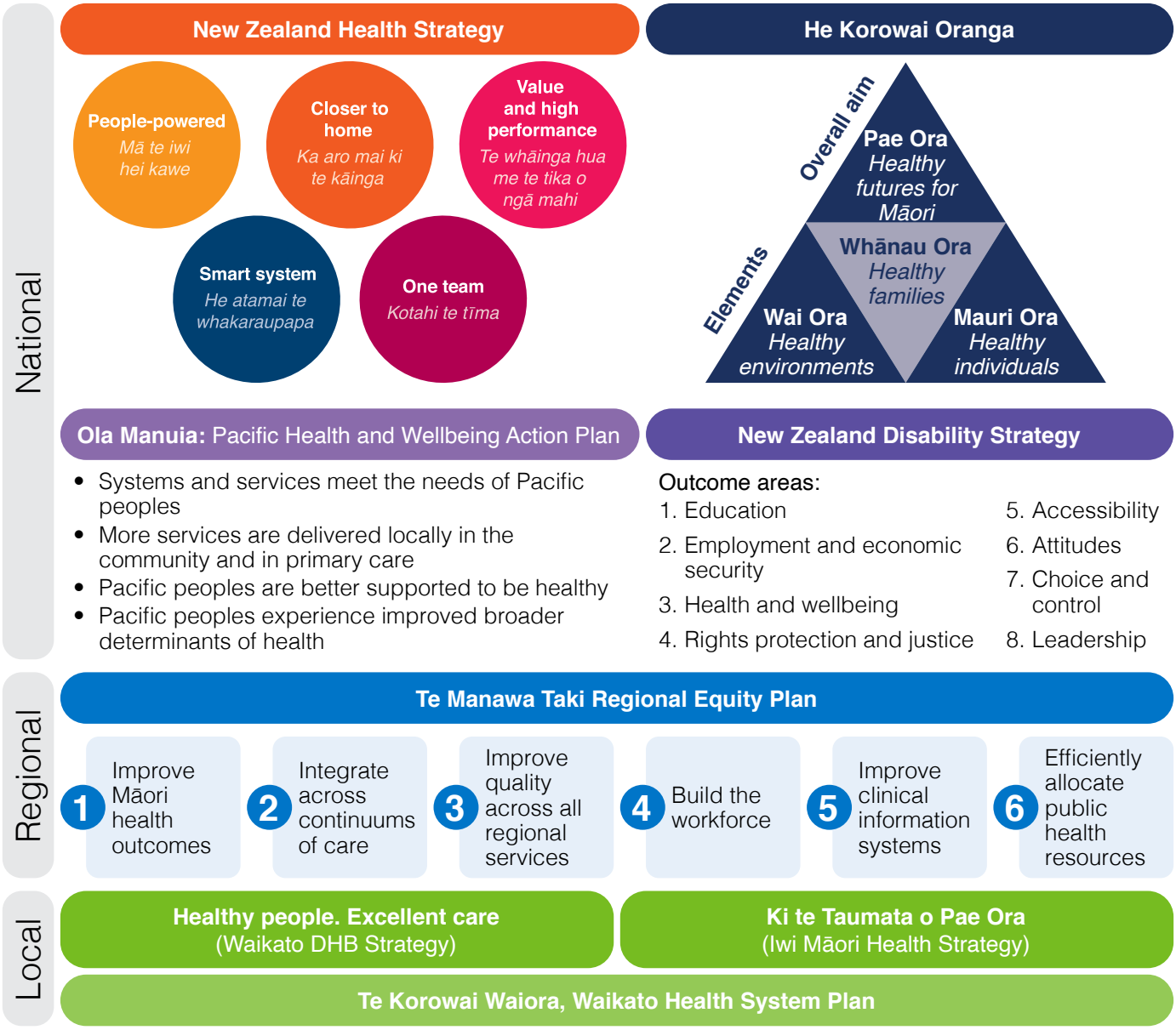


Figure: National, regional and local strategic intent

Te Tiriti o Waitangi

Te Tiriti o Waitangi is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of Te Tiriti and recognise the important role the health sector plays in the indigenous rights of Māori to achieve radical improvements in health and eliminate health inequities.

Central to the implementation of Te Tiriti principles is a shared understanding that health is a 'taonga' (treasure). The Treaty principles of partnership, tino rangatiratanga, active protection, equity and options, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work.

New Zealand Health Strategy

The New Zealand Health Strategy is the key source of direction for the health sector. The refreshed New Zealand Health Strategy provides the sector with clear strategic direction and a road map for the delivery of integrated health services for all New Zealanders. The strategy has a 10-year horizon so impacts on immediate planning and service provision as well as enabling and requiring DHBs and the sector to have a clear roadmap for future planning.

He Korowai Oranga

New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). DHBs in particular should consider He Korowai Oranga in their planning, to meet their statutory objectives and functions for Māori health.

Whakamaua: Māori Health Action Plan 2020-2025

The Whakamaua: Māori Health Action Plan guides the Ministry of Health (MoH), the whole health and disability system, and government to give effect to He Korowai Oranga. It sets out a suite of outcomes, objectives and priority areas for action that will contribute to the achievement of pae ora – healthy futures for Māori. Whakamaua means 'to secure, to grasp, to take hold of, to wear'. It also widely associated with the whakataukī used in this plan, 'Ko te pae tawhiti, whāia kia tata. Ko te pae tata, whakamaua kia tīna – Seek out the distant horizons, while cherishing those achievements at hand.

New Zealand Disability Strategy 2016-2026

The New Zealand Disability Strategy will guide the work of government agencies on disability issues from 2016 to 2026. This can also be used by any individual or organisation who wants to learn more about, and make the best decisions on, things that are important to disabled people.

The Strategy realises the rights of disabled people and supports implementation of the United Nations Convention on the Rights of Persons with Disabilities (the Convention) in New Zealand.

Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan

The Māori Disability Action Plan Whāia Te Ao Mārama is a culturally anchored approach to supporting Māori with disabilities (tāngata whaikaha) and their whānau because Māori are proportionately more likely to be disabled than the general population. Whāia Te Ao Mārama recognises that everyone must work together to achieve the vision – tāngata whaikaha pursue a good life with support. It outlines what the MoH is committing to do from 2018 to 2022 and provides examples of actions tāngata whaikaha, whānau, health and disability providers, iwi and other organisations can take.

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 (Ola Manuia) is a guide for the health and disability system and other government agencies in supporting Pacific peoples to thrive in Aotearoa New Zealand. Ola Manuia builds on the successes of the former plan, 'Ala Mo'ui 2014-2018. It identifies priority areas and where resources can be focused, as well as high-level actions that will contribute effectively to improving health and wellbeing for Pacific peoples.

The Healthy Ageing Strategy

The Healthy Ageing Strategy presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. It refreshes and replaces the Health of Older People Strategy 2002, and aligns with the new New Zealand Health Strategy 2016. The Healthy Ageing Strategy vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities". It takes a life-course approach that seeks to maximise health and wellbeing for all older people.

The UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities is the first United Nations human rights treaty of the 21st century. The Convention makes it explicit that member countries must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability. It will also help to ensure that mainstream services are inclusive of disabled people and delivered in non-discriminatory ways.

Regional

Te Manawa Taki region, formally Known as the Midland region, has a diverse population that consists of a much higher proportion of Māori than any other region in New Zealand as well as having a high number of people living in rural areas and a higher proportion living in areas identified as high deprivation. It is important that we work together and ensure our population receive the best health service possible with the resources available. Taking a collaborative approach makes best use of scare resource while balancing standardising processes and improving clinical outcomes with our drive to revolutionise the way in which healthcare is delivered in Te Manawa Taki.

For 2021/22 the agree priorities for Te Manawa Taki will be:

- planned care pathways and activities
- home and community support services for equity
- childhood immunisations
- youth mental health
- COVID-19

About **Te Manawa Taki**

21%

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

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

5 DHBs

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

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

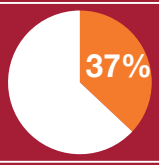
1,007,405 people (2021/22 population projections), including 265,360 Māori (27 percent) and 43 local iwi groups.

Te Manawa Taki iwi

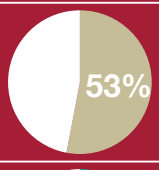
Māori population

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

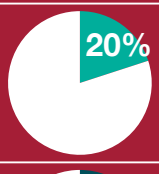
Lakes DHB
Te Arawa, Ngāti Tūwharetoa, Ngāti Kahungunu ki Wairarapa



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



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



Waikato DHB
Hauraki, Maniapoto, Raukawa, Waikato, Tūwharetoa,Whanganui, Maata Waka

Key
- Bay of Plenty DHB
- Lakes DHB
- Hauora Tairāwhiti DHB
- Taranaki DHB
- Waikato DHB

HealthShare is the shared services agency jointly owned by the Te Manawa Taki DHBs – Waikato, Bay of Plenty, Lakes, Hauora Tairāwhiti and Taranaki. HealthShare is tasked with supporting sustainable health service delivery through regional planning and providing operational support to areas identified as benefiting from a regional solution.

Regional collaboration forms a small but important part of the New Zealand Public Health System and involves working on a shared issue(s) that may be progressed more efficiently, collectively, as a region. Examples of such current shared issues for Te Manawa Taki include:

- equity and visibility: Monitoring equity of activity and outcomes as a region (e.g. oral health of children). This then enables DHBs to progress actions specific to their communities, share learnings from activities, etc.
- very highly specialised services: To monitor equity of access to services and to ensure the pathways of care for very highly specialised clinical services are streamlined and effective (e.g. Midland Trauma System, vascular surgery, cardiothoracic surgery, cancer services).
- resourcing: Ensuring the resources of specialised services are coordinated and sustainable (e.g. Internal Audit and Audit and Assurance services, Taleo IS services for recruitment).
- coordination for consistent care: Coordination of 'like' clinical services in hospitals across the region, where this is needed to support timely access (e.g. cardiac services, renal services) and to ensure care is delivered consistently.
- workforce: Coordinated workforce planning, where collective development/delivery of training is more efficient.
- systems: ICT systems development, deployment, and service coordination.
- initiatives and activities: Activities that have a finite life in their resourcing and are small, yet common, to each DHB (e.g. Hepatitis C eradication programme).

For the first time, in 2020/21 HealthShare transitioned the 'Midland Regional Service Plan' to Te Manawa Taki, Regional Equity Plan (REP). The REP focuses on key actions and outcome measures across a number of service areas that will ensure progress towards achieving equity at a regional level. While the Government begin to implement the findings of the Health System Review (Heather Simpson, 2020), nationally directed regional service planning is paused for 2021/22. Te Manawa Taki will continue with the 2020/21 actions and has put in place a governance structure which brings together chief executives, chairs of DHBs and our commissioner and chairs of Iwi Māori Council in a true partnership.

Table: Summary of key projects within the REP
For full detail on actions/outputs and outcome measures, see REP pages 37-63

Service	Network/Group	DHB Chief Executive Lead
Cancer Services	Cancer and Palliative Care Services	Kevin Snee, Waikato DHB
	Bowel Screening Regional Centre	Kevin Snee, Waikato DHB
Cardiac Services	Cardiac Clinical Network	Kevin Snee, Waikato DHB
Child Health Services	Child Health Action Group	Jim Green, Hauora Tairāwhiti
Healthy Ageing Services	Health of Older People Action Group	
Hepatitis C Services	Hepatitis C Service	Jim Green, Hauora Tairāwhiti
Mental Health and Addiction Services	Mental Health and Addiction Network	Nick Saville-Wood, Lakes DHB
Planned Care Services	Vascular	Rosemary Clements, Taranaki DHB
	Ophthalmology	Rosemary Clements, Taranaki DHB
	Infectious Diseases	Rosemary Clements, Taranaki DHB
Radiology Services	Radiology Action Group	
Stroke Services	Stroke Network	Rosemary Clements, Taranaki DHB
Trauma Services	Midland Trauma System	Rosemary Clements, Taranaki DHB
Regional Enabler groups		
Pathways of Care	Pathways of Care Governance Group	Jim Green, Hauora Tairāwhiti
Quality	Regional Quality Network	Rosemary Clements, Taranaki DHB
Workforce		
Data and Digital Services		Kevin Snee, Waikato DHB

Te Manawa Taki DHBs working together – Midland Trauma System

The Midland Trauma System is a network of specialised clinical personnel based in each of the five Te Manawa Taki DHBs. The clinical teams provide patient care, coordination and oversight of complex patients, provide local governance and direction through trauma committees, collect and review data with an emphasis on inequities and quality improvement including regional guideline creation and implementation and pre-destination matrices.

The clinical teams are supported by a hub service that runs and administers the Midland Trauma Registry (MTR), leads quality improvement initiatives, develops regional documentation and monitoring of workplans. The MTR also completes reporting at local, regional and national levels and provides regional governance and support. The hub includes the Midland Trauma Research Centre (MTRC) which identifies and monitors trauma issues translating data into knowledge whether the issues are clinical, system infrastructure or injury awareness and prevention in nature.

Recent activities have included:

- regional trauma guidelines
- streamlined trauma reception protocols
- pre- and interhospital referral matrices
- “Trauma Reach” virtual follow-up clinic
- “Safety Net” concept development
- ORAT Program (Optimised Recovery After Trauma)
- Patient Diary for major trauma

Over the next 12 months there are plans to progress the following:

- Extend the Trauma reach clinic to include high risk groups not under trauma admitting bed card-this will improve transition from hospital to discharge enacting the principles of whānaungatanga.
- Develop the Te Manawa Taki Trauma Task force with Ngā Toka Hauora to address inequity issues affecting Māori
- Engage groups to review the lack of whānau centred rehabilitation and create this as a kaupapa of care
- Reviewing responsibilities for DHBs and researchers towards consent and data sovereignty

Local strategic intentions

This annual plan articulates Waikato DHB's commitment to meeting the Minister's expectations, and our vision of "Healthy people. Excellent care." It makes clear links to national, regional and local agreed strategic priorities including the Waikato DHB Strategy (2016) and Te Korowai Waiora, Waikato Health System Plan (2019).

The Waikato Health System Plan, Te Korowai Waiora will focus the DHB's work on what is needed to support our population to improve their health, make services easier to access and improve the way services are delivered over the next decade. Waikato DHB is committed to working in partnership with local iwi, community service providers and consumers, as well as with the other Te Manawa Taki DHBs to achieve this.

Waikato DHB Strategy

In July 2016, Waikato DHB published its strategy with the vision of "Healthy people. Excellent care." This encompasses our aspiration that people will stay healthy and live healthy lives in their community. However, if care is required it will be easy to get to, be consistently good and user friendly.

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

The strategy describes the organisation as part of a wider health and social system, outlining six key strategic imperatives. Under each strategic imperative are four priorities which connect the strategy with the day-to-day activities of the Waikato DHB. These priorities are areas of work that will be our focus.

Waikato DHB Strategy

Vision
Healthy people. Excellent care

Mission
Enable us all to manage our health and wellbeing
Provide excellent care through smarter, innovative delivery

Values

People at heart
Te iwi Ngakaunui

Give and earn respect – *Whakamana*
Listen to me; talk to me – *Whakarongo*
Fair play – *Mauri Pai*
Growing the good – *Whakapakari*
Stronger together – *Kotahitanga*

Whanaketanga
Productive partnerships

Oranga
Health equity for high need populations

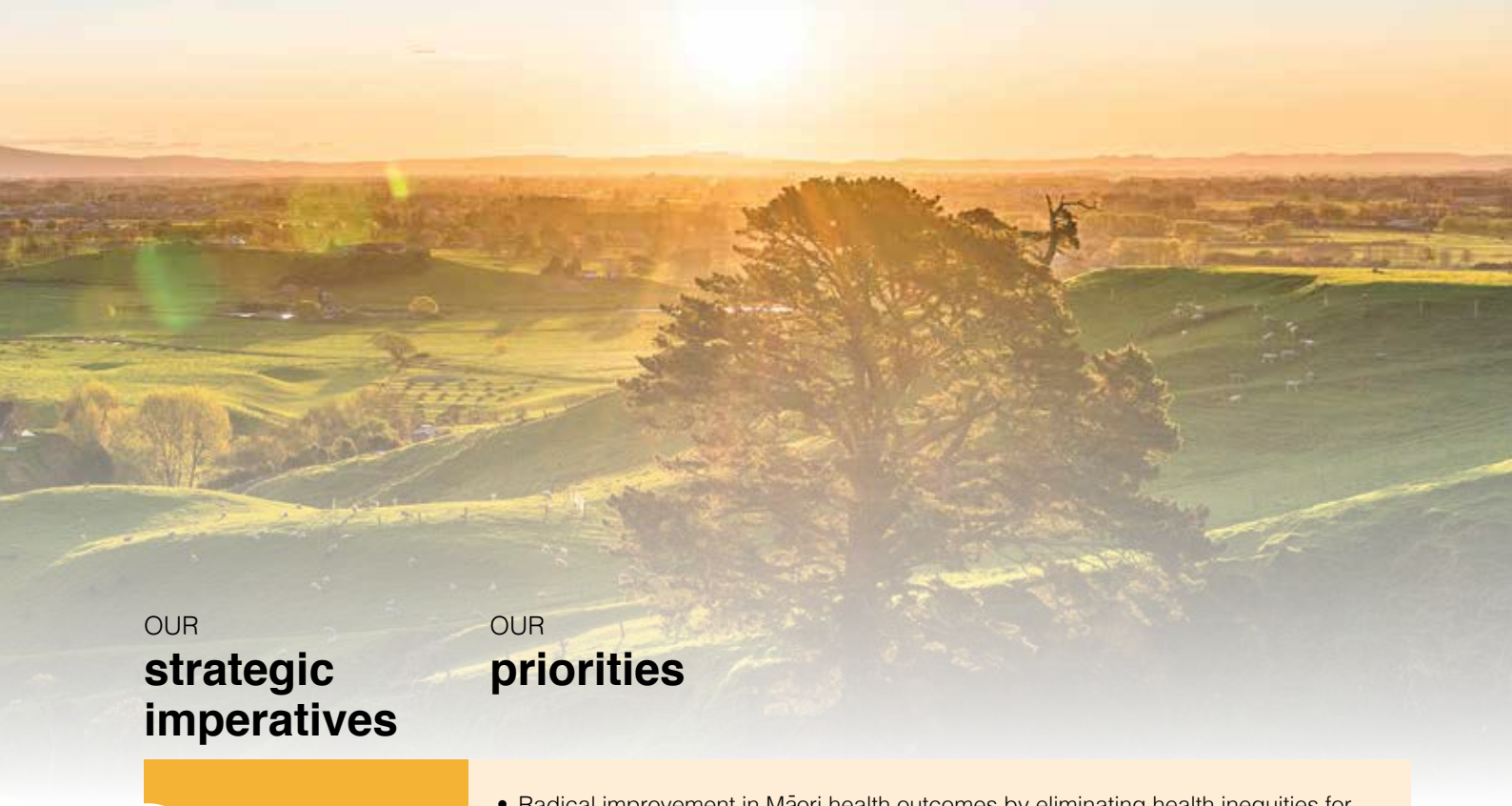
Haumaru
Safe, quality health services for all

Manaaki
People centred services

Ratonga a iwi
Effective and efficient care and services

Pae taumata
A centre of excellence in learning, training, research, and innovation

Figure: Waikato DHB strategy wheel incorporating our vision, mission and strategic imperatives



OUR strategic imperatives	OUR priorities
Health equity for high need populations ***Oranga***	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services
Safe, quality health services for all ***Haumaru***	• Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement, and innovation • Prioritise fit-for-purpose care environments • Early intervention for services in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives
People centred services ***Manaaki***	• Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whānau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy
Effective and efficient care and services ***Ratonga a iwi***	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and efficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services
A centre of excellence in learning, training, research, and innovation ***Pae taumata***	• Build close and enduring relationships with local, national, and international education providers • Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research • Cultivate a culture of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our population
Productive partnerships ***Whanaketanga***	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services

Figure: Waikato DHB strategic imperatives and priorities

Te Korowai Waiora, Waikato Health System Plan (Te Korowai Waiora, Waikato HSP)

During 2019 extensive engagement took place to inform the development of Te Korowai Waiora, this plan identifies seven goals that will guide the delivery of health services across the Waikato into the future.

The locality development programme will support implementation of Te Korowai Waiora bringing to life our vision "Healthy people. Excellent care" and Ki te Taumata o Pae Ora.

Te Korowai Waiora seven goals:

goal 1	Partner with Māori in the planning and delivery of health services
goal 2	Empower whānau to achieve wellbeing
goal 3	Support community aspirations to address the determinants of health
goal 4	Improve access to services
goal 5	Enhance the capacity and capability of primary and community health care
goal 6	Strengthen intermediate care
goal 7	Enhance the connectedness and sustainability of specialist care

The full Te Korowai Waiora, Waikato HSP is available on the Waikato DHB website: www.waikatodhb.health.nz/hsp

Locality development

The Waikato DHB Localities Development programme is the mechanism by which we can achieve the goals and actions in Te Korowai Waiora (2019-2029), and contribute to the health system transformation that is needed to achieve equity in health outcomes.

Informed by the community voice embedded in Te Korowai Waiora, the approach will identify key priorities across the health and well-being system in seven specific geographical areas of the DHB, and bring together the service alignments and collaboration needed to establish a local platform for action to address these priorities.

The Localities Programme will be embedded in the DHB governance framework and Iwi Engagement Strategy. It will have executive level sponsorship and be advocated to respective teams across the health system as collective strategic priorities driving the DHB towards integrated services that are closer to home and responsive to the health needs of the local population. The programme will be enabled by a range of supporting activities and funding to ensure capability, capacity and outcomes are enhanced - particularly in the primary and community care space.

An evaluation framework will monitor success as well as inform review, and be meaningful to our population at locality level. An equity lens is applied over all outcome measures, targets and process measures – with data shared, collected, collated, aggregated and disaggregated by ethnicity and iwi affiliation.

Urgent and emergency care report recommendations (2019)

With increasing demand being experienced across the DHB's Emergency Departments and growing pressure on existing general practice and urgent care centres, a review was commissioned to assess:

- Current and future demand and provision needs;
- The challenges and opportunities across the system to develop efficient and outcome focussed models of care;
- How to increase access and ensure services are available at an appropriate level; and
- How to assure service coverage levels are appropriate to localities.

The review produced a set of recommendations for each locality which Waikato DHB is continuing to explore, and implement where action will achieve progress towards the seven Te Korowai Waiora goals. Actions that relate to the implementation of these recommendations are contained throughout the section two activity table.

Commissioner priorities 2021/22

Commissioner priority	What will this look like?	Resourcing from *(estimated and subject to change)*
Financial and clinical sustainability/ Quality	Develop and implement an effective leadership and manager development programme, which includes core skills in relation to people management, financial sustainability and health and safety requirements.	Internal (no additional cost)Internal (no additional cost)
	Assessment will be completed to gain a better understanding of; the current price per unit of measure, the internal and external allocations, the cost construction of fixed and variable components, element, and cost drivers.	Internal (no additional cost)
	The outsourcing of Surgical services where clinically appropriate in sub specialities. Target areas will be services where the step costs for internal service provision take the DHB in excess of the national price.	Additional cost (included in the budget)
	Enable direct access to diagnostics for GPs to streamline the patient journey through the health system.	Additional cost (included in the budget)
	Continue with the diabetes retinal screening pilot roll out into localities where optometrist services are operating.	
Evidence based pathways	Delivery of whānau ora.	Additional cost (included in the budget)
	Implement Mate Huka. A new and additional diabetes initiative targeting Māori and Pacific to prevent and treat type 2 diabetes.	External funding (MoH sustainability funding)
	Renal.	Additional cost (included in the budget)Additional cost (included in the budget)
	Cancer.	External funding
	Mental Health (Whānau pai collaborative).	Additional cost (included in the budget)
	Clinical Services Plans for all services.	
Equity	Waikato DHB will establish an Equity Governance Group that will have accountability for the DHBs equity programme of work.	Additional cost (included in the budget)
	Equity fund for agreed investment to implement priorities as co-designed by the alliance group below and approved by the governance group.	Additional cost (included in the budget)
	Establish an Operational Alliance for Equity. This Alliance will report quarterly to the new Equity Governance Group.	Additional cost (included in the budget)
	Expand the membership of the Clinical Equity Leadership Group (CEG) to include experts from clinical professions such as nursing, allied health and primary care.	Additional cost (included in the budget)
	Waikato DHB will establish a Director of Māori and Public Health Research.	Additional cost (included in the budget)
	Waikato DHB will support Iwi Māori aspirations through a co-design process with Iwi Māori Council to increase Governance development and training opportunities.	Additional cost (included in the budget)
	Whānau Pai Collaborative.	External funding
	Redesign WHIRI for the cancer pathway from referral to diagnosis.	Additional cost (included in the budget)

Commissioner priority	What will this look like?	Resourcing from *(estimated and subject to change)*
Locality development	Governance and Iwi Engagement frameworks that support local partnership models to achieve health equity. Executive-level sponsorship for the programme, ensuring 'one voice' across the health system in the DHB rohe. Iwi partnerships and principle-based high trust relationship agreements in place as relevant for each locality. Robust and on-going health needs analysis and data interpretation ensuring an equity lens. An agile and flexible framework that enables the DHB to respond quickly to changes arising from the national health system transition and the development of a Māori Health Authority – working proactively with local consumers and providers to ensure consistency of approach and equitable sharing of available resource. Collective priorities for each locality, according to that population's health needs, that inform work plans and resourcing. An intersectoral community leadership group providing local governance for the programme portfolio; supported by DHB internal operational leadership and Locality Programme management. Work group(s) and resources to do the mahi. Action on local recommendations, for example - cost-benefit analysis of different service models supporting collective priorities and completion of relevant business cases to progress health system transformation such as Telehealth / Integrated health and social service hubs / models of care. Frequent feedback and communications to communities in a form that is easily understood around what was done and what outcomes were achieved e.g. Community Dashboard.	Additional cost (included in the budget)
COVID-19 response, ongoing management and vaccination	Community testing Resurgence planning/management Māori testing rates Vaccination programme	External funding (MoH)

In December 2020 our PHO partners met with the commissioner and presented a number of primary care priorities and their strategic aim for 2021. There was close alignment to the commissioner and Waikato DHB priorities (see Te Korowai Waiora and Annual Plan activity table) signalling a system that is working in partnership towards a common goal; delivering the best health services possible to our population within current resourcing.

Throughout the following plan there are activities that demonstrate how the DHB and PHOs will be working in partnership to drive progress of our shared priorities. Where the PHOs and the DHB are to jointly oversee delivery and outcomes, the activity will be identified as a partnership activity: 

Table: Waikato DHB PHO strategic aims

PHO strategic aims 2020-2022		
Improving health outcomes	Community and iwi partnerhips	Building the infrastructure
• Health equity, particularly for Māori and Pacific • Consistency of essential, core service provision across the district • Reducing obesity trend and disease impact; diabetes, COPD • First 1000 days • Reduction in active smokers • Improving mental health and wellbeing	• Community determination in service design and delivery • Community determination of service provision above essential services • Integration and expansion of kaupapa Māori services	• Integrated health and social care teams (Tier 1) • Easy access to diagnostics – especially rural communities • Integrated patient information systems for best value care • Ensure a sustainable and skilled primary care workforce • Develop the Māori workforce

DAME KAREN POUTASI

Message from the Commissioner

Auē! Taukiri ē…
Mai ngā kōkōna e whā
O Pare Waikato, ki Pare Hauraki
E rere tonu ki te tonga
Ki ā Ngāti Tūwharetoa
Ka peka atu ki te taha uru
Ko Ngāti Hāua rāua ko, Ngāti Maniapoto
Haere tonu ki te raki kei Wharepūhunga, ko Raukawa tērā
Tae noa hoki ki Waikato, ki te Rūnanga o Kirikiriroa
Mā turuturu ana mai o whiti whakamaua
Kia tina! tina! haumi ē… hui ē..
Tāiki e.…

E whakaruruhau te korowai o te Atua ki runga i a tātou
Ko ia te kupu, ko te kupu ko ia,
ko ia te Atua te timatatanga me te whakamutunga ō ngā mea katoa.
Ka huri ki te Kīngi Māori ā Tuuheitia Pootatau te Wherowhero te Tuawhitu
Me te Kahui Ariki whānau, whānui tonu
Ā rire, rire, hau
Paimarire
Ka huri ki te tonga mai he tīpare ataahua ō ngā maunga o Ngāti Tūwharetoa
I te whakaruruhau o te Ariki o te Heuheu e.. i…
No reira
Tēnā koutou, haere mai koutou tēnā tātou katoa
He hari koa, ki a hōnore mātou kia puta mai tēnei mahere ā tau kia koutou
E rau rangatira mā ka huri te ao
Ka pāhuri ake tētehi tau, aha koa ngā piki me ngā heke
I raro te urutā/mate korona
Hei tūwhera te tātou pūrongorongo o te Whare Waiora o Waikato
“Ka tae ki te wā me hoe tahi tō tātou waka”
Kia Kaha!

The critical role healthcare services play in protecting our communities and caring for the wellbeing of every individual has been highly visible over the past year.

Waikato DHB staff, along with our iwi, primary, community and allied health providers delivered leadership, guidance and care for our community in the face of the global COVID-19 pandemic, and we are incredibly grateful for their mahi.

It is a welcome contrast that today our primary challenge is ensuring everyone in our community has access to their free vaccination against this virus.

The commissioners support the approach taken nationally, and by this DHB, to ensure those most vulnerable in our community are prioritised for vaccinations. Accessibility and equity remain the key measures for the success of our wider vaccination programme, particularly across an area as large and diverse as the Waikato.

The COVID-19 response demonstrated the effectiveness of partnerships with community providers, being mobile, and providing a variety of ways for people to access services, all of which have been built into our vaccination approach to ensure better health outcomes for our communities.

Last year we noted that the pandemic would likely have lasting impacts and this has proven true as it has accelerated what was already a rapidly growing demand for healthcare services. As described in our Health Services Plan, Te Korowai Waiora, we must continue to focus on prevention and work across the DHB region to support our community wellbeing by delivering healthcare where people live.

This is something we will continue to drive to free up health services for those who need it most.

This year the DHB also published its equity report, Rapua Te Ara Matau, which illustrated the health inequities experienced by Māori and Pacific people in New Zealand. This report described the impact of inequities, how they can compound across the course of a lifetime, and the urgency required to work collectively and enable all New Zealanders to achieve their full health potential.

The DHB is committed to improving health outcomes for all Waikato communities by ensuring equity is considered across all plans and actions. We see positive progress being made and would like to acknowledge those working within the DHB and across related sectors for their tireless work to make meaningful change. The equity report reminds us how urgent this work is and it remains a key priority.

The DHB experienced a cyber security incident on 18 May which had significant impact on services. Patient care and safety was the priority for all DHB staff and the ability and willingness of our people to respond during this crisis was inspiring. The initial response focused on maintaining critical services and enabling services to operate with manual processes in place. This has now shifted to recovery as the DHB restores services to full capability and works to resolve any clinical and data backlogs. The DHB has continued to show great resilience in order to provide a high standard of care to patients throughout this event.

The Government announced sector-wide change with Health NZ to be formed next year as a national body in place of the current district health boards. A new Māori Health Authority will also be established. This will be the single biggest transformation of our health system in decades. Although there are always challenges when managing change on this scale, this is an opportunity to strengthen and unify the healthcare sector for the benefit of our patients and staff. The objective of the transformation is to build a system better able to be cohesive, equitable, accessible, and people-centred. We look forward to working with the Transition Unit over the coming months as this new model takes shape.

It is also imperative that DHBs continue to deliver on their plans to improve and invest in services for our communities over the next year and Waikato DHB will do that.

The key objective for all healthcare providers is the delivery and continuous improvement of services for our communities and wider New Zealand and this will continue under any new structure.

Dame Karen Poutasi

DR KEVIN SNEE

Message from the Chief Executive

Koi te mata punenga,
Maiangi te mata puihoiho
Takiri mai te ata, korihi te manu
Tino awatea ka ao, ka ao, ka ao te rā.
Tīhei mauri ora

E ngā waka, e ngā hapu
E ngā reo, e ngā kārangaranga
Tēnā koutou, tēnā koutou, tēnā tātou katoa

E mihi mahana tēnei ki a koutou
E rau rangatira mā ō tā tātou takiwa o te Whare Waiora o Waikato
He hōnore mōku e mahia ngā mahi hei mōkai mo koutou te iwi
Kei te mōhio tātou ngā awangawanga, raruraru hoki
E noho ana tātou i te mate o te ao korona-19
Heoi, aha koa he uaua rawa atu ētehi wā i tā mātou ao hauora
E whakatukaha ai a tātou waka ki mua mo te painga ō tātou iwi

Noreira e te iwi e kore tātou e wareware ana he whānau pani, rawakore me te pouwaru
Ki a rātou mauiui ana e tae maha ana i roto i nga hohipera
Ka tau
Ki te Kīngi Māori aa Tuuheitia Pootatau te Wherowhero te tuawhitu
Me te Whare Ariki o Te Heuheu
Paimarire.

Waikato DHB continues to strengthen its services and partnerships in the community, which form the foundation of a strong local healthcare system that best meets the individual needs of its people.

Guiding our models of care today is a patient-centric ethos. As we face further challenges ahead to manage growing demand on the health system, it is this partnership approach that we must continue to follow to achieve sustainable patient care.

A successful roll out of the COVID-19 vaccination programme is critical for us this year to ensure we keep our communities protected and our whānau well.

I would like to thank the team who are driving this campaign, those working in our community vaccination centres, as well as our iwi partners, kaupapa Māori and Pacific providers, general practices, community pharmacies, public health nurses, aged residential care providers and other health providers who are administering vaccinations. There is still a large programme of work ahead of us, but through strong partnerships we expect everyone will have an opportunity to receive the vaccine in their own community and in many instances, from a known and trusted healthcare provider.

Another focus is the ongoing recovery from the cyber attack in May, which resulted in critical systems supporting healthcare services being taken offline. The immediate and universal response of our staff to enable the ongoing delivery of care and ensure patient safety in the days after this attack cannot be overstated. Similarly, the tireless efforts by DHB staff and supporting agencies to rapidly stand-up critical services was crucial to minimising the impact on our community.

While we are close to having all of our information systems now reinstated back into the business, service recovery will continue to be a focus over the coming months, with clinical services given priority throughout.

Further acknowledgement should be given to staff who throughout the year's challenges have remained committed to meeting the needs of patients and implementing service improvements, while also working within our agreed funding levels. This has been essential to keep our budget on track. As we continue to face growing demand, effectively managing our resources as we deliver quality care is essential.

We are now in the second year of implementing our Health Services Plan, Te Korowai Waiora. The level of services across the localities is strengthening, and we continue to invest in this plan to promote proactive care and wellbeing and reduce the pressure on our hospitals.

The Government has now confirmed the move from 21 DHBs to a single entity, Health NZ, from July 2022. While DHBs today seek to collaborate and share services wherever possible, the transition this new structure provides further opportunities to share best practice, boost efficiency, and build a system which is truly patient-centric.

Our focus will be on making this transition as seamless for staff and patients as it can be, and ensuring the investments and projects underway to improve healthcare in our region continue to be supported.

The creation of a Māori Health Authority is another opportunity to drive equity and deliver better health outcomes for Māori. Health equity is a key priority across all DHBs and a national body to provide leadership and direct investment can deliver meaningful change for the benefit of all New Zealanders.

We look forward to supporting the development of Health NZ and are assured that any change to the healthcare system is intended to support the delivery of services and to benefit our community.

Dr. Kevin Snee

TE PORA
THOMPSON-EVANS

Message from the Chair, Iwi Māori Council

Ki ngā tāngata o ngā hau e whā
E ngā karangaranga maha
E ngā whānau
E ngā whanau whānui
E ngā iwi whanau
E ngā iwi o te Moana nui a Kiwa
E ngā mana, e ngā reo, e ngā waka
Tēnā koutou, tēnā koutou, tēnā koutou katoa.

Amohia ake te ora o te iwi,
Ka puta ki te wheiao
Kiingi Tuuheitia Pootatau Te Wherowhero te Tuawhitu

This tongikura from Kiingi Tuuheita was given at a time where we faced adversity and is a constant reminder that despite the challenges – the wellbeing of our people is paramount in all that we do.

Historically, times of social and economic hardship such as these have contributed to poorer health outcomes for Māori. We simply cannot let history repeat itself, and it is critical that we work together to close the equity gap and support whānau to have safe, equitable access and appropriate care in their time of need.

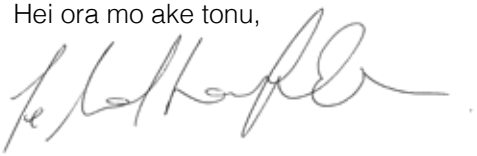
The success of Māori providers serving within our region alongside our Pacific providers have enabled a collective success in not just growing but realising the opportunities of the DHB to partner of the delivery of health care services.

The COVID-19 vaccination partnerships across the region is a clear demonstration to how partnership is critical to delivering equitable access, drawing on the lessons learned during our pandemic response during the previous year. We are immensely grateful to iwi partners, kaupapa Māori and Pacific providers, and other local providers for the work they are doing to either administer vaccinations or provide resourcing by way of vaccinators, administrators and Kai Maanaki in our community vaccination centres across the region.

The Equity Report, Rapua Te Ara Matua, published by the DHB this year, was welcomed by the Iwi Māori Council as a paper the clearly depicts of the real impact of inequities on individuals and whanau and will act as a powerful tool to measure the actions within this annual plan. Therefore, actions must be meaningfully implemented, tracked and monitored if we are truly going to eliminate inequities and be accountable to those we serve.

Returning to Kiingi Tuuheitia's tongikura to us all. As we face the welcomed Health System reform – it is only in unity and action that together we will keep our people well.

Hei ora mo ake tonu,



Te Pora Thompson-Evans
Chair, Iwi Māori Council

Signatories

Agreement for the Waikato DHB 2021/22 Annual Plan

between

Hon Andrew Little
Minister of Health

Date: 30 September 2021

Hon Grant Robertson
Minister of Finance

Date: 30 September 2021

Dame Karen Poutasi
Commissioner
Waikato DHB

Date: 28 July 2021

Dr Kevin Snee
Chief Executive
Waikato DHB

Date: 28 July 2021

Te Pora Thompson-Evans
Chair, Iwi Māori Council
Waikato DHB

Date: 28 July 2021

Minister of Health's planning priorities

The Government priorities and desired outcomes for New Zealand include planning priorities for health, wellbeing and equity. The 2021/22 annual planning priorities for all DHBs are:

- Achieving health equity and wellbeing for Māori through Whakamaua: Māori Health Action Plan
- Sustainability
- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management

Māori health improvement in DHB annual plans

Waikato DHB will meet its obligations as a Te Tiriti o Waitangi partner as specified in the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004. The refreshed Te Tiriti principles: options, equity, active protection, Tino Rangatiratanga and Partnership, identified by the Waitangi Tribunal will underpin all work.

The Waikato DHB provider arm restructure aims to increase health equity for Māori, with several new roles to focus on this vital area. The changes will be implemented in 2021 and will allow for a system that works collectively to improve health equity for our communities, ensure better outcomes for our patients, and place people at the heart of everything we do.

Te Puna Oranga, Waikato DHB Māori Health service and the Waikato Public Health unit (PHU) have been bought together under the executive director Māori Equity and Health Improvement to optimise the combined value and contribute more favourably towards our Te Korowai Waiora, Waikato Health System Plan goals.

The change will strengthen the team's ability to respond and proactively support the aspirations of the Iwi Māori Council and the vision they have for the health and wellbeing of the Māori population. A key focus for 2021/22 will be to develop a strategy and support action in partnership with our key stakeholders and clinical leaders to eliminate health inequities for our Māori, Pacific and priority populations such as whānau hauā (disabled peoples). The team will also continue work in collaboration with the Organisational Support team and the wider Executive Leadership team to eliminate institutional racism and unconscious bias within our hospitals, wider organisation and wider local health system.

Rapua Te Ara Matua, Waikato DHB Equity Report (2020) has been developed to highlight the gaps in our population health outcomes across a range of measures and hone our monitoring and elimination efforts of the ever present equity gaps that exist in the health system for Māori and Pacific peoples. This report demonstrates that there are persistent equity gaps for Māori and Pacific peoples in the Waikato DHB catchment. The report will identify areas where tangible actions are required to deliver the strategic transformation of Waikato DHB in line with Te Korowai Waiora and Whakamaua: Māori Health Action Plan.

Te Korowai Waiora and Rapua Te Ara Matua provide evidence that the DHB cannot improve Māori health outcomes working in isolation from our treaty partners. To ensure the goals of Whakamaua are embedded in the Localities Approach, we will build working partnerships with iwi based on shared principles:

- We recognise and respect the mana, statutory autonomy, and responsibilities of the other
- We will conduct our relationship in a mana-enhancing manner
- We support the importance of te reo me ona tikanga in our dealings
- We undertake to share information, discuss openly, and solve problems together
- We recognise and respect the diverse strengths and contributions we each bring to the relationship
- We recognise the importance of using effective channels of communication and establishing regular opportunities for formal dialogue
- We share responsibility for any outcomes and achievements that result from our collaboration
- We are committed to working collaboratively and to finding ways to get things done quickly in the areas and the ways we believe will accelerate improvements in hauora for iwi and within the community.

Achieving health equity in DHB annual plans

Te Korowai Waiora is a 10-year health system plan that will drive the DHB to focus on equity of health outcome and equity of access as its core purpose. The Locality Approach being developed supports these goals at a community level. Accordingly planning documents such as the annual plan will each year review and recognise progress and build on the actions needed to meet equity targets.

Equity for Waikato DHB means the achievement of a just and fair health system which reflects whānau aspirations, enables whānau to live, thrive and flourish and ensures that the right to equitable voice, access, quality, health outcomes and experience is met for Māori and other priority populations. This annual plan will have an equity lens across all priorities and align to Rapua Te Ara Matua and our equity position statement.

Rapua Te Ara Matua

Rapua Te Ara Matua is the Waikato DHB Equity Report published in 2021. It presents a snapshot in time of the persistent health inequities that exist for Māori and Pacific peoples. The report will be used to inform decision making and design fit for future solutions. A selection of 20 measures have been selected as key indicators of how life's journey is progressing for Māori and Pacific peoples, these closely align with focus areas of this annual plan and targets set in our Statement of Performance Expectations. Rapua Te Ara Matua measures are clustered into life stages and present the story of inequity from birth to end of life.

As the partnership between the Crown and Iwi continues to grow and the localities approach is embedded, addressing unmet need at a local level, progress against these 20 indicators will be monitored with the expectation the equity gap will reduce, and in time be eliminated.

To achieve equity Waikato DHB will:

- meet our obligations under Te Tiriti o Waitangi in contemporary ways at system, organisation and service levels
- support Māori and Pacific communities to design and deliver healthcare through the DHB, other mainstream entities and their own health providers
- prioritise, redistribute and purposefully invest resources to invest in equity and wellbeing gain for Māori and Pacific communities
- ensure that investments result in Māori and, or Pacific wellbeing and equity gain
- ensure that the health system is coordinated and responds more effectively to patients, whānau and communities
- measure and widely report health service equity results in access, quality and outcomes of care between Māori, Pacific and Others
- ensure the development of strong minimum standards for equitable care and provide resource needed to monitor and achieve these standards
- recognise the value of tikanga (values and practices) and mātauranga (Māori knowledge) for Māori.

Equity actions are identified throughout the Annual Plan and marked as 'EOA.' These actions reflect a change agenda to support improved equity outcomes, rather than business as usual approaches and ensure our day-to-day activities are driving progress towards achieving equity.

Responding to the annual plan guidance

The following activity table is based on the Government planning guidance and reflects the priorities identified by the Minister of Health for the 2021/22 year. A new approach to the planning process has been taken with activities moving away from a large list of 'business as usual/operations' activities to key initiatives that will drive equity or embed COVID-19 learnings. For 2021/22 the PHU annual plan will continue to be integrated into this annual plan.

The COVID-19 pandemic has been a challenge for the health system and will continue to be so as we continue with the ongoing management and response. While being one of the biggest challenges of our lifetime it has also bought with it great learning opportunities and shown what can be achieved when barriers are removed and the sector works together. While the ongoing response and management continues, reflection on key learnings has and will continue to take place.

Transition to Health New Zealand

This plan has been developed at a time of anticipated significant changes in the health system and its operating environment, our support to ensure the successful and seamless implementation of these changes will take priority and as more becomes known adaptation or changes to the activities within this plan may be required. Waikato DHB will be working with the Health and Disability Review Transition Unit (Transition Unit) as they develop the implementation plan and work programme for the transition to Health NZ. The main priority during this transition is to remain agile to ensure the transition is timely with limited disruption to service delivery. Improving equity of access and health outcomes has been the key strategic priority for Waikato DHB, this system change and the introduction of a Māori Health Authority presents the opportunity to take a radical new approach that will improve health outcomes for all New Zealanders for generations to come.

Response to COVID-19

A significant benefit from the disruptive impact of COVID-19 was the rapid development of high-trust relationships resulting in innovative collaboration between Waikato DHB and our Māori and Pacific providers as testing and vaccination regimes rolled out across the district. Doors have been opened to new ways of working together impacting on Māori and Pacific health, and the Localities Development programme has capitalised on this to sustain the impetus for further mahi tahi and data sharing to support Locality action plans.

Waikato DHB and our Public Health unit will continue to work with, and support the MoH to design and implement a national public health response where we will more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which we mount a surge response if needed and address future challenges. Ultimately, a safe and effective vaccine for COVID-19 is essential to protect our population and the roll out of such a vaccine will be a key piece of work for 2021/22. This work will take place in addition to the following planning priorities and subsequent activities.

Waikato DHB 2020-22 annual plan activity

Government planning priority			
Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025 (EOA)			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Partner with Māori in the planning and delivery of health services	**Engagement and obligations as a Treaty partner (EOA)**	
		Waikato DHB is committed to meeting our Te Tiriti o Waitangi obligations. Examples of how we intend to meet this obligation include:	
		Waikato DHBs equity programme of work will support local implementation of Whakamaua and drive progress towards our strategic priority of achieving health equity.	Q1 and ongoing
		The Waikato DHB Equity Governance Group will have accountability for the DHBs equity programme of work. The group will report quarterly to the Executive Leadership Team (ELT) and commissioner on progress.	Q1-Q4 Q2 and Q4
		Building meaningful partnerships with iwi is vital for improving equity of health access and outcomes. For this reason Waikato DHB will negotiate and enter into operational agreements with iwi in each locality. The agreements will recognise a shared commitment to local level Māori development and kaupapa Māori service solutions.	Q1-Q4
		The Localities Programme will be embedded in the DHB governance framework and Iwi Engagement Strategy.	Q2 and Q4
		Waikato DHB will support Iwi Māori aspirations through a co-design process with Iwi Māori Council to increase governance development and training opportunities.	Q4
		Waikato DHB will support the development and implementation of Te Manawa Taki Regional Equity Plan through active participation in regional planning and clinical governance groups.	
		Accelerate and spread the delivery of kaupapa Māori and whānau-centred services (EOA)	
		This is an important element in enabling Māori to exercise their authority under Article Two. Waikato DHB will ensure that Māori capability and capacity is supported through actions such as those listed below:	Q2 and Q4
		Iwi partnerships and principle-based high trust relationship agreements in place as relevant for each locality	Q1 and Q3
		The Waikato DHB Puna Waiora programme encourages Māori to enter the health sector. This is a kaupapa Māori support system driven to empower and support rangatahi Māori to pursue health careers. Our annual schedule of primary kaupapa include: • Wānanga ā-rohe – A series of locally-based wānanga for Year 11-13 rangatahi Māori focused on building skills, knowledge and connections to enhance rangatahi aspiration to enter the health workforce. • Te Tomokanga –Fit for purpose Gateway placements for Māori secondary school students across Waikato DHB and partner providers. • Wānanga Pūtaiao – An interactive science wānanga for Year 9-10 rangatahi Māori to inspire and increase uptake of sciences when they enter Year 11.	
		Whānau Pai Collaborative will increase access to and choice of kaupapa Māori primary mental health and addiction services. The Whānau Pai Collaborative is an integrated primary mental health and addiction service. This provides expanded access and choice of primary mental health services with layers of support available for all people, based on what they need, including linking to ongoing support. Health Improvement Practitioners (HIP), Health Coaches (HC) and cultural support/support workers will be trained and implemented into general practice to deliver care when needed.	Q1 and Q3
		Whānau Hauora Integrated Response Initiative (WHIRI) – In the Waikato, COVID-19 led to a rapid reconfiguration of hauora services to meet Māori need. This included the WHIRI; a wraparound whānau hauora assessment with proactive management and navigation by clinicians. There are well documented significant inequities from time of referral through to cancer diagnosis. Cancer nurse engagement is variable along this part of the cancer pathway, care quality is not well monitored, and the pathway is not pandemic resilient. We will redesign WHIRI for the cancer pathway from referral to diagnosis. This will be informed by evidence; clinical notes review; patient, whānau and staff interviews; and stakeholder engagement. We will pilot, evaluate and develop a service toolkit for national rollout.	Q2 and Q4
		Locality development – Iwi partnerships and principle-based high trust relationship agreements will be in place as relevant for each locality. An agile and flexible framework will be developed that enables the DHB to respond quickly to changes arising from the national health system transition and the development of a Māori Health Authority – we will work proactively with local consumers and providers to ensure consistency of approach and equitable sharing of available resource.	Q1 and ongoing

Government planning priority			
Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025 (EOA)			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Partner with Māori in the planning and delivery of health services	**Shift cultural and social norms (EOA)** **Is critical to ensuring that Māori can live and thrive as Māori. To address racism and discrimination in all its forms Waikato DHB will prioritise the following:**	
		The new Waikato DHB Operational Alliance for Equity will progress our equity aspirations (2.3 page 11) and goals. This alliance will report quarterly to the new Equity Governance Group.	Q1
		Expand the membership of the Clinical Equity Leadership Group (CEG) to include experts from clinical professions such as nursing, allied health and primary care. Having the CEG group in place will provide the Waikato DHB workforce with; a local mechanism for expert advice on how to accelerate the achievement of equity, review and critique of proposals and plans to achieve equity, ensure greater coordination of our operational equity endeavours across the system, and expert Tikanga and cultural capability.	Q1
		By June 2022 all Tier 1-5 staff will have completed endorsed antiracism, cultural safety and competence training.	Q4
		Waikato DHB has agreed to the six targets in the Tumu Whakarae and DHB CEO agreement on increasing Māori participation in the DHB employed workforce. Waikato DHB will be actively working towards achieving and will report on progress at least annually to the Waikato DHB Equity Governance Group. The Tumu Whakarae workforce targets include: 1. Waikato DHB will have zero percent of employees who have their ethnicity recorded in their employee profile as "unknown" by 30 June 2020. 2. Waikato DHB will employ a Māori workforce that reflects the Māori population (currently 23 percent) by 2030. 3. Waikato DHB will employ a Māori workforce with occupational groupings that reflect the Māori population by 2040. 4. DHB staff (clinical and non-clinical) who have contact with patients and whānau, Board members and those in people management or leadership roles will demonstrate participation in cultural competence training by 2022. 5. 100 percent of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview. 6. Turnover for Māori staff will be no greater than the DHB turnover for all staff.	Q4 and ongoing
		Reduce health inequities and health loss for Māori (EOA) **Achieving equity is a strategic priority for Waikato DHB and is a principle of Te Tiriti. Equity is a key driver of all our activity throughout not just this section, but the entire plan. Some examples of our equity activity are included below:**	
		Waikato DHB will work with iwi to a develop a COVID-19 vaccination roll-out plan and to establish a communication platform for the COVID-19 vaccine programme. By June 2022 there will be no equity gap in COVID-19 vaccination rates between Māori, Pacific and others.	Q1 and ongoing
		Waikato DHB has **developed measures of Māori health and disability outcomes and wellbeing to help measure pae ora** these were agreed in partnership with Iwi Māori Council and have been included throughout this plan.	Q4
		Waikato DHB will develop and publish an Equity Action Plan and Reporting Framework (agreed pae ora measures). **Equity Reporting will monitor progress towards pae ora and be publically available**. The Equity Governance Group will be responsible for delivery of the Equity Action Plan.	Q4

Government planning priority			
Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025 (EOA)			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Partner with Māori in the planning and delivery of health services	**Strengthening system accountability settings (EOA)** **This will support the overall goal of pae ora. Examples of how Waikato DHB will commission services and work with other agencies to support this goal include:**	
		Implementation of governance and iwi engagement frameworks that support local partnership models to achieve health equity.	Q1-Q4
		Each Waikato DHB operated service will have a Māori and Pacific Health Equity Action Plan in place by June 2022. This will support the implementation of system accountability frameworks that assure ownership of Te Tiriti obligations and accountability for Māori health equity.	Q4
		Waikato DHB has and will continue to engage with local iwi when developing the business case and plans for the new mental health facility at Waikato Hospital.	Q1 and ongoing
		As part of locality development robust and on-going health needs analysis and data interpretation with an equity lens will be completed and used to inform service planning.	Q2 and Q4
		Frequent feedback and communication to communities in a form that is easily understood around what changes have been implemented as a result of their feedback/engagement and what outcomes have been achieved e.g. Community Dashboard.	Q2 and Q4
		The Waikato DHB Clinical Equity Leadership Group will offer support to iwi or Māori providers to respond collaboratively to the development and implementation of research in Māori health equity priority areas.	Q4
		The new director of Māori and Public Health Research will be responsible for: advancing the priorities of the Equity Governance Group, overseeing the Clinical Equity Leadership Group, development and implemention of research in Māori health equity priority areas, and have oversight of the Operational Alliance for Equity.	Q2

Improving sustainability

Government planning priority			
Improving sustainability			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Ratonga a iwi – Effective and efficient care and services	Enhance the connectedness and sustainability of specialist care	***Short term focus (next 12 months)*** There are three key areas that will help Waikato DHB to improve short term sustainability: sustainability funding initiatives, national analytics and strengthened production planning. A snapshot of key activity occurring under each of these areas is below. Our budget has incorporated material cost reduction activities, with a total value of $40.3 million. These three key areas are central to achieving our cost reduction target, and therefore our budget. A total of $18 million is expected to be saved from direct hospital (internal provider) costs, linked to national analytics and production planning. $12.9 million of budgeted cost reductions relate to overheads	Q1 and Q3
		Sustainability funding initiatives Review the overhead allocation methods and understand the clinical and non-clinical overhead drivers of cost. Continue to sustainable funding initiatives which include: Mate Huka is a new and additional diabetes prevention and treatment programme that is specifically targeting high need populations. The programme has been co-designed including with iwi and Pacific partners, and will provide early screening and education with the aim of reducing the prevalence of type two diabetes. The WHIRI evaluation demonstrated a holistic health and social service needs assessment for Māori consumers and provides pathways to support based on whānau needs. It was integrated early during the DHB's COVID-19 response and will now be implemented in Waikato Hospital Emergency Department (ED) and piloted at the Tokoroa Hospital ED.	Q1 and Q3

Government planning priority			
Improving sustainability			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Ratonga a iwi – Effective and efficient care and services	Enhance the connectedness and sustainability of specialist care	**Locality Development** Locality work plans will address current priorities but also be developed with sustainability as a key factor. Decentralisation of specialist services, where possible, is a key part of the localities approach. The scoping of integrated health and social sector hub and spoke models where services and workforce are brought closer to service users – either through virtual or actual relocation – will be addressed by each locality as to whether this option is relevant in that area.	Q1-Q4
		National analytics Employ effective and efficient cost reduction strategies in both clinical and non-clinical operational activity. An assessment will be completed to gain a better understanding of; the current price per unit of measure, the internal and external allocations, the cost construction of fixed and variable components, element, and cost drivers.	Q2 and Q4
		Strengthened production planning The outsourcing of surgical services where clinically appropriate in sub specialities will help to drive progress in this space. Target areas will be services where the step costs for internal service provision take the DHB in excess of the national price. Procuring services with the open market will ensure the DHB is obtaining the best price whilst maintaining clinical efficacy and encouraging continued service improvement.	Q2 and Q4
		Medium term focus (next three years) **Waikato DHB is committed to reducing its cost growth over the next three years and to ensuring a sustainable path to breakeven. To support these priorities in 2021/22 we will:**	
		Sustainable system improvements Work in partnership with our primary care providers to improve access to diagnostics by maximising care closer to home and making best use of the current resource available. The 2021/22 focus will be on Radiology services with third party providers, ensuring these have a price per unit of measure that is within the national pricing levels.	Q1-Q4
		Plan to use mobile ultra sound unit in communities where no hospital radiology services are available. (EOA)	Q4
		Enable direct access to diagnostics for GPs to streamline the patient journey through the health system. This will also increase the conversion rate for appropriate referrals into First Specialist Appointment hospital clinics.	Q1
		As part of the new Planned Care Initiative and implementation of the three year transition plan Waikato DHB will continue with the diabetes retinal screening pilot roll out into localities where optometrist services are operating. Optometrists with an OCT machine will be of particular interest as they will be better placed to maximise patient assessment at the right unit price. This also provides care closer to home and will improve access to diagnostic services. Services will be fully integrated with peer review and ophthalmology clinical oversight. (EOA) *See the activities included in short term focus, these are all ongoing and will drive progress towards breakeven in the medium term.*	Q1
		An example of an innovative approach that will be embedded to improve sustainability as a result of COVID-19 learning is: The importance of both the hospital and community care working together was highlighted during the COVID-19 response. The whole health system worked together as one team overcoming traditional barriers to ensure our population still had access to services while the system responded to a pandemic. This has led to a more agile Waikato health system that can come together and respond quickly to any future COVID-19 resurgence. For example, community testing centres can be set up within four hours, elective surgical services can be completed in private hospitals to create capacity in Waikato Hospital, and surgical wards can be converted to medical and respiratory support units. Strategic responsiveness to allocate existing funding and scarce resource to support the COVID-19 response in the required localities. For example, the ability of case weight allocated to non-time critical events to be redeployed to assist with COVID-19 related healthcare requirements.	Q1 and ongoing

Improving maternal, child and youth wellbeing

Government planning priority			
Improving maternal, child and youth wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	**Enhance the capacity and capability of primary and community health care**	**Maternity and midwifery workforce** **The best way to achieve equity in maternity care is to have a sustainable workforce providing culturally safe services while ensuring integrated service models support primary birthing. Waikato DHB will be prioritising activity that helps to build a sustainable maternity and midwifery workforce by:**	
		Engaging with respective unions wherever any change in service or contract requires.	Q1-Q4
		Undertaking provision of opportunities for midwives working within the DHB to step up into secondment roles and to gain experience in leadership positions.	Q4
		Planned work will take place with the Senior Midwives Working Party to support succession planning and development of career domains and progression pathways in partnership with Māori health.	Q2
		Continuing to drive sustained improvement with midwives. An online cultural competency course will be completed during DHB orientation. There will be a planned portfolio of cultural competency resourced within the senior midwife role. Work in partnership with Māori health will also take place to identify a career progression pathway.	Q2
		The peer support programme and peer support groups within the service will continue to grow and further work with EAP services. We will ensure we meet the needs of midwives working rostered shifts, encourage engagement and reduce barriers to access the service. Implementation of the wellness programme and de-escalation training will also be completed.	Q4
		A key learning from COVID-19 that will be embedded is: Virtual clinics will continue to be used for early pregnancy assessment, obstetric triage and diabetes management outpatient.	Q2 and Q4
		Maternity care **Equitable maternity care is a priority for Waikato DHB, the priorities for 2021/22 will be supporting a sustainable workforce, providing culturally safe services, integrated service models and supporting primary birthing. Activities to support these priorities include:**	
		Locality development Iwi and community priorities related to maternal, child and youth health outcomes will drive specific actions in the locality action plans in each locality. Relevant targets in the Rapua Te Ara Matua report will be core measures included in locality action plans: An increase in the percentage of Māori women who are smokefree at two weeks postnatal • Workforce in rural areas • Immunisation • Oral health	Q1-Q4
		To better support primary birthing services and progress towards an integrated service model Waikato DHB will develop (Q2) and implement (Q4) a First 1000 Days model of care. (EOA)	Q2 and Q4
		Improving communication via social media about the choices of primary birth facilities in the Waikato region and home births for women with no complications. To communicate, inform, reassure and educate low risk women that primary facilities and home birth is a viable choice.	Q2 and Q4
		Collaborating with WINTEC to implement the Clinical Coach Midwife role, a successful initiative used in the Auckland region DHBs. This role supports midwives during their training placements within the DHB and during their transition as new graduate midwives employed by the DHB.	Q1-Q4
		Developing and implementing a Pacific antenatal class to meet the needs of our Pacific woman and fanau. (EOA)	Q2
		Perinatal and Maternal Mortality Review Committee (PMMRC) **To better support primary birthing services and progress towards an integrated service Waikato DHB has accepted and will be implementing and reporting on a number of recommendations made in the Thirteenth Annual Report of the Perinatal and Maternal Mortality Review Committee (2019). For 2021/22 the recommendations that will be of focus include:**	Q1 and Q3
		• DHBs should demonstrate that they have co-developed and implemented models of care that meet the needs of mothers of Indian ethnicity.	Q1-Q4
		• DHBs should monitor key maternity indicators by ethnic group to identify variations in outcomes. They should then improve areas where there are differences in outcome.	Q1-Q4
		• DHBs should demonstrate that they have co-developed and implemented models of care that meet the needs of mothers under 20 years of age.	Q1-Q4

Government planning priority			
Improving maternal, child and youth wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	**Improve access to services**	**Immunisation** **Is the best way to protect tamariki and whānau against infectious and serious diseases. To improve delivery and uptake of immunisations and reduce the equity gap Waikato DHB will:**	
		Reconfigure our current immunisation services to better meet the needs of whānau and improve immunisation rates. We have embarked on a wide ranging review of immunisation services and how they integrate with other community and primary care services. The aim is to create increased capacity and reduced duplication by combining services, service specifications and contracts to better meet the needs of whānau across a wider range of services than simply immunisation. Key milestones will include: (EOA)	Q1 and ongoing
		• Engagement and co-design with whānau and providers.	Q1
		• Develop service implementation and transition plans.	Q2
		• Implementation and initial review of the implementation phase. Full review of delivery will occur in 2022/23.	Q3 Q4
		Develop and implement general pro-immunisation messaging strategies which reflect the whānau voice from the engagement process. (EOA)	Q3
		Develop and implement First 1000 Days model of care which will be Māori focussed and include improvement actions with milestones to increase immunisation at two years old. (EOA)	Q1 and ongoing
		Waikato DHB will be working with primary care to increase the vaccination rates through GPs. This will contribute towards easing pressure off Outreach, releasing scare resource to focus on hard to reach populations, particularly Māori."	Q1-Q4
		A review of Outreach will be completed in the coming year to ensure the service is configured in a way that best meets the needs of our population.	Q4
		Waikato DHB will develop and implement an immunisation plan that will include actions to improve childhood vaccination uptake (at two years) and eliminate the equity gap for Māori and Pacific. (Q1 Deliver plan, Q2 Implement, Q3 and Q4 report progress/Q1-Q4) (Q1 Deliver plan, Q2 Implement, Q3 and Q4 report progress/Q1-Q4)	Q1-Q4
		Increase uptake of children's influenza vaccination, with a specific focus on the two year old immunisation targets, to prevent respiratory admissions (reported through SLM plan):	Q1-Q4
		• PHOs will provide practices with information on the children who are in the eligible population. Māori and Pacific children will then be prioritised from this list.	Q1-Q4
		• Use practice level data and quality improvement interventions to improve and monitor the improvement in Māori child immunisation rates	Q1-Q4
		• Co-design and trial community based immunisation interventions, including digitally enabled mobile vans targeting Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe.	Q1-Q4
		Locality development	
		The data suite informing any activity targeting immunisation measures will be collected, collated and analysed by locality as well as ethnicity and iwi affiliation.	Q1-Q4

Government planning priority			
Improving maternal, child and youth wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	**Improve access to services**	**Youth health and wellbeing** **Improving youth health and wellbeing is a focus for Waikato DHB. In 2021/22 we will be enhancing school based health services and improving youth access and utilisation through the following activities:** Identify school based health nurses who have experience working under standing orders in school clinics and have an established supportive/mentoring relationship with an authorised prescriber (e.g. school GP or nurse practitioner). These nurses will be offered to apply for and complete the Midland Community Nurse Prescriber pathway. The completion of the pathway allows the nurse to work at the top of scope prescribing a wider range of medications. This will remove the need for rangatahi to go to a GP for certain health care needs. Māori, Pacific and schools in high deprivation areas will be targeted to ensure the rangatahi most in need have better access to care. (EOA)	Q1
		Nurses who choose to complete the Midland Community Nurse Prescriber pathway will complete the course by January 2022.	Q3
		Youthchatpro is an online screening tool that rangatahi can complete in their own time and space. It will specifically be targeted to rangatahi who may not currently be engaged the in school system as this is often a high need group that will not have access to school based health services. Any health needs that are identified through completion of the screening tool are flagged with a GP who can provide care via phone or telehealth if required.	Q2
		Youthchatpro is fully rolled out in 17 schools. Partially in 13 schools with barriers to full roll out. The plan is to focus on these schools before moving to the remaining seven.	Q2 and Q4
		Complete an evaluation of the feedback from both rangatahi and clinicians on Youthchatpros's acceptability, youth friendliness and efficacy.	Q4
		Achieve a five percent reduction in intentional self-harm hospitalisations including short-stay hospital admissions through ED for 12-24 year olds. See SLM in Appendix B for further details on youth health.	Q4 (link to SLM plan
		Locality development Iwi prioritisation in South Waikato has indicated concerns about service sustainability for the Waka Taua programme for young Māori men. In 2021-22 relevant actions will be considered for the South Waikato work plan.	Q1
	Enhance the capacity and capability of primary and community health care	**Ambulatory sensitive hospitalisations for children age (0-4)** **Waikato DHB will:** Increase uptake of children's influenza vaccination to prevent respiratory admissions: • PHOs will provide practices with details of the children who are in the eligible population. Māori and Pacific children will then be prioritised from this list and contacted • Use practice level data and quality improvement interventions to improve and monitor the improvement in Māori child immunisation rates • Co-design and trial community based immunisation interventions, including digitally enabled mobile vans targeting Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe	Q1-Q4
		Support a decrease in respiratory admissions by addressing the determinants of health: • Primary Care and Waikato DHB to continue to promote referrals to healthy housing options • Making the BPAC referral process and the system easier for GPs to identify eligible whanau, make referrals, and report on the number of referrals made • Continue to promote the use of the a new BPAC referral form to Kainga Ora • Increase the number of Whare Ora/healthy housing referrals • Collaborating with Kainga Ora to instigate referrals through the patient's practice for immunisation and hauora checks • PHOs and Te Puna Oranga work together to increase coverage of influenza immunisation for whanau closer to home • PHOs combining their efforts to improve Outreach immunisation • Opportunistic immunisation in hospital, whare, GP clinic and Accident and Medical settings	Q1-Q4
		Waikato DHB has a set targets to drive progress in reducing ASH: • Reduce the Maori ASH rate from 18% to 13% by June 30 2022 • Reduce the Pacific ASH rate from 27% to 19.5% by June 30 2022 • 25% of eligible Maori children will receive their influenza vaccination.	Q4 Q4 Q4

Government planning priority			
Improving maternal, child and youth wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Haumaru – Safe, quality health services for all	**Empower whānau to achieve wellbeing**	**Family violence and sexual violence** **Waikato DHB will work in partnership with other agencies to address this priority. In 2021/22 we will:** Work in partnership with the Māori, Equity and Health Improvement directorate to enhance the opportunity for routine enquiry with whānau Māori by providing core Violence Intervention Programme (VIP) training to all community facing staff in the Māori, Equity and Health Improvement directorate; including but not limited to Kaitiaki, Kaitakawaenga, Whare Ora, Te Puna Waiora, Hāpu Wānanga, SUDI Prevention, Wai Ū Waikato, Hauora iHub, and director team members. Measure: The number of staff who have completed training – to be reported quarterly. (EOA) Work in partnership with Te Whakaruruhau (Waikato Women's Refuge), and the Māori, Equity and Health Improvement Directorate, LGBTQ+ Community (Rainbow Tick), Work Well, and Organisational Support team to ensure Waikato DHB's response programme for staff experiencing family or sexual violence is safe, culturally appropriate, and endorsed. (EOA) Meet all VIP Governance and Advisory Group composition requirements, prioritising diverse Māori and Pacific representation. Locality development At a locality level, through iwi partnership and work group composition, there will be a commitment to collaborate across the sector and work with communities to design solutions that influence determinants of health and remove barriers to service delivery and consumer engagement. Where barriers are directly impacting on local priorities, activities will be agreed that support whānau outcomes.	Q1-Q4 Q1-Q4 Q1-Q4 Q1-Q4

Improving mental wellbeing

Government planning priority			
Improving mental wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	**Empower whānau to achieve wellbeing**	**COVID-19 Psychosocial and Mental Wellbeing Plan** **Waikato DHB will contribute to the goals set out in Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan by implementing the following activities in 2021/22:** Waikato DHB will provide mental health and addictions service support to the Hamilton based managed isolation facilities (MIF). This means people staying at the MIF have timely support and access to mental health and addictions service input to aid their overall mental and physical wellbeing. This will prevent possible deterioration in their mental health and need for specialist/ acute services. Release planning is also part of the support provided, for example a referral will be made to the person's local mental health service within their DHB domicile for continued support upon release from the MIF. Waikato DHB, iwi and iwi led services will be working in partnership to deliver integrated primary and secondary mental health and addictions service in Hauraki. The development of additional treatment beds Piri ki te Kāinga, will act as an earlier alternative to the admission pathway to the Henry Rongomau Bennett Centre. (EOA) One of the learnings from COVID-19 was the benefit of providing responsive and integrated mental health and addictions service support to meet the needs of communities. As a result, the DHB in partnership with key stakeholders and providers have tried and tested processes that can be stood up quickly in the event of a COVID-19 resurgence to ensure whānau and communities receive the necessary support to aid wellbeing and prevent possible deterioration in mental state and overall wellbeing. (EOA)	Q1 and ongoing Q2 Q1 and ongoing
		Equity **To achieve equity we must provide earlier intervention responses, and strengthen our partnership with key stakeholders to increase engagement with Māori and Pacific whānau so they receive timely and responsive support. Some key activities that will be undertaken to drive this priority include:** • Delivery of improved facilitated access to appropriate services where specialist mental health and addictions services are not required upon exit from the ED. This will improve equity for Māori, given rates of presentation in times of crisis to the ED and will mean whānau and their families are better supported to access the appropriate help where they need it and when they need it. • Mauriora initiative: Waikato DHB in partnership with key stakeholders to provide this targeted approach to enhance clinical and social outcomes for Māori with complex and enduring illnesses. • Work alongside key Pacific stakeholders to engage and work with Pacific populations to meet their needs. Measures will include: • Monitoring of "Did Not Attend" appointments (split by Māori, Pacific and other) • Monitoring of tcode activity (split by Māori, Pacific and other) • Average time from referral to first face to face (split by Māori, Pacific and other) • Average bed night occupancy (LOS) in the mental health and addictions service inpatient unit (split by Māori, Pacific and other) • Overnight admissions to the mental health and addictions service organisation's inpatient unit(s) for which a community service contact was recorded in the seven days immediately preceding that submission (split by Māori, Pacific and other) • Overnight discharges from the mental health and addictions service organisation's acute inpatient unit(s) that result in readmission within 28 days of discharge.	Q1 Q2 Q4

Government planning priority			
Improving mental wellbeing			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	Empower whānau to achieve wellbeing	**Continue to report on rates of follow-up within seven days post-discharge from an inpatient mental health unit (MH07) (Prevention of suicide and self-harm** **Waikato DHB prioritises follow-up within seven days post-discharge for our mental health and addictions service tangata whaiora as it is important for the prevention of suicide, self-harm, and other negative outcomes such as readmission. To support this priority in 2021/22 we will:**	
		Target that 95 percent of all patients receive follow-up within seven days is consistently met by Waikato DHB. We will continue to complete monitoring and exception reporting to ensure sustained performance. This will be completed through the quarterly Ministry report "MH07: Transition/discharge planning."	Q1-Q4
		Improve performance in community collection of HoNOS. Post seven day follow up contact will include HoNOS community collection as routine.	Q3
		As part of improving consistency in post seven day follow up, and performance in HoNOS community collection Waikato DHB Mental Health and Addictions service will use the following contributory measures: • Percentage of Māori and Pacifika clients discharged from mental health and addictions adult inpatient services that are followed up within seven days • By Q2 50 percent of whānau will have had one community collection of HoNOS • By Q3 60 percent of whānau will have had one community collection of HoNOS • By Q4 75 percent of whānau will have had one community collection of HoNOS.	Q1-Q4
		Embed approaches to virtual service delivery on an ongoing basis. Options for service engagement will be offered to tangata whaiora in a means that is driven by individual preference for service engagement. Real time feedback will collect feedback about use of virtual methods of engagement in our service. Quarterly reporting will be provided identifying methods of engagement undertaken using location code to specify.	Q1-Q4
		Waikato DHB will improve the quality of transition communication to support enhanced experience in the journey from secondary to primary care.	
		By Q4, 95 percent of tangata whaiora discharged from community Mental Health and Addictions service will have a transition plan. This plan will facilitate good information between Mental Health and Addictions service, tangata whaiora and their GP. The internal service audit will monitor and track the quality of transition plans. Service users leaving hospital after a psychiatric admission with a formal discharge plan involving linkages with community services and supports, are less likely to need early readmission. (EOA)	Q1-Q4
		Locality development At a locality level, through iwi partnership and work group composition, there will be a commitment to collaborate across the sector and work with communities to design solutions that influence determinants of health and remove barriers to service delivery and consumer engagement. Where barriers are directly impacting on local priorities, activities will be agreed that support whānau outcomes.	Q4

Improving wellbeing through prevention

Government planning priority			
Improving wellbeing through prevention			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Ratonga a iwi – Effective and efficient care and services	Support community aspirations to address the determinants of health	**Communicable diseases** **The focus of 2021/22 will be the continued support of the COVID-19 recovery, resurgence planning and immunisation. Key activities will include:**	
		Continuing to support the local managed isolation facilities (MIFs) to prevent the transmission of COVID-19 to the community.	Q1-Q4
		Working with key stakeholders to schedule COVID-19 immunisation events that will enable the high uptake and equitable immunisation coverage. (EOA)	Q1-Q4
		Implementing health promotion programmes that educate the community on healthy behaviours that reduce the risk factors of developing communicable diseases.	Q2 and Q4
		Reviewing and amend standard operating procedures and systems as required following external (e.g. ESR, NCTS) or internal audits.	Q2 and Q4
		Enforcing the Health Act 1956, Health (Infectious and Notifiable Diseases) Regulations 2016 and other relevant legislation.	Q2 and Q4
Haumaru – Safe, quality health services for all	Support community aspirations to address the determinants of health	**Environmental sustainability** **Climate change threatens the health of all New Zealanders. To support the health sector's response to the greenhouse gas emissions reduction targets under the Climate Change Response (Zero Carbon) Amendment Act Waikato DHB will:**	
		Complete a carbon inventory audit (Totiu previously CEMARS), in alignment with other DHBs in New Zealand.	Q1
		Develop and implement the Sustainability Framework and Carbon Action Plan (COVID-19 has highlighted how we measure and report on emissions). (EOA)	Q2
		Climate related 'risks planning' will include the potential risks to our population's health (with a specific focus on Māori and Pacific populations) as a result from climate change. (EOA)	Q4 and ongoing
		Include sustainability criteria/weighting in all business case evaluations.	Q2
	Enhance the connectedness and sustainability of specialist care	**Antimicrobial resistance** **Antimicrobial resistance is an increasing global public health threat that requires immediate and sustained action to effectively prevent and mitigate its impact on individual and population health. Waikato DHB will contribute to key areas of focus in the New Zealand Antimicrobial Resistance Action Plan (2017-2022) through the following actions:**	
		Expanding the IV to oral SWITCH initiative to include surgical services is a key learning from the COVID-19 response. The aim of this is preparedness and a means to minimise antimicrobial waste and nursing time, both of which have become increasingly important during COVID-19. There will be a particular focus on; drug use and access, optimising nursing time, and anticipating for staff sickness. Moreover, COVID-19 may also be associated with increased incidence of inappropriate antimicrobial prescribing; therefore, means to optimise this is warranted. The IV to Oral SWITCH is keeping with the DHB's 'Know Your IV Lines' campaign, intended to minimise harms associated with intravenous lines.	Q1 and ongoing
		To advance progress towards managing the threat of antimicrobial resistance Waikato DHB will monitor and measure antimicrobial use in terms of quantity through calculated DDD/1000 occupied bed days and quality in terms of annual national antimicrobial prescribing survey (NAPS priority action area 12, activity 11 and 12).	Q4
		Advance antimicrobial resistance management across primary care, community (in particular age-related residential care services) and hospital services through use of a Waikato Antimicrobial Prescribing Policy. This policy will be involved in all aspects of antimicrobial prescribing, including admission and discharge.	Q1 and ongoing

Government planning priority			
Improving wellbeing through prevention			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Haumaru – Safe, quality health services for all	Support community aspirations to address the determinants of health	**Drinking water** **In addition to our compliance and enforcement activities relating to the Health Act 1956 Waikato DHB will use a public health risk assessment to identify and target vulnerable populations and ensure access to safe drinking water is maintained. In 2021/22 a key priority will also be supporting the transition to Taumata Arowhai:**	Q1
		Until the new drinking water agency, Taumata Arowhai, goes live Waikato DHB will meet our requirements as per part 2a Health Act 1956, and the environmental health manual section 8 (published by the Ministry of Health). Taumata Arowhai is currently expected to take over drinking water regulation on 1 July 2021, at which time part 2a of the Health Act will be repealed.	Q1 and ongoing
		Waikato DHB will continue to support the development and enactment of the Memorandum of Understanding between Taumata Arowhai and the Waikato Public Health Unit.	Q1 and ongoing
		Waikato DHB will highlight non-compliant supplies, or water supplies which predominantly serve Māori or Pacific, or those which potentially pose public health risk, to Taumata Arowhai at handover. (EOA)	Q1 and ongoing
		Waikato DHB will ensure prompt detection of potential waterborne illnesses and refer to Taumata Arowhai/local councils for action.	Q2 and Q4
		Waikato DHB will report on the performance measures contained in the Drinking water planning/ reporting template 2021/22.	Q2 and Q4
		Environmental and border health **In addition to delivering on the activities and reporting on the performance measures contained in the Environmental Health planning and reporting document Waikato DHB will also be focussed on supporting the COVID-19 response. These priorities for this focus area are capture in the below activities:**	
		Waikato DHB will undertake compliance and enforcement activities relating to the Environmental Health Manual, Health Act 1956 and any other environmental and border health legislations. Reporting on the performance measures contained in the Environmental and Border Health exemplar will be completed six monthly.	Q2 and Q4
		Waikato DHB's border health focus will be on managing COVID-19 at the port (PoFA) and supporting activities at the managed isolation facilities that are located in our district to minimise the risk of COVID-19 entering and spreading through the community. Such an out outbreak could have a catastrophic impact on our already high risk Māori and Pacific communities. Waikato DHB has public health Māori and Pacific teams established and ready to implement equity actions required for future COVID-19 responses, including CIMS structure, reporting, and communication. (EOA)	Q1-Q4
Oranga – Health equity for high need populations	Empower whānau to achieve wellbeing	**Healthy food and drink environments** **Healthy food and drink environments can be a form of prevention which results in a reduced risk of ill health and increased wellbeing. Waikato DHB will continue to support this priority through activities that have a particular focus on improving equity including:**	
		Waikato DHB will implement Healthy Active Learning in priority settings (decile 1-4 schools/kura, low equity index early learning services/early learning services with Māori/Pacific rolls > 35%). (EOA)	Q1 and ongoing
		Reporting will be completed on the number of settings engaged in Healthy Active Learning (HAL) and their progress in developing or reviewing a Healthy Food and Drink policy. This report will also include the number of early learning services, primary, intermediate and secondary schools that have been approached by HAL but declined the service.	Q1-Q4
		Waikato DHB will support the Ministry of Education and schools in implementation of Healthy Free Lunches in Schools programme through the Waikato district. Reporting will be completed on the number of schools supported. (EOA)	Q2
		Waikato DHB will cease offering for sale, artificially sweetened energy drinks across all sites on DHB premises.	Q2
		Contracts for providers of food items sold through vending machines on DHB premises will include mandatory compliance with National Healthy Food and Drink Policy (version 2).	Q2

Government planning priority			
Improving wellbeing through prevention			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Empower whānau to achieve wellbeing	**Smokefree 2025** **This is a key priority for Waikato DHB as smoking contributes to negative health outcomes and drives inequities. Some key activities to reduce smoking rates in 2021/22 will be:**	
		By June 2022 Waikato DHB will have a comprehensive smokefree strategy. This will include a target for the proportion of wāhine Māori who are smokefree at two weeks postnatal increasing by 25 percent from the number reported in June 2021 to June 2022.	Q4
		Smoking during pregnancy is a significant risk factor in sudden unexplained death in infancy (SUDI), glue ear, pneumonia, asthma and leukaemia making maternal smoking a target area for Waikato DHB. To reduce maternal smoking rates the DHB will be working in partnership with birth centres, LMCs, GP practices, ultrasound providers and pharmacies to increase effective screening and referrals of pregnant wahine/women who smoke to cessation services. (EOA)	Q1-Q3
		The workforce will be supported with 80 percent of LMCs and GP practices in priority areas[1] completing the DHB provided training to increase knowledge and confidence of staff in supporting women, particularly young Māori wahine to be smokefree. (EOA)	Q4
		Implement the Tupeka Kore Framework as a change management tool. Priority healthcare settings and professionals will be supported to make step- changes in their practise to increase effective referral and quality support for hapū/pregnant smokers. (EOA)	Q1 and ongoing
		The training of priority healthcare professionals in effective brief advice and referral cessation services will be of benefit to the wider population, including Pacific. (EOA)	Q4
		Waikato DHB will deliver tobacco control functions as per the Smokefree Compliance and Regulated Products (vaping) Enforcement Manual and advice and direction from the Ministry of Health. Regulatory activities undertaken to support compliance: • Carrying out retailer education • Conducting controlled purchase operations in priority areas • Assessment of smoking areas in licensed premises • Responding to complaints • Providing advice to the public • Advertising and promotion	Q1 and ongoing
		Develop and maintain an up to date database of tobacco / regulated products (vaping) outlets to assist with planning of compliance and enforcement activities to be accessible by all partners.	Q1 and ongoing
	Improve access to services	**Breast screening** **Early detection of breast cancer is the best way to improve health outcomes and reduce mortality. Reducing the screening equity gap that exists between our wāhine Māori and Pacific compared to non-Māori will be a key priority for Waikato DHB with activities including:**	
		By June 2022 Waikato DHB will meet or exceed the 70 percent national breast screening target for wāhine Māori.	Q4
		Waikato DHB will improve access to breast screening for wāhine Māori through a review of the mobile schedule. The aim of the review is to ensure vehicles go to high need populations for the appropriate length of time. Once the mobile schedule review is completed the recommendations will be implemented. (EOA)	Q4
		Develop and implement performance monitoring that provides accurate monthly equity performance for Waikato and BreastScreen Midland. (EOA)	Q1
		Waikato DHB will work with BreastScreen Midland (BSM) to develop and implement an Equity and Improvement plan in collaboration with iwi, and communities. This plan will highlight how BSM and Waikato DHB will engage with Māori and Pacific wāhine where the impact will be significant for improved health outcomes. (EOA)	Q4
		Develop and implement 'Test for Change' initiatives in the Waikato to improve wāhine Māori participation and screening coverage. (EOA)	Q1 and on-going

[1] Huntly, Ngaruawahia, Hauraki, Tokoroa, Te Kuiti, Taumarunui, and parts of Hamilton

Government planning priority			
Improving wellbeing through prevention			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Improve access to services	**Cervical screening** **Increasing coverage and improving equitable access to screening, with a particular focus on Māori and Pacific women will reduce the burden of cervical cancer in these priority groups. This will be Waikato DHBs priority in 2021/22 and the following actions will support this:**	
		Work with PHOs, Māori hauora providers and BreastScreen Midland to promote and provide support to each practice where the mobile breast screening is located to encourage dual screening. (EOA)	Q4
		In partnership with Māori and PHOs, Waikato DHB will develop and deliver a Māori centred awareness campaign to improve cervical screening coverage. (EOA)	Q2
		Deliver cervical screening awareness and education with Kaumatua and Plunket. (EOA)	Q3
		Increase awareness of the importance of screening in early childhood centres, kohanga reo, Ministry of Social Development, Emergency Housing and Womens Refuge to capture young parents and whānau for screening prevention and HPV vaccination criteria. Support will also be offered to help people access screening services.	Q2
		Develop and test a prototype programme for the provision of a rural, mobile opportunistic screening service for areas with lowest cervical screening and immunisation coverage (a mobile Hauora iHub model, supported by Māori workforce). (EOA)	Q3
		Work with PHOs and Pacific health providers on opportunities to promote and screen targeting Pacific communities. (EOA)	Q2
Whanaketanga – Productive partnerships	Support community aspirations to address the determinants of health	**Reducing alcohol related harm** **Waikato DHB will support activities that aim to reduce alcohol related harm including awareness of Foetal Alcohol Spectrum Disorder and the risks of drinking during pregnancy. In addition we commit to the following:**	
		Waikato DHB's medical officer of health will complete the obligations required under the Sale and Supply of Alcohol Act 2012, this will include regulatory functions and collaborating with Police and licensing inspectors to ensure ongoing monitoring and enforcement of the Act. We will also support the development and implementation of strategies to reduce alcohol-related harm. These strategies will have a particular focus on reducing alcohol related harm in our Māori, Pacific, and high deprivation populations.	Q1 and ongoing
		Six monthly reports will be completed on the performance measures contained in the Reducing Alcohol Related Harm: Health Protection planning and reporting document.	Q2 and Q4
Manaaki – People centred services		**Sexual and reproductive health** **Waikato DHB's 2019 syphilis action plan aligns closely with the national syphilis action plan and is based around the same four work streams: prevention and health promotion, testing and management, antenatal care, and surveillance and monitoring. The Waikato syphilis action plan will be reviewed annually and updated if necessary to ensure the actions remain relevant to any changing epidemiology. The key activities for 2021/22 will include:**	
		• Review the DHB's Syphilis Action Plan in collaboration with Sexual Health	Q4
		• Continue to support the implementation of the DHB's Syphilis Action Plan in collaboration with Sexual Health.	Q1 and ongoing
		• Continue to implement various local education and promotion activities as outlined in our 2019 DHB syphilis action plan	Q1 and ongoing
		• Provide subject matter expertise and input to the development of new national antenatal guidelines and new national promotional materials as part of the national syphilis action plan.	Q1 and ongoing

Government planning priority			
Improving wellbeing through prevention			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Whanaketanga – Productive partnerships	**Support community aspirations to address the determinants of health**	**Cross sectoral collaboration including health in all policies** **The wider determinants of health play a major role in the health and wellbeing of the community. For this reason in 2021/22 Waikato DHB will:** Contribute to regional leadership groups that provide cross-sectoral advice and action to support COVID-19 recovery and resurgence. This is important as Māori and Pacific communities are at higher risk of experiencing negative COVID-19 impacts. Māori and Pacific organisations participate in these groups. Report to be provided on progress and impacts. (EOA)	Q2 and Q4
		Co-design and implement Rapua Te Ahura Mowai the mental health and addictions service Homelessness Transition pilot. This pilot will offer complex tāngata whaiora leaving acute mental health services housing support, ongoing mental health and addictions service support, and other wrap around support according to their individual needs. The pilot will include Ministry of Housing and Urban Development, Kainga Ora, Ministry of Social Development, NGOs, Community Housing Providers, Ministry of Health, and Waikato DHB.	Q2
		The Alcohol and Other Drug Treatment Court (AODTC) will start in Q1. All people who come through the AODTC will be screened to identify if they require a comprehensive assessment and referral to supports such as housing and education. (six people per day will receive the comprehensive assessment).	Q1 and Q4
		Locality development A localities approach will enable communities to meaningfully identify issues and priorities that impact on the health outcomes of people with long-term conditions. Equity of access is a contributory factor to enable compliance with clinical pathways of self-management. Working collaboratively and across sector at the local level will identify barriers and opportunities and solutions to remove these barriers. One of these solutions could be the implementation of either virtual or actual integration of health and social support services in an integrated hub and spoke model to promote services closer to home for high users of health services i.e. those with chronic health conditions. In 2021-22 locality work plans will: • Ensure membership of locality work groups has the range of expertise and knowledge to address service gaps and poor health outcomes identified through service mapping and health needs analysis • Ensure alignment with local clinical and service initiatives for people with chronic health conditions that can be supported within the locality development programme and investment frameworks to address service gaps and barriers.	Q1 and Q4

Better population health outcomes supported by strong and equitable public health and disability system

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Partner with Māori in the planning and delivery of health services	**Delivery of Whānau Ora (EOA)** **Will contribute to Māori health advancement and health equity. Evidence based equity actions will be the focus for Waikato DHB in 2021/22:** Two urgent priority groups are hapū māmā (pregnant Māori women), and Māori with chronic disease. Research on the determinants of health for Māori mothers and adults with chronic diseases will be undertaken to help in the development of a responsive health system that delivers not only high quality health care, but also addresses the wider determinants of health. The study will use a kaupapa Māori co-design process, following the He Pikinga Waiora Framework. We will partner with a range of stakeholders to develop a hauora (wellbeing) tool and programme to assess and meet the needs for hapū māmā, and for Māori with chronic disease. Key learnings from COVID-19 that will be embedded include: The COVID-19 response created iwi led mobile units. These were developed and delivered in partnership with iwi and played a critical role in ensuring our pandemic response planning was whānau centred. These mobile units were successful, especially in our high need communities and will continue to be used to deliver care in 2021/22. Working in partnership with local Māori and Pacific providers is essential to effectively engage with whānau. COVID-19 highlighted this. The importance of having separate communications for our Māori and Pacific populations. Having resources available in both languages supported communities and health care workers. Resources will continue to be provided in both languages.	Q4 and ongoing (2 year research project) Q1 Q1
	Empower whānau to achieve wellbeing	**Ola Manuia: Pacific health and wellbeing action plan 2020-2025 (EOA)** **Pacific peoples experience long standing health inequities across a range of health and socioeconomic indicators. Waikato DHB is committed to reducing these inequities by supporting the implementation of Ola Manuia and the three outcomes within the plan:** **Outcome one: Pacific people lead independent and resilient lives** A key focus of Waikato DHB will be empowering our Pacific people and their communities by building health literacy and supporting their capacity, enabling them to take ownership of their health. Mate Huka and the COVID-19 vaccination programme are two examples of how this will be achieved. Mate Huka is a new and additional diabetes prevention and treatment programme that is specifically targeting high need populations. The programme has been co-designed including with iwi and Pacific partners, and will provide early screening and education with the aim of reducing the prevalence of type two diabetes. The new MMR programme will be rolled out and will be appropriate, and prioritise the needs and preferences of pacific youth and their fanau. The programme will contribute towards increased access and improved health equity for Pacific by: • Working with Pacific fanau in each rohe to provide information and advice that encourages increased uptake of the measles vaccination for Pacific aged 15 to 30 • Provide mobile vaccination services in communities with high Pacific populations • Promote and provide measles vaccination at events and venues that attract Pacific people and fanau • Seek out innovative ways in which to connect with Pacific populations. **Outcome two: Pacific people live longer in good health** The Director of Pacific Health role was recruited to Q4 2020/21. The role will lead the development and implementation of a Pacific health action plan for Waikato DHB. The action plan will set the direction for pacific workforce development, addressing key pacific health priorities (diabetes, cancer), and support the pacific element to locality development, particularly in Hamilton and South Waikato. The Director of Pacific Health will represent and be the voice of Pacific at the Waikato DHB Equity Governance Group. This group will have accountability for the DHB's equity programme of work and the Operational Alliance for Equity will report on progress to the Equity Governance Group quarterly.	Q1-Q4 Q1 Q2 and Q4 Q4 Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Empower whānau to achieve wellbeing	**Outcome three: Pacific people have equitable health outcomes**	
		Whare Ora is a cross-sectoral housing programme that targets high need populations including Pacific fanau. A key focus for 2021/22 will be to increase the number of referrals made to Whare Ora for our Pacific people and increase the number of assessments completed.	Q2 and Q4 Q4
		The number of Pacific fanau employed across all levels of the DHB will increase to reflect the Waikato population (3%).	Q1 and ongoing
		Workforce development will be a priority in the Waikato DHB Pacific health action plan.	Q4
		Plan and implement a Pacific health science academy – This would be similar to the Puna Waiora programme but will be designed specifically for Pacific students to encourage and support them into a career in health.	Ongoing
		COVID-19 learnings	
		During the COVID-19 response Waikato DHB's Public Health Pacific team led and advised on the communication process and key messages in collaboration with the national Pacific multi-sector response team, providers and translators. The Waikato Pacific Community Stakeholder Updates were key tangible communication outputs plus other more tailored culturally appropriate approaches were also successfully used.	Q1 Q1
		Waikato DHB will continue to send regular COVID-19 updates to our stakeholders including our Pacific providers around cases and close contacts, key compliance and safety messaging consistent to Alert levels, and other health, wellbeing and welfare support service information.	Q3
		Waikato DHB had considerable success increasing immunisation and COVID-19 testing rates as a direct result of working in partnership with Pacific providers to respond to COVID-19. Supporting Pacific leadership in the design and delivery of services was a key learning and will be taken forward.	Ongoing
		The measles immunisation (MMR) programme will take this learning and approach. The focus will be on empowering Pacific peoples aged 15 to 30 to make informed decisions regarding immunisation and provide flexible arrangements for vaccination services in a variety of settings.	Q1
		A key learning has been that our Pacific providers are best placed to show us how to engage effectively with whānau. Working together in a supportive, collaborative approach to combine the strength of the DHB and our Pacific providers results in better population health outcomes.	
		Waikato DHB will be recruiting a Pacific Health Equity role within Public Health. This role will provide Pacific peoples equity insight, advice, development and direction within the Waikato DHB approach and response to COVID-19 to improve Pacific peoples' health outcomes.	
	Improve access to services	**Care Capacity Demand Management (CCDM)** **Waikato DHB will undertake the following actions to ensure that implementation of CCDM is complete and maintained across the key components of: governance, patient acuity data, core data set, variance response management and FTE calculations:**	
		Governance: Waikato have good CCDM governance with both DHB wide and ward level implementation occurring. Waikato DHB is now implementing Trendcare and will have rollout complete by September 2021.	Q1
		To ensure good attendance at CCDM meetings and local data council meetings as per the terms of reference. Quarterly reporting of attendance.	Q1-Q4
		Validated patient acuity tool (Trendcare) will be rolled out across the DHB by September 2021. Compliance of each ward will be 100% six months after roll out. Report on roll out at each quarter including IRR testing completion at each quarter.	Q1-Q4
		Core data set: Dashboard will be complete by February 2022 and available from ward to board and on a Qlik app.	Q3
		FTE calculations: FTE calculations will commence in April 2022. FTE working group will meet in June 2021. FTE calculation rules will be agreed by February 2022.	Q3
		Variance response management: (VIS) Will be rolled out as each ward completes its IRR testing. IOC meetings will use TrendCare data as wards meet IRR and bench marking. We will report each quarter as to compliance to this.	Q1-Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Improve access to services	**Health outcomes for disabled people** **Waikato DHB is committed to improving health outcomes for disabled people who are generally at higher risk of illness than non-disabled people and have some of the poorest health outcomes of any group. In addition to developing a disability responsiveness plan we will ensure:**	
		Whānau hauā are included in the design, implementation, monitoring and review of services. To do this we will establish a process to include whānau hauā perspective in all stages of service development and delivery. (EOA)	Q2 and Q4
		Whānau hauā representatives on the Waikato DHB Consumer Council will provide leadership and oversight to systems performance and improvement for whānau hauā	Q1
		Online resources are in accessible formats, including Māori and Pacific languages, relating to the rights of whānau hauā when using health services. (EOA)	Q1
		Feedback is sought from whānau hauā and we act on this to improve responsiveness and service delivery. This will be done by establishing feedback mechanisms that are known, easy to use, culturally appropriate, and accessible to whānau hauā, for example, to identify improvement priorities. (EOA)	Q2 and Q4
		Gather, analyse and provide data and narratives to guide decision making and practices that include and support whānau hauā health and wellbeing, particularly for Māori and Pacific peoples respecting data sovereignty rights. (EOA)	Q2 and Q4
		Systems are developed to hold and easily retrieve relevant information across DHB services, including ethnicity, to aid effective decision making about the care of whānau hauā.	Q2 and Q4
Haumaru – Safe, quality health services for all		**Planned care** **Waikato DHB is now in our second year implementation of our three year plan to improve planned care delivery. Key actions across each of the five key principles (Equity, Access, Quality, Timeliness and Experience) include:**	
		Identify the expected access to service rates for Māori relative to the health requirement and population distribution by locality.	Q2 and Q4
		Enhance virtual health to more Waikato DHB specialties to improve access for rural communities (see data and digital). (EOA)	Q2 and Q4
		Extend shared care (GP/SMO) and other community providers with hospital teams to deliver services remotely (reducing the travel requirement for clinical intervention and potentially avoid "Did Not Attends"). (EOA)	Q2 and Q4
		Measure: Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 population for 0 to 4 and 45 to 65 year olds.	
		Māori rural initiative team will locally screen identified patients to prevent emergency cardiac events and hospital admissions where clinically appropriate. This will release scarce resource to be available for high and complex cases. (EOA)	Q2 and Q4
		Measure: PHO enrolled people within the eligible population who have had a Cardiovascular Disease (CVD) risk recorded within the last five years.	
		Enhance community referred diagnostic access. For example GPs will have direct access to community radiology providers for plain film (x-ray).	Q2 and Q4
		Locality development A localities approach will ensure any data suites used to inform planned care initiatives and acute care frameworks are collated by locality, ethnicity and iwi affiliation.	Q1 and Q4
		Local working groups and identified priorities will influence and guide local progress against planned care initiatives within specific localities – identifying barriers and providing a community voice and support to proposed system transformation.	
		In 2021-22 locality work plan targets will ensure alignment with known projects within each locality and propose additional opportunities as indicated.	

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Haumaru – Safe, quality health services for all	**Improve access to services**	**Acute demand** **For 2021/22 the acute demand priorities will be focussed on acute data capturing (SNOMED) and improving acute care flow, the following actions will support our improvement of these two key priorities:**	
		SNOMED will be fully utilised across our primary care partners and enabled within ED to ensure that clinicians irrespective of location, be it hospital or primary care have full access to the most recent clinical notes and diagnostics. Within such an environment, more informed clinical decision-making within acute and primary care will be enabled. This is particularly apparent with long term condition management which is over-represented in Māori, Pacific and those individuals within our most deprived communities.	Q1 and ongoing
		To address the increasing demand on emergency departments we will be working in partnership with primary care and other key stakeholders to implement accessible alternatives including:	
		• Provide GP's with direct access to senior General Medicine clinicians for telephone consults and timely acute assessment to reduce presentations to ED and where possible inform treatment plans, ensuring patients remain safely managed in primary care.	Q1 and ongoing
		• Increase use of the Frailty Admission Avoidance pathway to provide GP's with direct access to community supports through a telephone triage system. GP's can be confident that their patients are able to access the right care at the right time; supported rehabilitation at home, increased home supports, emergency respite, and planned admission if needed.	Q1 and ongoing
		• Seven venues will be established across the Waikato district in partnership with local iwi. The Māori Needs Assessment and Service Coordination will be based at these venues enabling clients and whānau to access culturally appropriate support that meets their needs. Improving access to community support is part of a community admission avoidance model that links in with the other community approaches including; acute support, supported rehab, allied health, primary care and aged residential care. (EOA)	Q2
		• Implement the WHA/WRAP service into ED – this provides whānau with an assessment and support to access required services that will help them achieve pae ora (e.g. healthy housing). (EOA)	Q1
		• The ED team will review monthly, patients that have been identified by ED as requiring a management plan. Waikato DHB then works collaboratively with the speciality services, primary health care, and the patient to put a management plan in place. This plan will be used each time the patient presents and is regularly updated with all concerned parties. This links in with community teams, with nurse practitioner led multidisciplinary meetings involving community providers so they collaborate to support clients in their community and prevent readmissions. (EOA)	Q1 and ongoing
		• Review and develop tools to support visibility at a glance in real time including wait times in ED and bed capacity allowing for timely identification and intervention and reduce any 'blocks' in access or flow where possible.	Q4
		Nurse practitioners in the consult area of the Waikato ED will be used to streamline lower triage trauma, chronic disease exacerbation and people who have presented to ED two or more times in six months. The Nurse practitioner will have strong links with community nursing teams and primary care to develop ongoing patient management plans that reduce the need for ED presentation and provide better health outcomes for the individual.	Q3
		Improving wait times and the experience of people who present at the ED requiring mental health services is a key priority. Waikato Hospital ED will have an additional mental health assessment area that provides a more appropriate environment (low stimulus) for treatment and assessment. Waikato DHB will also work with Oranga Tamariki and psychiatry to identify better assessment/discharge processes for fostered children with behaviour issues who need to move home urgently and how to better manage after hours transfer to Starship Hospital for mental health patients.	Q2
		Acute hospital bed days per capita (detail in SLM plan Appendix B)	

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Enhance the capacity and capability of primary and community health care	**Rural health (EOA)** **Rural populations often experience poorer health outcomes than urban, improving access and outcomes is a key priority for Waikato DHB and to drive improvements:**	
		All Waikato DHB rural health services (oral health, allied health etc.) will continue to screen patients for potential COVID-19 symptoms prior to appointments. This will mitigate the risk of infectious disease transmission and provide an additional opportunity to confirm the visit/appointment or reschedule if required.	Q1 and ongoing
		Drive community solutions and enhanced models of care by working in partnership with a key stakeholder to implement oranga (wellbeing) assessment tools (WHĀ, WHRAP, Harti Hauora) to connect Māori and Pacific whānau to wider holistic health, wellbeing and social services. The assessment tools will be used at Tokoroa ED when people present. This approach will also ensure continuity of care.	Q1
		The rural workforce is essential to sustainable service delivery in the future. Waikato DHB will work with local service providers to explore partnership models and opportunities to enhance career progression, succession planning, share knowledge and capability.	Q1 and ongoing
		Continue to implement the three year planned care plan which will help to improve timeliness and access to care for our rural populations.	Q1-Q4
Manaaki – People centred services	Strengthen intermediate care	**Implementation of the healthy ageing strategy 2016 and priority actions 2019-2022** **To improve the pandemic outbreak preparedness and response capability of the aged residential care (ARC) facilities, Waikato DHB will support ARC facilities to understand and implement the New Zealand Aotearoa ARC Pandemic Response Policy. Scheduled ARC forums will take place and a review of implementation will be completed. The outcome will be that ARC facilities know how best to prevent an outbreak and are prepared to respond to any outbreak that does occur.**	Q1-Q4
		In preparation for a COVID-19 resurgence, a toolkit will be developed and implemented within ARC facilities to support procedures and protocols during the planning and response phases. ARC sector stakeholders will be briefed on roles and responsibilities in the preparedness and management of an outbreak to reduce any risk of transmission.	Q1
		Waikato DHB will work with kaupapa Māori services to design a home and community support service model that aims to have client's access the service early in their care journey (particularly Māori and Pacific). The new model will have tools and training available to ensure the model delivers culturally appropriate assessments and care planning. Funding mechanisms to address equity for Māori and rural clients will also be investigated. This will help with early identification of frailty and early intervention to retain and restore the function of older people. (EOA)	Q3
		Waikato DHB is committed to supporting people with dementia to live well in their community. We will complete an evaluation of current dementia services, and dementia service need across each of our localities. This evaluation will be used to improve: service design, quality of the living well programmes, and respite services.	Q4
		Dementia services will be evaluated to ensure barriers and lack of understanding of dementia can be addressed through health promotion and workforce development.	Q3
		Waikato DHB is committed to providing service pathways that improve early supported discharges within each locality with a restorative approach that builds resilience and eliminates inequities. A locality approach will be taken in the design and commissioning of services within aged care facilities with a focus on the quality of short stay residential care and increasing rehabilitation opportunities for individuals through the START programme. (EOA)	Q4
		Locality development Te Korowai Waiora Goal 6 'Strengthen intermediate care' supports the Transition to Home and LINC worker service development components of the Waikato DHB health of older people model of care response to the Healthy Ageing Strategy. In 2021-22 locality working groups will map the NGO and inter-sectoral service environments across each locality that will contribute to these strategic service outcomes.	Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Haumaru – Safe, quality health services for all	**Enhance the connectedness and sustainability of specialist care**	**Health quality and safety** **Ensuring the continuous quality and safety of our hospitals and services is a key priority for Waikato DHB. To support the nationally directed priority areas of hand hygiene, equity, consumer engagement and zero seclusion, we will complete the following:** **Hand hygiene** All 40 clinical areas will have at least two hand hygiene gold auditors. To meet this requirement an additional four gold auditors will be trained in 2021. Training to be available to: • All clinical areas in Waikato DHB hospitals • Appropriate clinical staff	Q4
		Having gold auditors available in all clinical areas 24/7 enables timely feedback on hand hygiene compliance, and improved patient outcomes.	Q1 and ongoing
		There will be 24/7 hand hygiene product availability and correct placement in clinical areas for staff to perform appropriate hand hygiene.	
		Equity Implement the Mate Huka programme. This is a new Tainui Waka iwi diabetes partnership programme to provide additional early screening and education with the aim of reducing the prevalence of type two diabetes in Māori. (EOA)	Q1
		Consumer engagement Continue to support the governance group of staff and consumers that guide the implementation of the quality safety markers.	Q1 and ongoing
		Report against the quality safety markers twice-yearly via the online form on the Commission's website using the SURE framework as a guide.	Q1 and Q3
		Zero seclusion (mental health and addictions service) Waikato DHB will provide access to kaitakawaenga at critical times of the care pathway to ensure whānau and their whānau/family receive culturally responsive and appropriate support. This will achieve enhanced relationships and trust, reduced conflict and containment, and a safe environment for everyone. (EOA)	Q1 and ongoing
		Implement the Health of the Nation Outcome Scale (HONOS).	Q1 and ongoing
		Implement the Whānau Participation Policy. This policy formalises the importance of including whānau/families in the process of recovery plans, assessment and treatment, service planning, delivery, and evaluation. It also covers the importance of responding to the needs of whānau/families, providing support, education, information and feedback. Implementation of this policy will mean every person working in a mental health and addiction treatment service encourages and supports whānau/family to participate in the recovery of their whānau and ensure that whānau/families, including the children of whānau, have access to information, education and support. (EOA)	Q1 and ongoing
Oranga – Health equity for high need populations	**Improve access to services**	**Te Aho o Te Kahu – Cancer Control Agency** **Te Aho o Te Kahu is a stand-alone departmental agency hosted by the Ministry of Health reporting directly to the Minister of Health. These new arrangements provide the foundations for strong central leadership and oversight of cancer control. Waikato DHB is working in partnership with Te Aho o Te Kahu with our joint priority to implement the New Zealand Cancer Action Plan 2019-2029. In 2021/22 key activities will include:** **ACT-NOW project** Waikato DHB will undertake quality improvement work in response to the implementation and reporting of the nationally agreed ACT-NOW treatment regimens (national collection) for medical oncology and malignant haematology.	Q1-Q4
		Improve the standard of health data Waikato DHB will work with Te Aho o Te Kahu and local information services to plan and implement the adoption of the cancer related Health Information Standards Organisation (HISO) standards. (link to data and digital section).	Q1-Q4
		Waikato DHB is implementing the regional clinical pathway and MDM system that is HISO MDM standard compliant.	Q1-Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Improve access to services	**Improve radiation oncology** Waikato DHB will support the implementation of the national Radiation Oncology service plan that ensures that the model of service is fit for purpose to meet the current and future needs of the district.	Q2
		Below are the key process steps and timelines to develop the business case to implement the next linac replacement for Waikato DHB's cancer centre, where it has been identified, to participate in the Ministry of Health linac replacement capital programme.	

Process step	When	Who
Funding confirmation	13/11/2020	MoH
RFQ opens	17/12/2020	Procurement
RFQ closes	05/02/2021	Procurement
Solution selection	30/03/2021	Procurement/Oncology
Business case development	15/04/2021	Oncology
Business case approval	15/05/2021	Executive/MoH
Tender award	31/05/2021	Procurement
PO raised	30/06/2021	Finance
Installation	31/10/2021	Oncology
Commissioning	30/11/2021	Oncology
Go Live	20/12/2021	Oncology

Waikato DHB will work with the Ministry of Health linac capital programme team and Te Aho o Te Kahu on the planning of the replacement of the 2021-22 second linac replacement.	Q3-Q4
Waikato DHB will work with its regional partners and Te Aho o Te Kahu on the planning of the following 2021-22 (second) replacement linac.	Q2
Waikato DHB will review the implications of the ROWG and the Te Aho o Te Kahu workforce modelling tool (endorsed in December 2020) for radiation oncologist, based on national practice standards and benchmarking. A plan will be developed to address any gap in resource.	Q2
Improve outcomes for Māori, Pacific and those disadvantaged (EOA)	
Waikato DHB will consider findings and implement recommendations from the local community-based Māori hui in partnership with Iwi and Te Aho o Te Kahu.	Q4
Waikato DHB will investigate the viability of delivering chemotherapy and/or medical oncology clinics closer to home in Tokoroa and Te Kuiti through the development of business case proposals.	Q1
Identify how we can better provide transport and accommodation over the Christmas and New Year period for patients requiring treatment at this time.	Q2-Q4
Review and implement organisational telehealth initiatives within cancer services where doing so will promote health equity.	Q4
Waikato DHB will participate in Te Aho o Te Kahu travel and accommodation project that aims to improve cancer patient equity of access and support to cancer services/treatment for DHB and inter-district flow.	Q4
Faster Cancer Treatment (FCT)	
Waikato DHB will convert its FCT steering group to a Cancer Improvement Working Group to progress its Cancer Services Improvement Plan.	Q1
Key stakeholders will convene to make a plan to ensure cancer patients do not experience unreasonable treatment delays over the Christmas and New Year period. Success will mean FCT performance for Q2 and Q3 is maintained at 90 percent or higher, including for Māori. (EOA)	Q2 and Q3
Complete continuous monitoring, by ethnicity, of HSCAN/cancer patients to ensure achievement of the Faster Cancer Treatment pathway wait times (31 day and 62 day waiting time measures). (EOA)	Q1-Q4
Waikato DHB will plan to implement the cancer COVID-19 guidance developed by Te Aho o Te Kahu should there be a COVID-19 resurgence to ensure minimal impact on cancer patients.	Q1

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Oranga – Health equity for high need populations	Improve access to services	**Improve bowel cancer based on tumour Quality Performance Indicators (QPIs)**	
		Waikato DHB will have one cancer service improvement plan for lung, bowel and prostate cancers as there will be commonalities across all tumour streams. The plan will include a minimum of two significant initiatives from each tumour stream QPI report.	Q1
		Waikato DHB will select the Prostate Cancer QPIs where Waikato DHB is outside the national average (underperforming) to drive improvements.	Q4 and ongoing
		Waikato DHB will develop, revise and update cancer service improvement plans following publication of any cancer QPI reports or other advice / evidence.	
		Implement and report progress against our DHB Bowel Cancer Service Improvement Plan (informed by the Bowel Cancer Quality Improvement Plan, 2020; Bowel Cancer Quality Improvement Report, March 2019).	Q1-Q4
		Waikato DHB will continue to develop the regional bowel cancer clinical pathway and MDM system to support service improvement.	Q1 and ongoing
		Waikato DHB will support clinician participation in Te Aho o Te Kahu annual quality forum.	Q1 and ongoing
		Waikato DHB will engage with Māori, Pacific, DHB Consumer Councils and other key stakeholders in the development of our cancer improvement plan and services. (EOA)	Q1 and ongoing
		Prevention and screening Additional actions that focus on prevention and screening services can be found under breast screening, cervical screening, bowel screening and colonoscopy wait times.	
Ratonga a iwi – Effective and efficient care and services		**Bowel screening and colonoscopy wait times** Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time making wait times a key priority for Waikato DHB. To ensure we continue to meet wait time targets while successfully implementing bowel screening in our district we will	
		During COVID-19 there was a fast, responsive, and locally adapted and delivered programme using existing organisations with 'on the ground' knowledge and ability to mobilise community networks. The guidance was not prescriptive but based on general principles/ standards and trust. The impact was an engaged community working together to support the vulnerable and ensure needs were met. Key was trust and flexible use of central budget devolved to local decisions by groups who were expert in their community characteristics and needs. This localised response produced engagement, accountability and creative solutions. This is what we want to work with to improve outcomes.	Ongoing
		The COVID-19 response demonstrated that community care, primary care and secondary care could work together to develop better processes for patients. In 2021/22 the DHB, Community and Primary Care will continue to work together to identify and address barriers to access Colonoscopy and Bowel Cancer Screening. This will involve relationship building, no blame listening, prioritisation, troubleshooting, focussed actions, and a willingness to modify institutional behaviour to allow better pathway flow.	Q1 and ongoing
		Increase the 'champion' pool to at least eight individuals who are willing to share their story and encourage others to take part in the screening programme. This will be aimed at Māori and other high need populations. (EOA)	Q4
		Work with cancer society and other screening programmes to have an easy common message "know your whakapapa to protect your whānau." Knowing family history builds on a foundational knowledge of whakapapa. Trusting families to have conversations to identify those in their whānau that may be at increased risk of bowel cancer can allow earlier detection of cancers by encouraging people to take part in screening.	Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	Enhance the connectedness and sustainability of specialist care	**Health workforce** **Strengthening the workforce to ensure there is sufficient and sustainable supply of skilled workers now and in the future is a priority for Waikato DHB. In 2021/22 we complete the following to support this priority:**	
		Learnings from the COVID-19 response have driven Waikato DHB to use our health workforce differently. Moving forward we will enhance integrated care and support local iwi to deliver testing and vaccinations to rural communities. This improves access to care for some of our most high need populations and has been proven successful. This approach will drive success in achieving our targets of 75 percent of eligible population receive the influenza vaccination and 95 percent of our 15-30 year olds receiving the MMR vaccination.	Q1 and ongoing
		Waikato DHB will continue to develop digitally appropriate mechanisms to support staff to work from home effectively. Learnings from staff working from home during the COVID-19 outbreak are to be embedded to better support staff to work more flexibly and remotely whilst maintaining effectiveness and productivity. Key milestones include: • Development and endorsement of updated flexible working policy • Tools and support for staff mental health wellbeing from working from home developed • Audit undertaken to understand numbers of staff working from home on an annual basis.	Q1 and ongoing
		Waikato DHB will build on and utilise all of the union engagement forums and work with the Health and Safety Strategic Governance group to collaborate and develop initiatives and programmes to support flexibility and wellbeing within the workforce. This will include a full refresh of our Local Bipartite Action Group ensuring that we work collaboratively to prioritise issues pertinent to both parties and develop co-designed solutions.	Q1 and ongoing
		To increase the diversity of representation in leadership or decision-making roles Waikato DHB will be implementing the Māori workforce development strategy and action plan to ensure a focus on: • Increasing the number of Māori leaders and managers throughout the organisation from 8 percent to 10 percent by June 2022. • Increasing participation in Te Hono Whakataki from 70 percent to 80 percent • Continuing to report on diversity metrics to inform targeted actions to improve workforce diversity	Q4
		The DHB has an organisational wide integrated Health, Safety and Wellbeing strategy and Health and Safety policy which has been fully committed to and endorsed by our executive and commissioner groups. A key focus for 2021/22 will be implementation of a Wellbeing framework and initiatives.	Q2 and Q4
		Staff development (Undertaken Q1-Q4) • Develop and implement a comprehensive strategy to ensure its workforce is culturally safe and competent • Develop and deliver a 1 year Tikanga Māori training programme (to include Māori equity, Te Tiriti o Waitangi, te reo Māori and Māori models of care, and unconscious bias) to all new Tier 1-5 staff • Ensure te reo training is offered to all staff prioritising Māori • Review, refresh and implement policies relating to Te Ao Māori and Matauranga Māori • Develop and track quarterly Māori health workforce development performance dashboard that tracks our performance in terms of recruitment, retention and development of the DHBs Māori health workforce • Implement mentoring/coaching and prioritise professional/personal development plans for emerging and current Maori leaders	Q1-Q4
		Recruitment (Undertaken Q1-Q4) • Build employee brand (internally & externally) where Māori people, their values and aspirations are supported through work • Partner with Kia ora Hauora to understand current and future Māori candidate pool, with the ability to engage those nearing completion of studies to offer employment opportunities • Develop values based recruitment training and review current recruitment/selection policy to reflect Māori equity focus • Input Te Tiriti, Te Ao Māori intelligence and Māori health equity capabilities to position descriptions • Introduce KPIs for managers in regards to workforce Māori representation	Q1-Q4

Government planning priority			
Better population health outcomes supported by strong and equitable public health and disability system			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	**Enhance the connectedness and sustainability of specialist care**	**Targets** Increase the Māori workforce representation to 12.5 percent, through implementing values based recruitment and ensuring that all Māori candidates who meet the essential criteria for positions are shortlisted for interview.	Q4
		Increase Pacific workforce representation to three percent through implementing values based recruitment and ensuring that all Pacific candidates who meet the essential criteria for positions are shortlisted for interview.	Q4
		Fifty percent of all staff have completed Te Tiriti online training. The DHB will link to provide an online training programme to all staff over the next 12 months.	Q4
		To support the sustainability, and the health and safety/wellbeing including mental wellbeing of our workforce Waikato DHB will: • Develop and implement and broad ranging culture change programme to support the embedding of the values of the DHB. This will include the engagement with staff in regards to aspirations for our culture, the development of a behaviours framework and the rollout of values based recruitment. • Develop and implement an effective leadership and manager development programme, which includes core skills in relation to people management, financial sustainability and health and safety requirements. • Implement the endorsed, Health, Safety and Wellbeing strategy, ensuring compliance to the Health and Safety at Work Act, improving the DHBs Safe365 Safety Index score. *See further workforce activities on page 29 in the section 'shift cultural and social norms'.*	Q4
Ratonga a iwi – Effective and efficient care and services		**Data and digital enablement** *Please note that the priority for IS will be cyber attack recovery and this may cause delays or the need to re prioritise these activities* Progress the inpatient management upgrade which will help manage Telehealth appointments. Has been delayed due to the cyber-attack. However, IS will be signing a SLA with Strategy and Funding to progress the work later in the year.	Q3
		Implement the Cardiology Telehealth pilot. This will pilot is a GP, patient and cardiology specialist virtual consultations. If successful the pilot will be rolled out to other DHB specialist services.	Q2 and Q4
		Digitally enable four mobile vans to deliver health services in rural and remote areas (1x Hauraki PHO; 1x Ruakura NGO; 2x DHB) .	Q2 and Q4
		District nurses will be also be fully digitally enabled by December 2021 – will also use telehealth as well as opportunities to integrate across specialist and primary care services.	Q3
Whanaketanga – Productive partnerships	**Partner with Māori in the planning and delivery of health services**	**Implementing the New Zealand health research strategy** **Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes making the following key priority actions for 2021/22:** Waikato DHB has received a Health Research Council (HRC) grant to undertake a COVID-19 related research project: WHIRI – Pandemic system redesign to maximise Māori health gains. Waikato DHB will also continue to take part in relevant COVID-19 related research projects.	Q4
		Waikato DHB has received a Collaboration Grant and Activation Grant from HRC's Health Sector Research Collaboration funding round. The activation grant project (one year) will use a co-design process working with key Māori stakeholders to help build a bottom up research framework for future equity driven research. The Collaboration grant project (three years) will use a kaupapa Māori co-design process, partnering with a range of stakeholders to develop a hauora (wellbeing) tool and programme to assess and meet the needs for hapū māmā and for Māori with chronic disease.	Q4
		Work with the national DHB research office managers to identify ways to streamline research registration processes and resources to enhance DHB researchers' capability to collaborate regionally and nationally.	Q4
		Waikato DHB has a research policy which will be reviewed and updated, to better align the policy to the revised NEAC standards, and take into account innovation and practice improvement.	Q4
		Develop and present sessions to inform researchers, as part of a research day event.	Q4

Better population health outcomes supported by primary health care

Government planning priority			
Better population health outcomes supported by primary health care			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Manaaki – People centred services	Enhance the capacity and capability of primary and community health care	**Primary care** **Improving access to primary care services and working closely with our primary care partners is a priority for Waikato DHB. Some of the key activities for 2021/22 include:**	
		Complete and implement a COVID-19 testing strategy (Māori and Pacific). This will be done in partnership with Māori and Pacific providers and will be updated on an ongoing basis throughout the year.	Q1 and ongoing
		Improve access to, and sustainability of diagnostic services through the creation of pathways that provide GPs access to diagnostic services. Chest CTs are the first priority, followed by cardiac echo and later extending to ultrasound.	Q2 and Q4
		Enhanced Primary Care Integration (DNs and GPs). This project is a collaborative between the PHOs and DHB. It is aimed at developing an agreed model of nursing care that provides the best response to patient need.	Q1 and ongoing
		Primary care and third party providers will work alongside the rural hospitals to provide clinical care required for the locality such as community follow up from specialist procedures and visits. This ensures the appropriate follow up care is easily accessible reducing the chances of hospital admission or readmission.	Q4
		Locality development The localities approach will focus on Te Korowai Waiora Goal 5 'Enhance the capacity and capability of primary and community health care.' Locality work groups and action plans will ensure general and specific activities are consistent with the agreed local priorities across the rural primary care sector, and are aligned to meet Goal 5. In 2021-22 The Waikato DHB and PHO operational alliance will be formally recommissioned to ensure that the delivery of our Localities strategy, as well as a list of other critical transformation work streams, have executive level sponsorship and can be advocated to respective teams as clear, collective strategic priorities, through: • Ensuring priorities are consistent with regional primary care strategy • Ensuring that adequate resource is deployed in primary care and processes are in place within localities to support agreed priorities • Monitoring progress and outcomes at a DHB-regional level • Intervening to resolve problems and remove roadblocks when requested	Q1-Q4
		Pharmacy **Waikato DHB has, and will continue to develop pharmacist services, making better use of pharmacists' skills, within an integrated health and disability system that supports people to stay well throughout their lives. In 2021/22 key priority actions will include:**	
		Following on from last year's activity to commence a project on outliers, a data and reporting analyst has been appointed and a contract is in progress with MidCPG for a Pharmacy facilitation service to ensure best use of pharmacy and clinical outcomes for patients. In 2021/22 the aim is to identify where benefits can be made and then implement any changes required.	Q4
		Respiratory Increase uptake of children's influenza vaccination to prevent respiratory admissions through a number of activities including: • PHOs will provide practices with information on the children who are in the eligible population • Prioritising vaccination of eligible Māori and Pacific children • use practice level data and quality improvement interventions to improve and monitor the improvement in Māori child immunisation rates • Co-design and trial community based immunisation interventions, including digitally enabled mobile vans targeting Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe.	Q2 and Q4

Government planning priority			
Better population health outcomes supported by primary health care			
Waikato DHB strategic imperative	**Te Korowai Waiora, Waikato HSP**	**Key activity/initiatives**	**Key milestone or completion**
Ratonga a iwi – Effective and efficient care and services	Improve access to services	**Reconfiguration of the national air ambulance service project – phase two** **Air ambulance services are a critical part of how we respond to health emergencies across the Waikato district and beyond. This service enables equity of access to specialist clinical services. Cabinet have endorsed a two-phased 10-year reconfiguration of the national air ambulance service. Phase one is complete, preparation for phase two has begun:** Waikato DHB is committed to supporting the reconfiguration of the national air ambulance service project. The successful delivery of this project will ensure that there is a nationally consistent framework that ensures regardless of location, people will have access to ambulance services. With our diverse and often rural population, this is essential in ensuring equitable access to services no matter where you live. Support will be provided in the form of nominated attendees participating in required meetings and/or workshops, responding to information requests in a timely manner. Locality development Equity of access is the high level outcome of Te Korowai Waiora. Relevant data suites informing the national air ambulance project will be collected and collated by locality, ethnicity and iwi affiliation on request. The establishment of locality partnerships and work groups will provide opportunities to get a locality perspective on national projects.	Q4 Q1 and ongoing Q4
Manaaki – People centred services	Empower whānau to achieve wellbeing	**Long term conditions** **This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples making it a key priority for Waikato DHB. 2021/22 will see a focus on diabetes, CVD and obesity:** By June 2022 Waikato DHB will have a comprehensive long term conditions wellbeing strategy. As part of this, Waikato DHB will achieve equity in heart health screening rates between Māori, Pacific and Others by June 2022. The Māori rural initiative team will locally screen identified patients to prevent emergency cardiac events and/or hospital admissions where clinically appropriate. This will release scarce resource to be available for high and complex cases. Implement Mate Huka, a new innovative project that seeks to radically improve diabetes outcomes for Māori, Pacific and their whānau. This Tainui Waka iwi diabetes partnership programme will provide early screening and education with the aim of reducing the prevalence of type 2 diabetes. (EOA) Enhance current health pathways to enable access to secondary health services where required. Specific focus will be on diabetes management. Waikato DHB is working with WINTEC to provide second year midwifery students education on the importance of exercise for pre and postnatal wahine/women. Education will include why exercise is important, the benefits it can bring, and the types of exercise to encourage and what a safe exercise programme should include. By educating midwives, hapu wahine will be better supported to prevent excessive weight gain during pregnancy, and establish positive exercise routines that can continue. Exercise and weight management in pregnancy will help with postnatal recovery and have long term health benefits. **Ambulatory sensitive hospitalisations (ASH) adult**[2] Waikato DHB and our primary care partners aim for a two percent annual reduction in ASH rates for Māori adults aged 45-64. To help achieve this target Māori patients with ASH conditions (e.g. CHF, CVD,COPD, AF/ stroke and cellulitis) will receive appropriate clinical support, including: • PHOs will provide their general practices with prioritised lists to recall Māori, Pacific and other vulnerable patients for flu vaccinations. General practices will provide targeted outreach for specific population groups such as Kainga Ora/Housing NZ tenants. • Smoking is a major contributor to ASH rates. Smoking cessation will remain a key focus and include incentivised personal and group smoking cessation support, by Māori for Māori. Surveillance reporting will be completed to monitor smoking prevalence by ethnicity and age. Contributory measures: 1. Eligible Māori adults who receive the flu vaccine. 2. 15 to 74 year old PHO enrolled population who have had a smoking status of 'current smoker' within the last 15 months. **Hepatitis C** The DHB will work with primary care and wider community providers to identify opportunities to improve the health of the DHB population through access to hepatitis C treatments. This work will be ongoing and further refined following publication of the National Hepatitis C Action Plan.	Q4 Q2 Q1 and ongoing Q3 Q4 Q1-Q4 Q1

[2] Also see SLM plan in appendix B

SECTION THREE: Service configuration

All DHBs are required to deliver a minimum of services, as defined in the Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Waikato DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

Service coverage

All service reviews and changes with likely material impacts must be signalled to the Ministry of Health for an opinion about whether or not they can or should be actioned. Ultimately, if the impact is significant, consultation with key stakeholders, including our community, may be required before Ministerial approval is given.

The table below describes all known service reviews and service changes that have been approved or proposed for implementation in 2021/22. There may be other service changes required throughout the year as part of the DHB's 2021/22 Savings Plan. These service changes will be communicated to the Ministry as and when required.

Service change

It is possible that improvements in model of care, in line with best practice, national direction, our planned care initiatives, and COVID-19 recovery will result in some service changes, but these are unknown at the time of publication of this plan.

During 2021/22 Waikato DHB is continuing with our locality development programme that will be focused on improving responsiveness to local community needs and deliver services that are closer to home. This programme will inevitably involve reconfiguring services and may result in service changes to improve access and wellbeing for local communities.

DHBs are expected to manage any service change as significant service change if the proposed change will have a material or significant impact on the recipients of services, their caregivers or service providers such as:

- changes in service eligibility criteria
- access to services by the DHB's population including access to services provided in other DHBs or the way that services are provided
- meaningful shifts or additions in workforce/FTE including in individual services
- the financial position of DHB(s) proposing the change or for the other DHBs

For each change, DHBs must explain how the changes will deliver benefits. The table below includes known service changes. The Ministry will be notified as and when future proposed service changes become known.

FTE movements

Accrued FTE movements from 2020/21 to 2021/22 predominantly relate to FTE budgeted to be converted from outsourced personnel to staff, resulting in savings to the organisation. The low level of shifts and additions in workforce FTE includes much tighter controls following the appointment of the commissioner, but at the same time mitigating areas of clinical risk. Adjustments for appropriate nurse staffing levels and meeting requirements for CCDM have been included and continue to be reviewed.

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Mate Huka	Tainui Waka iwi diabetes partnership programme to provide early screening and education with the aim of reducing the prevalence of type 2 diabetes in Māori	Radically improve diabetes outcomes for Māori, Pacific people and their whānau	Local
Whānau Pai programme	Whānau Pai is part of the 'Access and Choice' initiative announced by the Ministry of Health aimed at increasing the range of integrated primary mental health and addiction services available to communities. Whānau Pai is made up of four kaupapa Māori services who deliver mental health and addiction services into 32 general practices here in the Waikato. Over time, in collaboration with the Ministry of Health more support will be made available to ensure Whānau Pai services are available within all GP practices.	Kaupapa Māori led approach for all. Services delivered by kaupapa Māori providers will positively contribute to the elimination of health inequities. Expansion of access to, and choice of, primary mental health and addiction services. Improved experience for whānau/ communities in accessing mental health and addiction support - so that anyone can access free mental health and addiction support when and where they need it. Whānau/communities have access to support sooner, reducing possibility of needing secondary and acute mental health and addiction services. Reduce flow/pressure of whānau entering secondary and acute mental health and addiction services.	Local
Mental Health Review implementation	Mental Health Review Implementation of agreed recommendations	System of change / clinical governance	Local
Surgical services	The outsourcing of surgical services where clinically appropriate in sub specialties	Target areas will be services where the step costs for internal service provision take the DHB in excess of the national price	Regional
Primary care – diagnostics	Enable direct access to diagnostics for GPs	Streamline the patient journey through the health system.	Local
Diabetes retinal screening	Continue with the diabetes retinal screening pilot roll out into localities where optometrist services are operating.	Improved access for high need populations.	Local
WHIRI	Redesign WHIRI for the cancer pathway from referral to diagnosis. This will be informed by evidence; clinical notes review; patient, whānau and staff interviews; and stakeholder engagement.	Improve cancer nurse engagement is variable along the cancer pathway, improve the monitoring of care quality, and ensure the pathway is pandemic resilient.	Regional
Locality development	Develop locality plans for each of the seven localities – these will determine based on local need how and what services will be delivered	Improved equity, improved access,	Local
Enhanced primary and community care	District nurses working with general practice to deliver integrated care	Improved access	Local

Managing our business

Waikato DHB has a statutory responsibility to improve, promote and protect the health of its people and communities. This section will outline the DHBs stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services. In addition it will show the organisation's commitment to working with sector partners to deliver services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

Organisational performance management

The DHBs performance is assessed on both financial and non-financial measures, which are measured and reported at various levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Table: External reporting framework

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

Funding and financial management

The DHBs key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHBs performance management process to stakeholders on a monthly basis. Further information about DHBs planned financial position for 2021/22 and out years is contained in the Financial Performance Summary section of this document on page [], and in appendix A: Statement of Performance Expectations on page [].

Investment and asset management

Property portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2021/22 Target
The percentage of Waiora Waikato hospital campus IL3 and IL4 buildings that have a seismic rating of less than 34% of the NBS. Note 1	Condition	7%	7%	6%	6%	0%	0%
Utilisation by DHB departments of Waiora Waikato hospital campus Building Core Services. Note 2	Utilisation	99%	99%	99%	99.5%	> 99%	> 99%
Waiora Waikato hospital campus disabled carparks as a percentage of total public car parking. Note 3	Functionality	5%	5%	13.3%	13.3%	> 13%	> 13%
Waiora Waikato hospital campus building energy efficiency savings as a percentage of targeted energy consumption. Note 4	Functionality	7%	16%	14%	21%	> 7%	> 7%
Percentage of Waiora Waikato hospital campus buildings with valid Building Warrant of Fitness.	Condition	N/A	N/A	N/A	N/A	100%	100%
Percentage of Waikato DHB rural hospitals and community facilities with valid Building Warrant of Fitness.	Condition	N/A	N/A	N/A	N/A	100%	100%

Clinical portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2021/22 Target
Percentage of CT Scanners (Radiology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	100%
Percentage Linear Accelerators (Oncology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	100%
For Waikato hospital Radiology department, actual CT scanned patients versus planned patient scans.	Utilisation	101%	103%	100%	120%	>90%	>90%
Percentage of the available time Linear Accelerators (Oncology) are used to carry out radiation treatment on patients	Utilisation	95%	92%	85%	72%	>86%	>86%
For Waikato hospital, planned day theatre usage versus actual usage. Note 5	Utilisation	74%	76%	73%	73%	>75%	>75%
For Waikato hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	100%	100%	98%	94%	>90%	>90%
For Waikato hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. Note 6	Utilisation	92%	92%	88%	86%	>85% and <95%	>85% and <95%
For Waikato DHB, elective surgery completed as a percentage of MOH elective surgery targets for last 12 months. Note 7	Utilisation	102%	105%	99%	92%	100%	100%
For Waikato DHB, weighted average age of clinical Fixed Assets versus Suppliers weighted average life expectancy.	Condition / Functionality	N/A	89%	56%	68%	>90%	>90%
Percentage of diagnostic monitors meeting Quality Assurance (QA) requirements.	Functionality (Fitness for Purpose)	N/A	N/A	N/A	N/A	100%	100%
Percentage of diagnostic Ultrasound machines meeting the International Accreditation New Zealand (IANZ) specified industry accepted standards	Functionality (Fitness for Purpose)	N/A	N/A	N/A	N/A	100%	100%

Information Communication and Technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2021/22 Target
Percentage of Computer hardware aged less than 5 years old, used by staff. Note 8	Condition	97%	82%	62%	66%	100%	100%
Availability of critical Clinical systems (iPM, CWS, iSL, PACS) to the Emergency Department. Note 9	Utilisation	99.95%	99.98%	99.78%	99.44%	>99.50%	>99.50%
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 -10 scale. Note 10	Functionality	86%	92%	91%	75%	> 90%	> 90%
User devices with the latest vendor-provided level of critical and security patching. Note 11	Condition	N/A	N/A	N/A	N/A	>= 85%	>= 85%
Percentage of server devices with critical and security patches, to latest vendor-provided level. Note 12	Condition	N/A	N/A	N/A	N/A	100%	100%

Shared service arrangements and ownership interests

The DHB has a part ownership interest in HealthShare Limited the Te Manawa Taki shared services agency and New Zealand Health Partnerships Limited the National Shared Services Agency. In line with all DHBs nationally, the DHB has a shared service arrangement with the Central Region Technical Advisory Services Limited (TAS) around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

The DHB has a formal risk management and reporting system, which entails incident and complaint management as well as the risk register (Datix management system) and routine reporting. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

The DHBs approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016 with the ongoing direction reflected in the DHB strategic imperatives. Progress is monitored by the executive leadership team. The consumer council ensures a person/whānau centred approach to organisational planning.

Building capability

Capital and infrastructure development

Work will continue on the mental health adult acute inpatient facility through 2021/22, which will see the finalisation/submission of the 'Detailed Business Case' and enable the progress of some of the preliminary site preparations and also commencement of the 'Implementation Business Case'.

Health Infrastructure Investment Programme (HIIP) projects will continue with significant engineering design underway for the Waiora building seismic project. The Tokoroa Hospital upgrade project is expected to be completed within the 2020/21 financial year.

The business case for the linear accelerator replacement is expected to be submitted during 2021.

Table of approved Crown Funded capital items

Project name	2021/22 $M	2022/23 $M	2023/24 $M	2024/25 $M	Crown funding requirement
Mental health adult acute inpatient facility	5	8	47	40	100
Waiora building seismic upgrade (HIIP)	5	-	-	-	5
Tokoroa Hospital (HIIP)	1	0	0	0	1
Linac machines	5	0	0	0	5
Total approved Crown Funding	16	8	47	40	111

Other strategic capital programme items as part of the broader (DHB funded) capital plan include:

- Laboratory services. Work has commenced on business case development for Laboratory accommodation upgrade
- Cancer services work towards facilities improvements and envisioning a new Regional Cancer Centre is underway
- Waikato Regional Renal facility accommodation project is in design phase and building works are expected to commence in 2022
- Waikato Regional Diabetes Services accommodation upgrade is expected to be completed in 2021/22

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

Workforce

Future workforce development - Our People Strategy – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy. Further detail can be found in the section on local and regional enablers within this document. In summary the key areas are:

Organisational culture

The DHB aspires to be an inclusive, supportive and safe place to work with a culture of innovation. Understanding the organisation's current Employee Value Proposition (EVP) will inform the strengths in its organisational culture. Embedding this culture will require organisational leaders to champion it.

Leadership

TThe DHB supports leadership development via a number of programmes which provide learning opportunities for new or experienced managers, or those with leadership potential in the Te Manawa Taki DHBs.

The organisation also aspires to drive future performance through focusing on leader development, building valuable team management skills. Values-based leadership is increasingly important with leaders and teams hiring, retaining and developing teams an individuals based on organisation values. For Waikato DHB this is: Whakamana (give and earn respect), Whakarongo (listen to me, talk to me), Mauri Pai (fair play), Whakapakari (growing the good) and Kotahitanga (stronger together).

Workforce development

To achieve for the communities and consumers it serves, the DHB must focus internally on all its employees. The organisation's strategic direction for "Our People" is about putting people at the heart of everything it does. This means putting people at the centre of how the organisation shapes what it's like to work here, how it develops people's capability, and building a workplace to best serve patients and communities.

To make this a reality Human Resources (HR) is working towards implementing a workforce plan which will be used to inform which workforce capabilities are required and what development/learning opportunities the organisation needs to provide for its workforce.

We will continue to focus on implementing and rolling out workforce data through the introduction of positon management and dashboards for managers ensuring they have information to make informed decisions in regards to their teams.

Māori workforce development

TThe DHB is committed to attracting and retaining Māori staff and to building partnership capabilities in both Māori and non-Māori staff. The organisation's workforce must reflect its population; this means 23 percent of the DHB's workforce should be Māori in all role types and at all levels across the organisation, to ensure Māori experiences and expertise can be found everywhere.

HR will continue to build on the previous year's progress to ensure integration of Tikanga into all HR processes and traditional Māori culture and language will be upheld and valued. This means that karakia, waiata, whakawhānaungatanga, powhiri and Te Reo Māori will be embedded into organisational practices to better support Māori staff. A number of metrics will be developed and reported by Māori and non-Māori so potential inequalities in the future workforce can be eliminated.

Co-operative developments

The DHB works and collaborates with a number of external organisation and entities, including:

- local government (local and regional territorial authorities)
- Ministry of Education
- Corrections
- Ministry of Justice
- NZ Police
- Ministry of Social Development
- Oranga Tamariki
- other DHBs
- NGO health care providers.

Health and Safety

The DHB aspires to be an inclusive, supportive and safe place to work with a culture of innovation. Understanding tThe DHB has an organisational wide integrated Health, Safety and Wellbeing strategy and Health and Safety policy which has been fully committed to and endorsed by our executive and commissioner groups. Over the next 12 months the focus will be on:

- Implementation of a Wellbeing framework and initiatives
- Working collaboratively with the 20 DHB Health and Safety Manager group
- Implementation of initiatives to mitigate the risks of workplace violence
- Rolling out of all staff and manager/leader training in regards to Health and Safety responsibilities
- Hazardous substances – review and creation of centralised inventory and effective training for relevant staff.

Information technology (IT) –

On the 18th of May 2021 Waikato DHB suffered an unprecedented cyber attack that caused significant cyber disruption shutting down all systems across our DHB including all five hospitals for five weeks. By late July 2021 we are still not back to full capacity and the team continue to work to get back to normal as quickly as possible however, this will take some time. Recovery will remain the priority for our IS department into 2021/22 leaving little capacity to progress new projects and initiatives. The Ministry will be kept informed of progress and activities can be re prioritised as systems are restored and we return to full capacity.

Improving equity through IT

Progress in health equity towards pae ora includes developing good-quality ethnicity data, developing knowledge and reconfiguring services to deliver high quality health care meeting the needs of Māori and other groups where inequity has been proven.

The DHB Information Services (IS) team is working with the Waikato DHB Consumer Council and the Clinical Leads of the newly formed Clinical equity leadership group specifically on our Telehealth Programme of work and will continue to partner with these groups to co-develop and implement the DHB's Digital strategy.

Development of new database tools is ongoing and will enable us to capture ethnicity, allowing for transparency and easy recognition of inequities. Overlying databases with business intelligence tools such as Qliksense in the future will provide ready reporting and data access to clinicians allowing them to improve practice, disclose and address proven inequity.

Provision of health services via digital technology

Currently the DHB supports telehealth hubs in Thames, Taumarunui, Te Kuiti and Tokoroa to provide; acute stroke support (diagnosis and thrombolysis), ad hoc emergency support, virtual ward rounds to Assessment, Treatment and Rehabilitation patients in Thames, infectious disease support, outpatient clinics in renal medicine, respiratory medicine and oncology, and wound care clinic (currently under development).

In addition, the DHB provides support for speech language therapy delivered to the patient location on a smart device with developing service for renal transplant patients and community health (in particular delivery of Video Direct Observation of Therapy).

Other Telehealth services include: supply of a variety of clinics to the Midland DHBs and mental health services within the DHB (including support to patients relating with police officers acutely).

The Waikato Health System Plan includes a goal on improving access to services. Actions under this goal have a focus on supporting DHB service delivery models with technology and information (including virtual care, virtual consults, tele monitoring, and integration across the continuum of care).

Given the DHBs large territory, being able to work remotely is vital, particularly to community teams. Many of the organisation's clinical teams have been issued with mobile devices to enable remote access to Clinical Workstation and tools such as Lippincott to enable guideline based care.

Health Pathways are currently being developed for many services and these are directly available through Clinical Workstation when accessing a patient's record (for remote staff, inpatient teams and community and primary care partners) as well as via the DHB intranet.

Aligning with national and regional IT initiatives

At a practical level the DHB is focused on leveraging maximum value from regional investments and avoiding investment duplication through; ensuring all local initiatives are reviewed with reference to the Regional ISSP to ensure effort is not duplicated or in competition, initiatives related to or delivering functionality similar to eSpace are progressed through the regional eSpace Programme Board for endorsement, and all significant investments are progressed through the Regional Capital Committee.

Regional solutions utilised by the DHB include; Midland Clinical Portal Foundation Platform, Datix, ePharmacy and PACS/RIS. The objective of the regional eSpace Programme is to deliver a regional clinical information system. The DHB has a significant investment ahead over the next three years to enhance the regional functionality for eOrders, eReferrals, Results Management and Medication Management.

Key IT Initiatives for 2020/21

Initiative	Key milestones 2021/22
Progress the Inpatient Management upgrade which will help manage Telehealth appointments. Has been delayed due to the cyber-attack. However, IS will be signing a SLA with Strategy and Funding to progress the work later in the year.	Q3
Implement the Cardiology Telehealth pilot. This will pilot is a GP, patient and cardiology specialist virtual consultations. If successful the pilot will be rolled out to other DHB specialist services.	Q2 and A4
Digitally enable four mobile vans to deliver health services in rural and remote areas (1x Hauraki PHO; 1x Ruakura NGO; 2x DHB)	Q2 and Q4
District nurses will be also be fully digitally enabled by December 2021 – will also use telehealth as well as opportunities to integrate across specialist and primary care services.	Q3

SECTION FIVE: Performance measures

The DHB monitoring framework and accountability measures have been updated for 2020/21 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance:

- The health and disability system has been asked to focus on the following priorities:
  - Improving child wellbeing
  - Improving mental wellbeing
  - Improving wellbeing through prevention.
  - Better population health outcomes supported by strong and equitable public health and disability system
  - Better population health outcomes supported by primary health care.

Summary overview of the DHB accountability measures for 2021/22			
Government priority	Improving the wellbeing of New Zealanders and their families		
Government priority outcomes	Ensure everyone who is able to, is earning, learning, caring or volunteering	Support healthier, safer and more connected communities	Make New Zealand the best place in the world to be a child
Vision	Pae Ora Healthy Futures		
Outcomes	We live longer in good health	We have improved quality of life	We have health equity for Māori and other groups
2021/22 DHB accountability measures Note: some measures such as those under review as part of the planned care work and whānau ora are not currently included in this table	Improving the wellbeing of New Zealanders and their families		
	Strong and equitable public health and disability system SS03: Ensuring delivery of service coverage	Strong and equitable public health and disability system SS01: Faster cancer treatment (31 days)	Child Wellbeing CW02: Oral Health – Mean DMFT score at school Year 8
	Strong and equitable public health and disability system SS05: Ambulatory sensitive hospitalisations (ASH adult)	Mental wellbeing MH01: Improving the health status of people with severe mental illness through improved access	Child-wellbeing CW01: Children caries-free at five years of age
	Mental health MH04: Mental Health and Addictions service Development (to be reviewed following decisions that are made in regard to the MH&A Inquiry).	Mental wellbeing MH02: Improving mental health services using wellness and transition (discharge) planning	Child wellbeing CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years
	Strong and equitable public health and disability system SS04: Delivery of actions to improve Wrap Around Services for Older People	Mental wellbeing MH03: Shorter waits for mental health services for under 25-year olds	Child wellbeing CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service.
	Strong and equitable public health and disability system SS05: Better help for smokers to quit in public hospitals	Primary care and prevention PH01: Improving system integration and SLMs	Child wellbeing CW05: Immunisation coverage
	Child Wellbeing CW06: Improving breast- feeding rates		Primary care and prevention PH02: Improving the quality of data collection in PHO and NHI registers
	Child wellbeing CW07: Improving newborn enrolment in General Practice	Strong and equitable public health and disability system SS10: Shorter stays in Emergency Departments	Primary care and prevention PH03: Improving Māori enrolment in PHOs to meet the national average of 90%

2021/22 DHB accountability measures	Strong and equitable public health and disability system PV02: Improving Cervical Screening coverage	Strong and equitable public health and disability system SS11: Faster cancer treatment (62 days)	Mental health MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders
	Strong and equitable public health and disability system SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Strong and equitable public health and disability system SS13: Improved management for long term conditions	Child wellbeing CW10: Raising healthy kids
	Mental wellbeing MH06: Output delivery against plan	Strong public health and disability system SS07: Planned Care Measures	Child wellbeing CW12: Youth health
	Child wellbeing CW08: Increased Immunisation		
	Primary health care PH04 :Better help for smokers to quit (primary care)	Improving mental wellbeing MH07: Improving mental health services by improving inpatient post discharge follow-up rates	Strong and equitable public health and disability system SS12: Engagement and obligations as a Treaty partner
	Child wellbeing CW09 :Better help for smokers to quit (maternity)		Strong and equitable public health and disability system SS15: Improving waiting times for colonoscopies
			Strong and equitable public health and disability system SS17: Delivery of Whānau Ora

Waikato DHB non-financial performance measures 2021/22

Code	Dimension
CW	Child wellbeing
MH	Mental wellbeing
PV	Prevention

Code	Dimension
SS	Strong and equitable health and disability system
PH	Primary care and prevention

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	61%	
		Year 2	61%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.55	
		Year 2	<0.55	
CW03	Improving the number of children enrolled and accessing the Community Oral Health service	Children (0-4) enrolled (≥95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the Community Oral Health service)	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall (≤10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the Community Oral Health service)	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	Year 1	≥85%	
		Year 2	≥85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		

Performance measure		Expectation		
CW06	Child health (breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with general practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW11	Youth mental health initiatives	Focus area 1 (Youth SLAT): Provide reports as required		
		Focus area 2 (school based health services): Provide reports as required		
		Focus area 3: (youth primary mental health services) refer MH04		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19)	Māori	5.17%
			Other	4.72%
			Total	4.82%
		Age (20-64)	Māori	10.05%
			Other	4.05%
			Total	5.31%
		Age (65+)	Māori	2.65%
			Other	2.39%
			Total	2.43%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan		
		95% of audited files meet accepted good practice		
MH03	Shorter waits for mental health services for under 25-year olds	Provide reports as specified		
MH04	Rising to the Challenge: The Mental Health and Addictions Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (section 29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addictions services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat		
SS03	Ensuring delivery of service coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Māori	9384 per 100,000	
		Pacific	9999 per 100,000	
		Total	3858 per 100,000	

Performance measure		Expectation		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking		Only applies to specified DHBs
SS07	Planned Care Measures	Planned care measure 1: *Planned Care Interventions*	TBC	
		Planned care measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% – zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% – zero patients are waiting over 120 days for treatment
			ESPI 8	100% – all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned care measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within six weeks (42 days)
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned care measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service	
		Planned care measure 5: *Cardiac Urgency Waiting Times*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency	
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely re-admitted post discharge improves from base levels	12.8%
		Planned care measure 7: *Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental*	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year	

Performance measure		Expectation		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>2% and < or equal to 4%
		Focus area 2: Improving the quality of data submitted to National Collections	Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus area 3: Improving the quality of the Programme for the Integration of Mental Health Data (PRIMHD)	Provide reports as specified	
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an ED within six hours		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus area 1: Long term conditions	Report on actions, milestones and measures to: Support people with LTC to self-manage and build health literacy	
		Focus area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care.	
			Ascertainment: target 95-105% and no inequity	
			HbA1c<64mmols: target 60% and no inequity	
			No HbA1c result: target 7-8% and no inequity	
			90% of enrolled people aged 15-74 in the PHO who are high risk have been referred for podiatry services and no inequity.	
		Focus area 3: Cardiovascular health	Provide reports as specified	
		Focus area 4: Acute heart service	**Indicator 1: Door to cath –** Door to cath within three days for >70% of ACS patients undergoing coronary angiogram	
			Indicator 2a: Registry completion – >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/ PCI registry data collection within 30 days of discharge and **Indicator 2b –** ≥99% within three months	
			I**Indicator 3: ACS LVEF assessment –** ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).	

Performance measure		Expectation	
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator – In the absence of a documented contraindication/ intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge – Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) – ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes) – Beta-blocker if LVEF<40% (five-classes) **An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device registry completion – ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/ replacement have completion of ANZACS-QI Device PPM forms completed within two months of the procedure.
			Indicator 6: Device registry completion – ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/ replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within two months of the procedure.
		Focus area 5: Stroke services *Provide confirmation report according to the template provided*	**Indicator 1 ASU –** 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval – 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation – 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within seven days of acute admission
			Indicator 4: Community rehabilitation – 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within seven calendar days of hospital discharge
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95% or above	
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

APPENDIX A: Statement of Performance Expectations including Financial Performance

Waikato District Health Board

2021-22 STATEMENT OF PERFORMANCE EXPECTATIONS

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Contents

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Signatories

Agreement for the Waikato DHB 2021/22 Statement of Performance Expectations

between

Hon Chris Hipkins
Minister of Health

Date: 30 September 2021

Dame Karen Poutasi
Commissioner
Waikato DHB

Date: 28 July 2021

Dr Kevin Snee
Chief Executive
Waikato DHB

Date: 28 July 2021

Waikato DHB (the DHB) has worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which it provides measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2021/22. The performance measures chosen are not an exhaustive list of all of the organisation's activity, but they do reflect a good representation of the range of outputs that the DHB fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, included with each measure is the past performance as baseline data.

Activity not mentioned in this section will continue to be planned, funded and/or provided to a high standard. The DHB reports quarterly to the Ministry of Health and/or internally to governance on performance related to this activity.

National performance story

Health system future direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
Strategic themes	People-powered	Closer to home	Value and high performance	One team	Smart system

Regional performance story

Te Manawa Taki vision	He kapa kī tahi – a singular pursuit of Māori health equity					
Regional strategic outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional strategic objectives	Health Equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB performance story

Our vision	Healthy people. Excellent Care					
Our strategic imperatives	Achieving health equity for high needs populations	Ensuring safe, quality health services for all	Providing people centred services	Delivering effective and efficient care and services	Becoming a centre of excellence in learning, training, research and innovation	Developing productive partnerships

Service performance

Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood oral health Long term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence	People receive prompt acute and arranged care People have appropriate access to ambulatory, elective and arranged services Improved health status for those with severe mental illness and/or addictions More people with end stage conditions are supported appropriately
Outputs*	Percentage of eight months olds will have their primary course of immunisation on time	Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

Stewardship

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

Impacts

Over the long-term, the aim is to make positive changes in the health status of the population. As the major funder and provider of health and disability services in the Waikato, the decisions made about which services will be delivered have a significant impact on the population and, if coordinated and planned well, will improve the efficiency and effectiveness of the whole Waikato health system. Understanding the dynamics of the population and the drivers of demand is fundamental when determining which services to fund and at which level. Just as fundamental is the ability to assess whether the services purchased and provided are making a measureable difference in the health and wellbeing of the Waikato population.

One of the functions of this document is to demonstrate how the DHB will evaluate the effectiveness of the decisions made on behalf of the population. Over the long–term, this by measuring our performance against the desired impacts outlined below. That way we demonstrate our commitment to an outcome-based approach to measuring performance.

Impact measures – measure of performance

The DHB seeks to make a positive impact on the health and wellbeing of its population and contribute to achieving the longer-term impacts we seek. Impact measures are defined as "the contribution made to an outcome by a specified set of goods and services (outputs), or actions or both". While the DHB expects its outputs will contribute to achieving the impact measures, it must be recognised that there are outputs from other organisations and groups that will also contribute to the results obtained for the impact measures. The following impact measures will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

Long-term impact one: People are supported to take greater responsibility for their health

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

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

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

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

Long-term impact two: People stay well in their homes and communities

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

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

Long-term impact three: People receive timely and appropriate specialist care

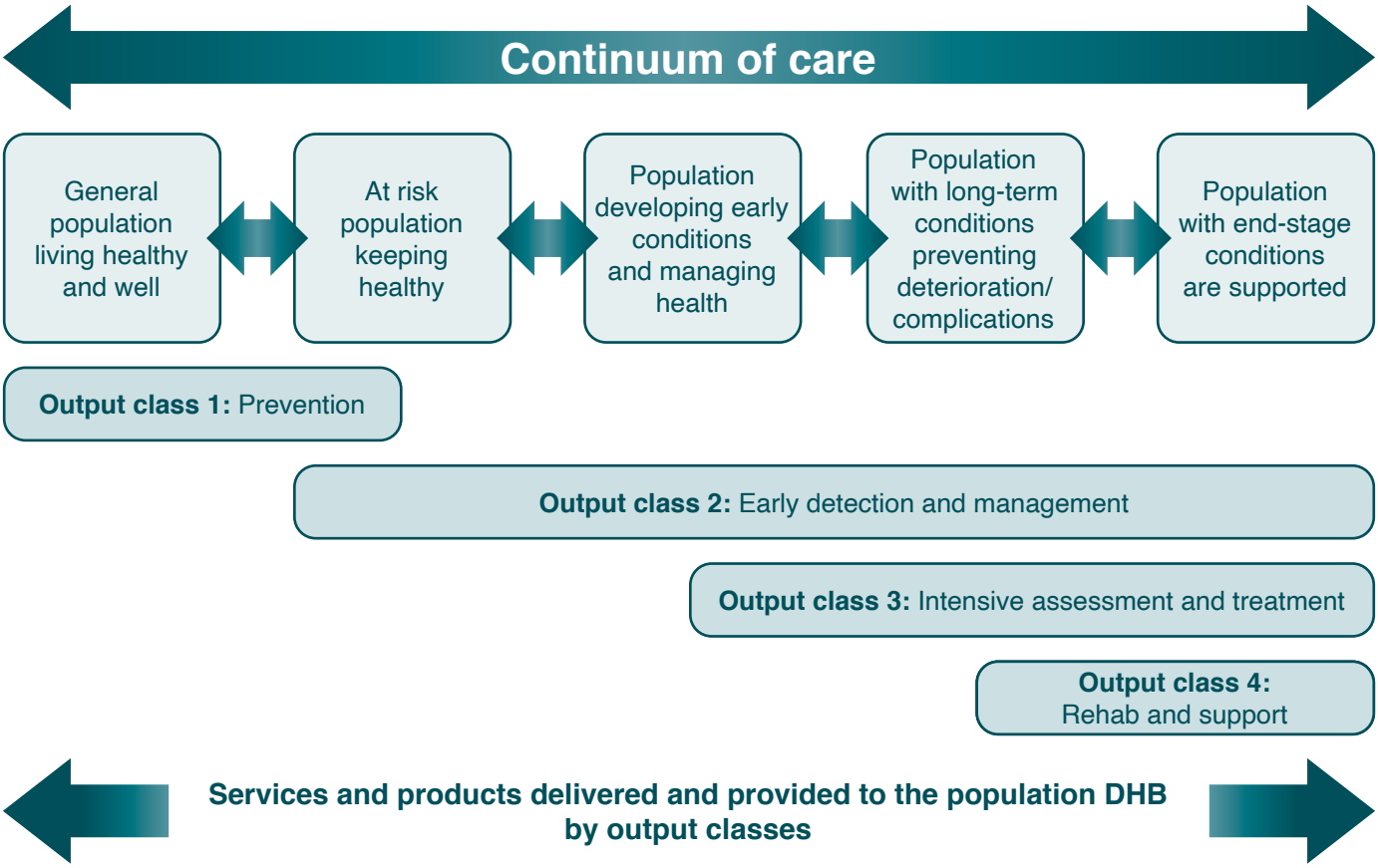
Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience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

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

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

Output measures

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum care and are applicable to all DHBs. Identifying a set of appropriate measures for each output class can be difficult. We do not simply measure 'volumes.' The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.



In order to best demonstrate this, we have chosen to present our Statement of Performance Expectations using a mix of measures of timeliness, quantity and quality – all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health impacts we are seeking over the intermediate and longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year – and therefore reflect a reasonable picture of activity across the whole of the health system.

Output class

Prevention

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

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

Preventative services include health promotion to ensure that illness is prevented and equity of outcome is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation.

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

Early detection and management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Intensive assessment and treatment services

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

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

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

Rehabilitation and support

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Co-ordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services.

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

Setting targets

Wherever possible, we have included baseline data to support evaluation of our performance at the end of the year. All baseline data is taken from 2019/20 unless stipulated. In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Our targets reflect our commitment to reducing inequalities between population groups, and hence most measures are reported by ethnicity. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Measures that relate to new services have no baseline data.

Where does the money go?

Table 1: Revenue and expenditure by Output class

Forecast statement of cost and revenue	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
REVENUE				
Prevention	35,984	37,204	38,830	40,453
Early detection and management	363,179	375,498	391,907	408,289
Intensive assessment and treatment	1,306,163	1,350,471	1,409,486	1,468,402
Rehabilitation and support	158,311	163,681	170,833	177,974
TOTAL REVENUE	**1,863,637**	**1,926,854**	**2,011,056**	**2,095,118**
EXPENDITURE				
Prevention	34,865	35,476	37,027	38,574
Early detection and management	369,087	375,561	391,973	408,358
Intensive assessment and treatment	1,315,218	1,338,289	1,396,770	1,455,155
Rehabilitation and support	174,467	177,528	185,286	193,031
TOTAL EXPENSES	**1,893,637**	**1,926,854**	**2,011,056**	**2,095,118**
SURPLUS/DEFICIT	**(30,000)**	**-**	**-**	**-**

People are supported to take greater responsibility for their health		
Long term impact	**Intermediate impacts**	**Impact and outputs**
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer (LMC) are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Percentage of two year olds are fully immunised and coverage is maintained Percentage of eligible children fully immunised at five years of age Percentage of eligible 12 year olds have received HPV dose three Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions Newborn GP enrolment rate at six weeks Newborn GP enrolment rate at three months

Fewer people smoke

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of babies living in smokefree homes at six weeks	1	Qn	Māori 31% Pacific 48% Other 65% Total 53%	Māori 60% Pacific 60% Other 60% Total 60%	Māori 60% Pacific 60% Other 60% Total 60%

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn	Māori 87% Pacific 82% Other 86% Total 86%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn	Māori 92% Pacific 91% Other 89% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking	1	Qn	Māori 64% Pacific N/A Other 70% Total 66%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%

Reduction in vaccine preventable diseases

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	1		Maori 3.1 Pacific 0.0 Other 2.0 Total 2.3	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn	Māori 82% Pacific 91% Other 92% Total 88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	Māori 85% Pacific 94% Other 92% Total 89%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible children fully immunised at five years of age	1	Qn	Māori 83% Pacific 89% Other 89% Total 87%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible 12 year olds have received HPV dose three	1	Qn	Māori 62% Pacific 53% Other 53% Total 56%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%
Seasonal influenza immunisation rates in the eligible population (65 years and over)	1	Qn/T	Māori 48% Pacific 47% Other 59% Total 58%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%

Improving health behaviours

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2021)	1		Māori 100% Pacific 100% Other 100% Total 100%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline (Q4 2019/20)	Target 2020/21	Target 2021/22
Newborn GP enrolment rate at six weeks	1	Qn	Māori 46% Pacific 61% Other 74% Total 63%	Māori 55% Pacific 55% Other 55% Total 55%	Māori 55% Pacific 55% Other 55% Total 55%
Newborn GP enrolment rate at three months	1	Qn	Māori 62% Pacific 78% Other 106% Total 86%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 85% Pacific 85% Other 85% Total 85%

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

An improvement in childhood oral health

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Mean decayed missing and filled teeth score of Year 8 children	2		Māori 0.84 Pacific 0.60 Other 0.44 Total 0.57	Māori <0.55 Pacific <0.55 Other <0.55 Total <0.55	Māori <0.55 Pacific <0.55 Other <0.55 Total <0.55

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	Māori 82% Pacific 48% Other 88% Total 84%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	Māori 51% Pacific 58% Other 42% Total 45%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	Māori 46% Pacific 55% Other 77% Total 65%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 85% Pacific 85% Other 85% Total 85%

Long-term conditions are detected early and managed well

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	Māori 81% Pacific 81% Other 85% Total 84%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of 'eligible Māori men in the PHO aged 30-44 years' who have had their cardiovascular risk assessed in the past five years	2	Qn	65%	90%	90%
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	2	Qn/T	Māori 66% Pacific 70% Other 73% Total 71%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 80% Pacific 80% Other 80% Total 80%
Percentage of eligible women aged 50-69 who have a BreastScreen Aotearoa mammogram every two years			Māori 52% Pacific 59% Other 65% Total 62%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 70% Pacific 70% Other 70% Total 70%

Fewer people are admitted to hospital for avoidable conditions

Impact measure	Output class	Measure type	Baseline 2019/20 (per 100,000)	Target 2020/21 (per 100,000)	Target 2021/22 (per 100,000)
Ambulatory sensitive hospitalisation rate per 100,000 for the following age groups: • 0-4 year olds • 45-64 year olds	2		**0-4 year olds** Māori 8387 Pacific 8852 Total 7008 **45-64 year olds** Māori 8726 Pacific 9000 Total 4335	**0-4 year olds** Māori 9927 Pacific 10,924 Total 6423 **45-64 year olds** Māori 9384 Pacific 9999 Total 3858	**0-4 year olds** Māori 9927 Pacific 10,924 Total 6423 **45-64 year olds** Māori 9384 Pacific 9999 Total 3858

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of eligible population who have had their B4 School checks completed	1	Qn/T	Māori 42% Pacific 59% Other 66% Total 57%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	2		3.5/100,000	1.2/100,000	1.2/100,000

More people maintain their functional independence

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Average age of entry to aged related residential care: • Rest home • Dementia • Hospital	2		**Resthome** 86 years **Dementia** 82 years **Hospital** 84 years	**Resthome** >84 years **Dementia** >80 years **Hospital** >85 years	**Resthome** >84 years **Dementia** >80 years **Hospital** >85 years

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/T	100%	100%	100%
Percentage of people enrolled with a PHO	2	Qn/T	Māori 87% Pacific 100% Other 98% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days	2		94%	100%	100%

People receive timely and appropriate specialist care		
Long term impact	**Intermediate impacts**	**Impact and outputs**
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
	People have appropriate access to elective services	Standardised intervention rates (per 10,000) Percentage of patients waiting longer than four months for their first specialist assessment Improved access to elective surgery, health target, agreed discharge volumes Did-not-attend percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-24 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Percentage of child and youth with a transition (discharge) plan Average length of acute inpatient stay Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives Number of new patients seen by the Waikato Hospital Palliative Care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days) Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days) Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days) Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People have prompt and appropriate acute and arranged care

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	3		Māori 84% Pacific 85% Other 82% Total 82%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	3	Qn/T	87%	90%	90%

People have appropriate access to elective services

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Standardised intervention rates (per 10,000): • Major joint replacement procedures • Cataract procedures • Cardiac surgery • Percutaneous revascularisation • Coronary angiography services	3		 22 31 5.9 12.4 33.8	 21 27 6.5 12.5 34.7	 22 28.4 6.8 13 36.4

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	19.2%	0%	0%
Number of planned care interventions completed *Previously called: Improved access to elective surgery, health target, agreed discharge volumes*	3	Qn/T	23,257	25,459	25,459
Did-not-attend percentage for outpatient services	3	Qn/T	Māori 18% Pacific 16% Other 6% Total 8%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%
Elective surgical inpatient average length of stay	3	Qn/T	1.5 days	1.5 days	1.5 days
Acute inpatient average length of stay	3	Qn/T	2.5 days	2.3 days	2.3 days

Improved health status for those with severe mental illness and/or addiction

Impact measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
28 day acute readmission rates	3		Māori 12% Pacific 4% Other 11% Total 11%	Māori <13% Pacific <13% Other <13% Total <13%	Māori <13% Pacific <13% Other <13% Total <13%

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of young people aged 0-24 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks			**3 weeks** Māori 71% Pacific 59% Other 59% Total 64% **8 weeks** Māori 88% Pacific 78% Other 79% Total 83%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 Weeks** Māori 95% Pacific 95% Other 95% Total 95%
Mental health clients discharged have a transitional (discharge) plan	3	Qn/T	(2018/19 data) Māori 92% Pacific 96% Other 92% Total 92%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Average length of acute inpatient stay	3	Qn/T/QI	Māori 19.19 days Pacific 19.91 days Other 18.28 days Total 18.74 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days
Rates of post-discharge community care	3	Qn/T/QI	Māori 80% Pacific 87% Other 79% Total 80%	Māori 90-100% Pacific 90%-100% Other 90%-100% Total 90%-100%	Māori 90-100% Pacific 90%-100% Other 90%-100% Total 90%-100%
Improving the health status of people with severe mental illness through improved access: • 0-19 years • 20-64 years • 65 plus years	3	Qn	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 24.78% **20-64 years** Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12% **65+ years** Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	**0-19 years** Māori 5.17% Pacific 3.36% Other 4.72% Total 4.82% **20-64 years** Māori 10.05% Pacific 5.17% Other 4.05% Total 5.31% **65+ years** Māori 2.65% Pacific 3.43% Other 2.39% Total 2.43%	**0-19 years** Māori 5.17% Pacific 3.36% Other 4.72% Total 4.82% **20-64 years** Māori 10.05% Pacific 5.17% Other 4.05% Total 5.31% **65+ years** Māori 2.65% Pacific 3.43% Other 2.39% Total 2.43%

More people with end stage conditions are supported appropriately

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%	100%
Number of new patients seen by the Waikato Hospital Palliative Care service	3	Qn	740	727	727

Support services

Output measure	Output class	Measure type	Baseline 2019/20	Target 2020/21	Target 2021/22
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	3	Qn/T	49%	95%	95%
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	2	T	Māori 67% Pacific 63% Other 73% Total 72%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)	2	T	Māori 72% Pacific 70% Other 73% Total 72%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	2	T	98%	90%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T	88%	70%	70%
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer than 84 days beyond the planned date	2	T	75%	70%	70%
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	T	100%	100%	100%

Financial performance

Table: Statement of prospective comprehensive income

Forecast statement of comprehensive income	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
REVENUE						
Patient care revenue	1,600,355	1,759,888	1,840,568	1,905,251	1,988,510	2,071,630
Other operating income	22,067	28,571	22,706	21,227	22,157	23,085
Finance income	521	680	363	376	389	403
TOTAL REVENUE	1,622,943	1,789,139	1,863,637	1,926,854	2,011,056	2,095,118
EXPENSES						
Personnel costs	709,776	822,262	801,305	835,841	873,454	912,759
Depreciation	50,862	52,228	55,959	58,605	61,323	63,059
Amortisation	5,935	6,189	7,694	6,395	5,657	5,837
Outsourced services	85,545	94,610	76,663	76,266	78,554	80,911
Clinical supplies	168,074	187,852	182,333	195,519	202,399	206,410
Infrastructure and non-clinical expenses	90,538	96,610	90,892	58,843	62,925	70,992
Other district health boards	65,303	65,825	72,459	73,089	76,283	79,472
Non-health board provider expenses	484,982	531,152	568,778	583,314	608,802	634,252
Finance costs	796	81	21	36	37	38
Capital charge	33,507	30,824	37,533	38,946	41,622	41,388
TOTAL EXPENSES	1,695,318	1,887,633	1,893,637	1,926,854	2,011,056	2,095,118
Share of profit of associates and joint venture	(14)	245	-	-	-	-
SURPLUS/(DEFICIT)	(72,389)	(98,249)	(30,000)	-	-	-
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	(51)	240,318	-	-	215,250	-
TOTAL COMPREHENSIVE INCOME (DEFICIT)	(72,440)	142,069	(30,000)	-	215,250	-

The forecast financial result is a $30 million deficit for the year. This budget has incorporated material cost reduction activities – total value of $40.3 million. Specific and tangible plans are in place and will be closely monitored.

Holidays Act costs for 2021/22 of $10 million have been included. No revenue funding has been included to offset these Holidays Act costs, in accordance with Ministry of Health advice. This treatment is consistent with all other DHBs.

The budget also includes new investment to deliver against the priority areas identified by the commissioners. $4 million of investment has been included in 2021/22 to initiate delivery against these priorities. This spend is crucial to the attainment of strategic imperatives of our DHB, but requires additional savings to be generated (included in the $40.3 million noted above) for the DHB to achieve target of a $30 million deficit result for 2021/22.

The significant restructure in our Provider arm has been completed. We are therefore now in a much stronger position than we were for 2020/21 (when the restructure was being embedded) to effect the changes that are required in order to achieve our budget target.

The Waikato DHB has budgeted to breakeven across the forward estimates of 2022/23 to 2024/25. A key cost driver across the forward estimates will be our ability to increase the annual spend on the priority areas identified by the commissioners. Simultaneously we need to invest (capital as well as operating expenditure) in meeting increasing demand on our services. This comes after several years of provider arm constrained costs, which has resulted in a build-up of pressures relating to unrequited demand. An underlying assumption for the 2021/22 budget is that demographic growth impact on provider resources will again be absorbed. We therefore expect increasing challenges in meeting budget for the out years.

The key budget assumptions and risks are set out on page 22.

Table: Statement of prospective position

Forecast statement of financial position	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
CROWN EQUITY	624,492	763,352	756,472	937,272	1,257,325	1,308,130
CURRENT ASSETS						
Bank balances, deposits and cash	27,058	28,035	9,460	9,460	9,960	9,960
Receivables	58,894	96,327	77,060	76,979	78,727	81,765
Inventory	12,649	12,516	12,571	12,876	13,189	13,510
Non-current assets held for sale	1,381					
	99,982	136,878	99,091	99,315	101,876	105,235
CURRENT LIABILITIES						
Bank overdraft	-	-	28,823	41,052	43,227	37,834
Short term loans	135	50	-	-	-	-
Payables and accruals	74,329	100,690	81,800	76,035	74,685	77,819
Employee entitlements	187,831	283,908	279,727	162,038	165,909	169,874
Provisions	1,044	1,065	1,374	1,641	1,521	1,401
	263,339	385,713	391,724	280,766	285,342	286,928
Net working capital	(163,357)	(248,835)	(292,633)	(181,451)	(183,466)	(181,693)
NON CURRENT ASSETS						
Fixed assets	792,996	1,014,676	1,052,712	1,124,475	1,448,956	1,500,403
Investments	429	673	673	673	673	673
Prepayments	12,872	15,025	13,187	10,894	8,601	6,307
	806,297	1,030,374	1,066,572	1,136,042	1,458,230	1,507,383
NON CURRENT LIABILITIES						
Borrowings	50	-	-	-	-	-
Employee entitlements	9,786	8,473	8,473	8,473	8,473	8,473
Provisions	312	399	270	122	242	363
Restricted trust funds	8,300	9,315	8,724	8,724	8,724	8,724
	18,448	18,187	17,467	17,319	17,439	17,560
NET ASSETS	624,492	763,352	756,472	937,272	1,257,325	1,308,130

Table: Statement of prospective movements in equity

Forecast statement of movements in equity	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
Crown equity at start of period	579,404	624,492	763,352	756,472	937,272	1,257,325
Surplus/(deficit) for the period	(72,389)	(98,249)	(30,000)	-	-	-
Increase in revaluation reserve	(51)	240,318	-	-	215,250	-
Equity injection from Crown	120,000	-	25,254	182,993	107,000	53,000
Repayment of capital to the Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in equity	(278)	(1,014)	60	1	(3)	(1)
Crown equity at end of period	624,492	763,352	756,472	937,272	1,257,325	1,308,130

Table: Statement of prospective cashflow

Forecast statement of cashflows	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
OPERATING CASHFLOWS						
Cash was provided from Crown agencies and other income sources	1,619,818	1,760,163	1,875,951	1,926,871	2,008,534	2,091,713
Cash was disbursed to employees, suppliers and finance charges	(1,634,068)	(1,717,375)	(1,846,221)	(1,983,511)	(1,939,191)	(2,015,630)
	(14,250)	42,788	29,730	(56,640)	69,343	76,083
INVESTING CASHFLOWS						
Cash was provided from interest and sale of fixed assets	540	680	1,743	376	389	403
Cash was disbursed to purchase of assets	(49,676)	(40,161)	(101,348)	(136,764)	(176,211)	(121,899)
	(49,136)	(39,481)	(99,605)	(136,388)	(175,822)	(121,496)
FINANCING CASHFLOWS						
Cash was provided from proceeds of borrowings and equity	120,000	-	25,254	182,993	107,000	53,000
Cash was disbursed to repayment of borrowings and equity	(2,373)	(2,330)	(2,777)	(2,194)	(2,197)	(2,194)
	117,627	(2,330)	22,477	180,799	104,803	50,806
Net increase/(decrease) in cash held	54,241	977	(47,398)	(12,229)	(1,676)	5,393
Add Opening cash balance	(27,183)	27,058	28,035	(19,363)	(31,592)	(33,268)
CLOSING CASH BALANCE	27,058	28,035	(19,363)	(31,592)	(33,268)	(27,875)
Made up from:						
Bank balances, deposits and cash	27,058	28,035	(19,363)	(31,592)	(33,268)	(27,875)

Fixed assets

Fixed assets carrying value is reviewed annually and there are no material issues in valuation. We conduct annual desktop revaluations and revalue periodically in accordance with international public sector accounting standards.

Disposal of land

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

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

We cover a significant area and have many parcels of land required by historical patterns of service delivery. All land is assessed on an annual basis against the models of service delivery to apply for the future. If it is concluded that land is not required for the foreseeable future, then the legislative process for disposal of land is followed with a view to obtaining a maximum price for Waikato DHB.

Capital expenditure / investment

The Capital Plan cash flow is set out below:

New capital expenditure	2021/22 $M	2022/23 $M	2023/24 $M	2024/25 $M
Under $50,000	5	5	5	5
Over $50,000	67	55	52	58
Contingency	3	2	4	4
Strategic	26	75	115	55
Total capital expenditure	101	137	176	122

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

Potential strategic capital spend includes:

Project name	Business case start date	Business case completion date	Business case expected approval date	Approx. $	Crown cap requirement
Adult Mental Health	2016/17	2021/22	2021/22	$100m	$100m
Waiora Seismic	2020/21	2020/21	Approved	$5m	$5m
Rergional Cancer Centre	2020/21	2021/22	2022/23	$50m	$50m
Linac Machines	2020/21	2020/21	2020/21	$5m	$5m
Oncology Building (interim)	2018/19	2021/22	2021/22	$5.0m	$0m
Renal Expansion	2020/21	2020/22	2021/22	$10m	$10m
Laboratory Services (interim)	2020/21	2021/22	2021/22	$8.0m	$0m
Laboratory Services (long term)	2021/22	2022/23	2022/23	$52.5m	$52.5m
Tokoroa ED Upgrade	2020/21	2020/21	Approved	$1.2m	$1.2m
Rural Development Programme	2021/22	2021/22	2021/22	$5.75m	$0m

We have a working capital financing facility of no greater than 1 month of Provider revenue, including GST, as part of a Shared Banking arrangement with New Zealand Health Partnerships Limited, in order to manage our working capital requirements.

Planned financial performance by division

Table: Prospective financial targets and measures DHB provider

DHB provider forecast statement of financial performance	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
REVENUE						
Patient care revenue	1,009,439	1,074,636	1,166,907	1,106,547	1,154,903	1,203,178
Other operating income	22,046	28,816	22,706	21,227	22,157	23,085
Finance income	521	680	362	376	389	403
TOTAL REVENUE	1,032,006	1,104,132	1,189,975	1,128,150	1,177,449	1,226,666
EXPENSES						
Personnel costs	706,162	817,576	797,245	832,061	869,504	908,631
Outsourced services	84,933	93,800	76,317	75,920	78,198	80,544
Clinical supplies and patient costs	181,237	200,942	194,668	207,354	213,575	219,982
Infrastructure and non-clinical supplies	168,204	172,233	179,444	150,711	160,100	167,447
Internal recharges	(2,421)	(2,442)	(2,429)	(2,492)	(2,567)	(2,645)
TOTAL EXPENSES	1,138,115	1,282,109	1,245,245	1,263,554	1,318,810	1,373,959
SURPLUS/(DEFICIT)	(106,109)	(177,977)	(55,270)	(135,404)	(141,361)	(147,293)

Table: Prospective financial targets and measures DHB governance

DHB governance forecast statement of financial performance	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
REVENUE						
Patient care revenue	7,906	10,887	8,181	8,711	9,091	9,471
Other operating income	6	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	7,912	10,887	8,181	8,711	9,091	9,471
EXPENSES						
Personnel costs	3,613	4,685	4,060	3,780	3,950	4,128
Outsourced services	613	810	347	346	356	367
Clinical supplies and patient costs	1	48	4	4	4	4
Infrastructure and non-clinical supplies	271	561	316	275	283	292
Internal recharges	2,421	2,442	2,428	2,492	2,567	2,644
TOTAL EXPENSES	6,919	8,546	7,155	6,897	7,160	7,435
SURPLUS/(DEFICIT)	993	2,341	1,026	1,814	1,931	2,036

Table: Prospective financial targets and measures DHB funding

DHB funding forecast statement of financial performance	2019/20 $000 ACTUAL	2020/21 $000 FORECAST	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED	2024/25 $000 PLANNED
REVENUE						
Patient care revenue	1,527,858	1,669,122	1,759,169	1,829,113	1,909,045	1,988,843
Other operating income	-	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	1,527,858	1,669,122	1,759,169	1,829,113	1,909,045	1,988,843
EXPENSES						
Governance administration	7,906	10,861	8,181	8,711	9,091	9,471
Personal health	1,140,929	1,214,120	1,331,325	1,290,037	1,346,411	1,402,691
Mental health	150,961	162,481	176,335	178,140	185,924	193,696
Disability support	175,183	183,006	209,623	208,348	217,452	226,542
Public health	14,027	15,167	2,864	3,391	3,539	3,687
Māori services	6,125	6,100	6,598	6,896	7,198	7,499
TOTAL EXPENSES	1,495,131	1,591,735	1,734,926	1,695,523	1,769,615	1,843,586
SURPLUS/(DEFICIT)	32,727	77,387	24,243	133,590	139,430	145,257

Significant assumptions

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

Key assumptions	2021/22	2022/23	2023/24	2024/25
Employee agreement assumptions	0% - 1.9%	0% - 1.9%	0% - 1.9%	0% - 1.9%
Payments to NGOs (cost pressure)	2% - 3%	2% - 3%	2% - 3%	2% - 3%
Payments to suppliers	1% - 5%	1% - 5%	1% - 5%	1% - 5%
Capital charge – fixed rate	5.00%	5.00%	5.00%	5.00%

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

The dominant other key assumptions applied are

Key budget assumptions	
Revenue	The latest information has been applied to all aspects of revenue. In our capital plan we have not included any unapproved future strategic asset projects, and therefore have not assumed any unapproved direct Ministry of Health funding.
Impact of COVID-19	We are following Ministry of Health guidance that "DHBs should exclude any allowance for COVID-19 impacts" in our annual plans. There is a high level assumption that costs will be matched by direct Ministry of Health COVID-19 funding including: • costs of COVID-19 vaccine and immunisation programme • satisfying the unmet demand in costs of elective surgery volumes • satisfying the unmet demand in costs of outpatient clinics • costs of expediting treatments that were deferred • costs of Community Based Assessment Centres • cost of COVID-19 tests • increased consumption of personal protection equipment • impacts of Managed Isolation Quarantine Facilities • impact on costs of community dispensing • impact on sick leave as the threshold for staying away from work has changed due to COVID-19 • impact on any other MECA, of industrial relations type aspects resulting from COVID-19 • Impact on SSP arising from COVID-19
2020/21 business cases	Where relevant any business cases applied during 20/21 have been extrapolated to reflect the full year effect.
Demographic growth	Demographic growth has been applied to external contracts where relevant, but not applied to Provider resources. Underlying assumption is thus that demographic growth impact on Provider resources will be absorbed.
Savings applied	A 5 percent saving target has been applied to non-clinical areas to reduce overheads and locked into budgets. Plans have been defined and will be monitored closely.
Personnel costs	0-1.5% increase for all unresolved MECAs and IEAs. This includes an assumption that Ministry of Health will fund all MECA increases above 1.5%. Neither costs nor funding above 1.5% have been included.
Annual leave taken	100% of annual leave earned by staff is taken, i.e. leave accrued must equal leave taken.
Holidays Act remediation	• A provision for 2021/22 costs has been included, which is the remediation cost that has been calculated and expensed in 2020/21. This continues to be our best estimate for the ongoing cost to Waikato DHB. The national Memorandum of Understanding (MOU) interpretation has lifted the overall cost structure significantly. • A one off settlement by Ministry of Health for remediation costs, to occur in 2022/23. This impacts on our balance sheet only.
NGO costs	Increases in funding to NGOs are in line with national uplifts.
Other provider costs – non personnel	Known cost increases have been included, plus general escalation where relevant.

To the extent that these assumptions differ from reality, the budgeted result will be at upside and downside risk.

Major risks	Mitigation strategy
The significant savings plan and the effort required to move to sustainability requires considerable focus that may be challenging in the face of day to day pressures.	• Specific plans and monitoring processes in place. • Ensure that we manage to the bottom line financial outcome, which incorporates saving plans.
The ability to essentially absorb demographic growth in the provider arm.	• Do whatever is practical to manage demand. • Optimise the clinical service delivery.
The COVID-19 recovery costs may not be fully covered by additional Ministry of Health funding.	• Engage effectively with the Ministry of Health at all stages.
The imposition of unbudgeted costs from central agencies that we have not budgeted for.	• Do whatever we can to encourage effective consultation and decisions that provide optimal value propositions.
Resistance to increased funder contract management may have an impact.	• Engage effectively with all stakeholders.
The assumed leave taken percentage may be too challenging.	• Ensure we have effective leave management practices in place in all areas, with clear visibility of level of achievement.
Our ability to re-prioritise information technology investments in order to increase functional delivery to the Provider arm.	• Ensure effective engagement between the provider arm and Information Services, facilitated by the Enterprise Portfolio Office, in order to optimise delivery of functional gains to enhance clinical service delivery.
The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages, especially as a flow on from MECA settlements. A one percent increase or decrease in wage rates equates to approximately $7 million in additional payroll costs.	• Actively engage in national processes around relevant settlements • Ensure stakeholders, including the Ministry of Health, are aware of the local “total cost of settlement”.
There is risk that cost increases for the goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures.	• Review contracting arrangements and negotiate more favourable terms. • Participate in national procurement initiatives to take advantage of bulk purchasing. • Take opportunities noted in the Resource Review.
Costs of the cyber-criminal attack may, at least in part, not be covered by insurance.	• Ensure best practice processes are in place for incurring costs associated with the cyber-criminal attack.
Achievement of savings plans and business improvement initiatives may be complicated by the ongoing impact of the focus on recovery following the cyber-criminal attack.	• Recovery structure in place supports improvement plans and BAU to continue with minimised on-going impact from the cyber-criminal attack.
Findings from the cyber-criminal attack result in additional unbudgeted BAU cyber-security costs, including costs mandated by Ministry of Health.	• Seek funding from Ministry of Health for mandated costs, particularly for initiatives implemented across the sector. • Any additional costs to be highlighted in our monthly financial analysis as being met from outside of funding provided by Ministry of Health.

Additional information and explanations to fairly reflect the operations and position of the DHB

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

Subsidiaries

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

APPENDIX B:
System Level Measure Improvement Plan

Waikato District Health Board

2021/22

SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

Waikato District Health Board

Pinnacle Midlands Health Network

HAURAKI PHO

National Hauora Coalition

Contents

Introduction

The System Level Measure (SLM) Framework is a Ministry of Health led tool for integration to support district health boards to work in collaboration with primary care, community and hospital. There is a focus on children, youth and vulnerable populations, and this work is included as part of the district's annual planning with the overall improvement targets and plan set locally while sitting within the appendix of the Annual Plan.

Signatories

The 2021/22 milestones, contributory measures and activities have been decided and agreed by the below parties:

Dr Kevin Snee

Chief Executive Officer

Waikato DHB

Justin Butcher

Dep. Chief Executive Officer

Pinnacle Midlands Health Network

Riana Manuel

Chief Executive Officer

Hauraki PHO

Simon Royal

Chief Executive Officer

National Hauora Coalition

Executive summary

Waikato DHB, Pinnacle Midland Health Network, Hauraki PHO and National Hauora Coalition have jointly developed a 2021-22 System Level Measure (SLM) Improvement Plan. Quality improvement is at the heart of this plan with continuous improvement in the quality of care delivered and health outcomes experienced by our population being the main goal. We know we can improve health system performance through focusing on making the health care delivery effective, efficient and sustainable.

The SLM framework and subsequent plan has been developed in response to the Health Quality and Safety Commission (HQSC) and the Ministry of Health call for greater recognition of the value of quality improvement and shifting resources accordingly to deliver on the key government priorities and to meet the goals of the NZ Triple Aim.

With equity of health outcomes being at the forefront of priorities in the Waikato district, this improvement plan has been developed with a Māori and Pacific lens to ensure our priority populations are at the centre of any quality improvement activity undertaken. Equity gaps for Māori and Pacific exist across all SLMs providing a great opportunity to develop targeted milestones and activities to address these gaps.

All SLM partners are committed to developing additional contributory measures and activities over the medium to longer term and acknowledge that the annual SLM plan is a small snapshot of activity occurring across the sector in each of the six areas.

Purpose

The SLM Improvement Plan will be applied across the Waikato district. It summarises how improvement will be measured (contributory measures) and the high-level activities that will drive improvement across each of the six SLM areas towards achievement of the milestones.

Background

The New Zealand Health Strategy 2016 identifies ‘value and high performance’ as a key theme. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a framework and suite of SLMs that provide a system-wide view of performance and a platform to deliver on the Government’s priority of improving the well-being of New Zealanders and their families. The six SLMs are the result of a clinically led co-design process over several months. They evolved from an initial list of over 100 measures.

SLM plans are developed each financial year by Waikato DHB and our health system partners (primary care, community care and hospital) in accordance with Ministry of Health expectations. Measures within the plan are outcome focused and provide for continuous quality improvement and system integration. The six SLMs are set nationally and focus on children, youth and vulnerable populations. The contributory measures have been chosen based on local needs, demographics and service configurations and are used to measure local progress against quality improvement activities.

The current nationally set SLMs include:

0-4 Ambulatory Sensitive Hospitalisation (ASH)

ASH rates in 0-4 year olds seek to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care. In children, these conditions are mainly respiratory illnesses, gastroenteritis, and skin infections. ASH rates are higher for Māori and Pacific children and addressing this inequity would significantly reduce potentially avoidable hospitalisation rates.

Acute bed days

Acute hospital bed days per capita measure the use of hospital resources, predominantly relating to adults and older people. Effective management of long-term illnesses and disease prevention in primary care prior to hospitalisation and the provision of effective care in the community after discharge have the potential to reduce hospital bed days.

Patient experience of care

The patient experience of care measurement tools in primary and secondary care give insight into how patients experience the health care system, and how integrated their care was. Patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care such as screening services and immunisations and ability to use the health resources available effectively. This measure will provide new information about how people experience health care.

Amenable mortality

Amenable mortality is a measure of the effectiveness of health care-based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It is a measure of premature deaths in under 75 year olds that could have been avoided through effective health interventions at an individual or population level.

Babies living in smoke free homes

Babies living in smokefree homes aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. The measure at six weeks aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora providers and general practitioners occurs. Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. This measure promotes the roles which collectively, service providers play in the infants' life and the many opportunities for smoking interventions to occur. It also enables the health sector to connect infants and their family/whānau with maternity and childhood health care such as immunisation.

Youth access to health services

Engagement with education, employment and training is critical as is building healthy relationships and making good choices. The youth SLM was co-developed with input from a broad range of people with a particular interest in youth health including: Ministry for Social Development, Ministry of Education, Office of the Children's Commissioner, sector groups such as Ara Taiohi, Youth One Stop Shops, clinicians from across primary and secondary care, academia, and the Ministry of Health. The Ministry also worked with youth agencies to facilitate several youth focus groups and one-on-one interviews to seek feedback from young people on what was meaningful to them and what this SLM should look like.

Development of the plan

This plan has been developed in partnership with Hauraki PHO, National Hauora Coalition, and Midland Health Network. In light of COVID-19 we are realistic about what we will be able to achieve in 2021/22 as resources must be re-prioritised to focus on COVID-19, limiting capacity within the PHOs and the DHB for the foreseeable. The plan also takes into consideration the experience(s) gained from the collaborative management of COVID-19 pandemic.

Our commitment to Māori and Pacific health gain remains and the key focus of this plan is eliminating health inequities. To ensure we make real progress a number of achievable activities that build on those from 2021/22 have been agreed.

The joint approach to SLMs allows the development of a plan that will enable quality improvement across the sector and ensure we are improving health outcomes for our population as one cohesive team.

Structure

The SLM plan has oversight from the Waikato Primary and Community Healthcare Alliance (Membership still being finalised but currently PHOs, DHB, Pharmacy, St John) who will receive quarterly updates on progress against the SLM activities. A smaller working group supported by the Alliance will be responsible for delivery and implementation of the 2021/22 plan.

System Level Measure 1: 0-4 Ambulatory Sensitive Hospitalisation (ASH)

Aim: Reduce hospital admission rates for avoidable conditions through prevention or management in primary care.

NB: for the purpose of target setting the data to Dec 2019 will be used. This is due to the impact that COVID-19 had on the Dec 2020 data

DHB	Ethnicity	12 months to December 2017	12 months to December 2018	12 months to December 2019	12 months to September 2020 (impacted by COVID-19)	Performance against target
Waikato	Māori	9263	12,472	10,238	5726	18%
Waikato	Pacific	10,804	14,867	10,924	6452	27%
Waikato	Other	7328	8132	7137	4991	12%
Waikato	Total	8209	10,053	8474	8474	16%
National	Total	6564	7009	6615	4315	6%

Rationale

Respiratory

Respiratory conditions have been identified as one of five key areas that can contribute to Iwi and Government Whānau Ora aspirations. New Zealand has high rates of asthma with symptom severity greatest among Māori and Pacific children. Individual level interventions have been shown to be effective in reducing avoidable hospitalisations due to asthma.

Enrolment

We know from NCHIP data that infants who are enrolled early in general practice are less likely to be admitted to the emergency department, or to be subject to an ambulatory sensitive hospital admission. Early enrolment and engagement with primary care gives opportunity for timely immunisation, support with breastfeeding and smoking cessation services. It enables maternal and child health to be accessible, and supports whānau to access services when needed through precall and recall activities. Early enrolment has more impact on Māori whānau than others, a universal process is needed to capture all Māori infants.

Improvement milestone: What is to be improved, population group, by how much?

Target: ASH rate for Māori to reduce by 12.5% from 10,238 in December 2019 to 8,958 in June 2022 (5% annual reduction)

Target: ASH rate for Pacific to reduce by 18.75% from 10,942 in December 2019 to 8,876 in June 2022 (7.5% annual reduction)

Waikato activity	Contributory measure	Lead responsibility
Respiratory Increase uptake of children's influenza vaccination to prevent respiratory admissions by:		PHOs
• PHOs will provide practices with information on the children who are in the eligible population. Māori and Pacific children will then be prioritised from this list	Influenza vaccination rates for eligible Māori children. Target 25%	PHOs
• use practice level data and quality improvement interventions to improve and monitor the improvement in Māori child immunisation rates		PHOs
• Co-design and trial community based immunisation interventions, including digitally enabled mobile vans targeting Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe		DHB and PHOs

Waikato activity	Contributory measure	Lead responsibility
Support a decrease in respiratory admissions with social determinants by:		
• Primary Care and Waikato DHB to continuing to promote referrals to healthy housing options. Making the BPAC referral process and the system easier for GPs to identify eligible whānau, make referrals, and report on the number of referrals made	Number of referrals to healthy housing.	DHB and PHOs
• continue to promote the use of the a new BPAC referral form to Kainga Ora		PHOs
• increasing the number of Whare Ora/healthy housing referrals		PHOs
• collaborating with Kainga Ora to instigate referrals through the patient's practice for immunisation and hauora checks		PHOs
• PHOs and Te Puna Oranga working together to increase coverage of influenza immunisation for whānau closer to home		DHB and PHOs
• PHOs combining their efforts to improve outreach immunisation		PHOs
• opportunistic immunisation in hospital, whare, GP clinic and accident and medical settings		DHB and PHOs

System Level Measure 2: Acute bed days

Aim: Improved management of demand for acute care.

NB: for the purpose of target setting the data to Dec 2019 will be used. This is due to the impact that COVID-19 had on the Dec 2020 data

Standardised acute bed day rate 100,000 (at December 2019)

Ethnicity	Year to December 2019	Year to December 2020
Māori	83/1000	438/1000
Pacific	415/1000	444/1000
Other	528/1000	479/1000

Waikato DHB is an outlier nationally for stroke, heart failure and neonates for Māori bed days per population. The higher bed days per capita rate can be linked to poorer determinants of health outcome scores in the Waikato region, particularly obesity and deprivation levels, both of which are significant risk factors for stroke.

Rationale

Care management

Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services.

Māori are overrepresented in ASH conditions.

Smoking

Respiratory illness and its complications are a key issue for acute bed day use that we expect to be impacted by activities in smoking cessation and adult vaccination in particular for influenza in eligible populations.

Acute Demand Management Programme

Acute Demand is driven by a range of conditions. A strategic approach to acute demand management requires continual demand/capacity oversight and continuous quality improvement across our system of delivery.

Improvement milestone:	• reducing the acute bed day rate by 3% for Māori populations from 483/1,000 to 455/1000 by 30 June 2022 • reducing the acute bed day rate by 3% for Pacific populations from 415/1,000 to 391/1000 by 30 June 2022

Waikato activity	Contributory measure	Lead responsibility
Care management		
Māori patients with ASH conditions (e.g. CHF, CVD,COPD, AF/ Stroke and Cellulitis) receive appropriate clinical support:		DHB
• Māori patients who are eligible for a flu vaccine are targeted	Seasonal target of 75% of eligible Māori patients adults who receive the flu vaccine.	DHB and PHOs
• To encourage the patients to have their influenza vaccinations the practices: – make phone calls – text – opportunistically vaccinate patients when they visit the practice, hospital, pharmacy, and accident and emergency centres.	Number of 75+ year olds 'Other' with two or more emergency admissions. Number of 65+ year old Māori and Pacific with two or more emergency admissions.	PHOs DHB and PHOs
• PHOs to provide their general practices with prioritised lists to recall Māori, Pacific and other vulnerable patients for flu vaccinations, who have not already received their flu vaccination	ASH rate for Māori adults aged 45-64 years old. Target 2% reduction.	PHOs
• General practices to provide targeted outreach for specific population groups such as Kainga Ora/Housing NZ tenants		PHOs
• PHOs to run ongoing communication campaigns to encourage patients to have their flu vaccinations		PHOs
• PHOs are also using their other home visiting services to administer the flu vaccinations		PHOs
• PHOs to use their long term conditions staff to provide a mobile flu vaccination service delivered to the homes of high risk patients		PHOs
• PHOs and general practices to work alongside Te Puna Oranga, local iwi and the wider Waikato network to reach high needs populations, especially Māori whānau and achieve the 90% CVDRA target	CVDRA rate for eligible Māori and Pacific population	DHB and PHOs
• All outreach, community pharmacies and mobile services to ensure data is uploaded to the NIR in a timely manner, thus ensuring there is no unnecessary follow up for patients already vaccinated		DHB and PHOs
Smoking		
PHOs and community pharmacy will refresh their focus on smoking cessation with new resources to support practices. Patient outcomes related to harm from smoking will be improved by:	15 to 74 year old PHO enrolled population who have had a smoking status of current smoker within the last 15 months.	DHB and PHOs
• Incentivised personal and group smoking cessation support, by Māori for Māori	ASH rate for Māori adults aged 45-64 years old. Target 2% reduction.	DHB and PHOs

Waikato activity	Contributory measure	Lead responsibility
• Regular reporting rates and referrals to cessation support and rates of medication therapy in primary care	Number of PHO enrolled patients who smoke offered help to quit smoking by a health care practitioner in the last 15 months.	PHOs
• Use of a surveillance reporting to monitor smoking prevalence by ethnicity and age		PHOs
The importance of smoking cessation as an intervention will be promoted by:		
• continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services to increase the number successful quit smoking attempts.	ASH rate for 45-64 year old Māori and Pacific.	DHB and PHOs
Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS.		DHB and PHOs
Acute demand management programme		
As a part of the acute demand management plan, both the DHB and PHOs have developed an Extended Primary Care (EPC) service that includes the existing Primary Options for Acute Care (POAC) and Planned Care services. Overall the EPC aims to reduce ED presentations and hospital admissions by providing care closer to home through the general practices, non-governmental agencies and DHB lead community services. The EPC will also continue to use the existing Clinical Monitoring and Improvement Group to provide ongoing leadership and governance to the service and will develop the following services in 2021-22:	PHOs to report ethnicity/age based utilisation of the POAC service.	PHOs
• Based on the ED patient presentations data analysis, systematically identify specific groups of patients or conditions that could be managed safely in the community through general practices	Reduction in frequent ED attendee presentations by 60%, including those with three or more ED presentations in the last 12 months.	DHB and PHOs
• Further expand frequent ED Attendees existing services to better manage the patients in the community for all age groups including pediatrics	Report, the number of frequent attendees managed under the POAC service.	PHOs
• Develop processes and systems for GPs to be able to discuss their patients with the relevant senior medical officers on-call to develop a treatment plan to manage their patients in the community rather than referring to the hospital ED	Develop and implement an ethnicity based reporting tool.	DHB and PHOs
• Work with Saint John Ambulance, GPs (PHOs), urgent care clinics, and Waikato DHB to collaboratively manage low acuity and non-emergency patients in the community	Number of specialist services' trialing and using Telehealth services	DHB, Saint John Ambulance, PHOs and urgent care clinics
• DHB and PHOs to work in collaboration to explore options to co-design and implement Telehealth services for patients' residing in rural and remote areas to improve access to specialist services and eliminate inequalities		

System Level Measure 3: Patient experience of care

Aim: Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Rationale

Primary care

Patient experience is a vital but complex area. Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a patient e-portal, people can better manage their own health and provide feedback that will inform service improvement.

For Waikato, the lowest scoring question within the Primary Care Patient Experience Survey is "In the last 3 months when you contacted your GP/nurse clinic about something important (other than booking an appointment), did you get an answer the same day?." Our focus on improving our response rate score will include increasing the volume of patients registered on the Patient Portal's will increase transparency of health information to patients (e.g. consult notes, lab results, medications) and in some cases the provision of secure messaging direct with their GP.

Medicines knowledge

One of the consistently low scoring questions in the patient experience survey is that patients are not being informed of the side effects of prescribed medications.

Improvement milestone:

- Improve same day response in primary care to 8.5 for all patients
- Co-develop interventions that improve patients understanding of medication use (by ethnicity) by 10% for national patient primary and hospital survey

Waikato activity	Contributory measure	Lead responsibility
Improve national patient primary survey accessibility for Māori, Pacific and other high need populations by offering alternative ways to participate i.e. via SMS text, hardcopy, patient portal app, etc.	Survey response rate by ethnicity.	
Primary care		
Continue to promote the primary care portal to consumers. Promotion activities will include: • Face-to-face discussion during consultation • Email to practice patients providing information and guidance on signing up to the portal	Number of patients who indicate the awareness of PCPES and use the patient portal.	PHOs
Improvements will be made where required (easy access, less cost).	Total patients registered/Total patients enrolled.	PHOs
Develop and implement an improvement plan for the three lowest scoring questions in the PES.	Number of patients received information related to the side effects of medication.	DHB and PHOs
Medicines knowledge		
Currently Waikato DHB have two dedicated pharmacist roles working through general practices with high risk patients with diabetes to improve their medications understanding and management. The learnings from these will be used to further develop and expand the service. Using PDSA cycles of improvement, test co-designed multidisciplinary interventions likely to improve the patients understanding and management of medications.		DHB and PHOs

System Level Measure 4: Amenable mortality

Aim: Reduction in number of avoidable deaths and reduced variation for population groups.

Rationale

Coronary/CVD

Amenable mortality in the latest figures available (2016) shows Māori inequity at its starkest.

In Waikato Māori amenable mortality numbers show a preponderance towards cardiovascular diseases. Well supported practices that are connected to their communities and have the right systems in place have the best opportunity to identify and engage with eligible patients, particularly Māori in their communities.

With Māori men being at high risk for CVD this work will specifically target this population group. Modification of risk factors through self-management, lifestyle and pharmaceutical interventions has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD and diabetes.

Diabetes

Diabetes affects 6% of the enrolled population with Māori and Pacific disproportionately represented at 6% and 11% respectively. Only 42% of diabetics have their HbA1c levels managed adequately and Māori and Pacific are once again overrepresented in these figures. (Figures as at Q3 2018/19) Focusing on diabetes management through the following activities will reduce these inequities as well as overall morbidity and mortality.

Improvement milestone: For Māori and Pacific reduce amenable mortality rates by a total of 4% and sustain by 30 June 2023.

Waikato activity	Contributory measure	Lead responsibility
Coronary/CVD		
Clinical health pathways are implemented and accessed.	Clinical Health pathways rates of access.	DHB and PHOs
PHOs to provide information to their practices of which patients are high risk of CVD and require follow up. Opportunistic screening will also take place when patients present.	CVRA rates Māori males 30-44 and rate of those with a >15% risk with a management plan.	PHOs
PHOs will continue to educate general practice teams in Equally Well approaches to improve access for Māori men with serious mental health issues to CVRA.	CVRA rates for Māori. Goal 90%.	PHOs
Ethnicity based reporting will be completed to monitor and improve any equity gap.	Percentage of Māori and Pacific people with identified CVD risk who are prescribed dual therapy (primary prevention). Goal 60%	PHOs
Diabetes		
Incentivising the improvement activity at practice level around diabetes management through a quality plan. These plans will incorporate the following initial activity: • Upskilling of practice nurses to help manage more complex diabetic patients. • Level 7 diabetes paper to be promoted for all nurses.	Proportion of people with diabetes who have an HbA1c <64, by ethnicity (Māori, Pacific and other).	PHOs
• Provision of prioritised lists to practices to contact patients who need to be targeted for better control of diabetes with Māori and Pacific prioritised	Rate of diabetes annual reviews by ethnicity (Māori, Pacific and other)	PHOs

Waikato activity	Contributory measure	Lead responsibility
• Referral of Māori, Pacific and other high risk population groups to culturally appropriate providers for self- management and support i.e. Whānau Ora and mobile long term conditions teams	Monitor the number of patients by ethnicity with HbA1c >80 to support the activities targeting this cohort	DHB, PHOs and pharmacies
• Develop and implement a diabetes model of care that will include pharmacist, nursing, general practitioner and DHB specialist services to specifically work with high risk patients with diabetes (HbA1c >80). This model of care will be co-designed with iwi and Pacific partners using a locality approach		DHB and PHOs

System Level Measure 5: Babies living in smoke free homes

Aim: Reduction in the number of maternal smoking as well as the home and whānau/family environment.
The equity gap between Māori and Non-Māori is 32.4%.

Ethnicity	Numerator	Denominator	Percentage babies living in smoke free homes Baseline (year to Dec 2019)	Percentage babies living in smoke free homes Result (year to Dec 2020)
Māori	290	950	28.2%	30.5% (June 2020)
Non-Māori	1187	1848	60.6%	64.2% (June 2020)

Ethnicity	Numerator Jan 20 - Jun 20	Denominator Jan 20 - Jun 20	Rate of smoke free homes Jan 20 - Jun 20
Māori	290	950	30.5%
Pacific	58	127	45.7%
Other	1187	1848	64.2%
Total	1535	2938	52.2%

Rationale

Pregnancy

Equity: Significant equity gap between Māori and NZ European. This measure targets Māori results to enhance equity focus for monitoring and activity. Utilisation and access: Low numbers accepting referrals to smoking services. Smoking during pregnancy leads to increased carbon monoxide concentration in the blood of both the mother and her baby, resulting in reduced oxygen and nourishment available to the baby. This increases the risk of babies being born with a low birth weight and increases the risk of neonatal mortality, sudden and unexpected death in infancy and long-term respiratory problems for the child.

Lifespan

Placing the spot-light on particular data sets has resulted in data quality improvement in the past and it is anticipated this will occur for these datasets as well.

Improvement milestone: A reduction in the equity gap between Māori and non-Māori living in a smoke free household at 6 weeks from 34% to 17%.

Waikato activity	Contributory measure	Lead responsibility
Pregnancy		
Increase referrals to maternal incentives smoking cessation programmes by 10% for pregnant women and whānau.	Smoking cessation referral rates for Māori and Pacific. Target 10% increase.	DHB, PHOs and LMCs
Implement the toolkit that enables the use of the Tupeka Kore framework in primary care (LMCs/GPs/Well Child Tamariki Ora).	Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total).	DHB, PHOs and LMCs
Hapū Māmā (our district wide maternity support programme for pregnant Māori women) will have increased capacity for smoking cessation support for pregnant mums. Initial activity will include.	Smoking cessation programme completion rates for Māori and Pacific will increase by 25%.	DHB, PHOs and LMCs
• Increased focus on being smoke free during pregnancy and providing stop smoking support and/or referral to Once and for All stop smoking service.	Smoking rates of postnatal women and households at 6 weeks (by Māori, Pacific, Other and Total).	DHB
• Introduction of programmes such as Generation2040 and utilisation of associated Apps.	Number of smoking cessation referrals and quit rates.	PHOs and NGOs
• Provide incentives to stop smoking for hapū māmā ("Once and For All" programme).	DHB to audit the referral and "Once and For All" programme completion rates by ethnicity (Māori, Pacific and other).	DHB
Lifespan		
The DHB will roll out training to Tamariki Ora providers and monitor their smoking cessation referral rates. Multi-stakeholder promotion of Smoke-free Environments (Prohibiting smoking in motor vehicles carrying children) Act comes into force on 28 November 2021.	Well Child Tamariki Ora enrolment rate by ethnicity (Māori, Pacific, Other, Total).	

System Level Measure 6: Youth access to health services

Aim: Intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 12-24 year olds.

Baseline is year to December 2019, the latest national data available

Ethnicity	Waikato rate per 10,000 Baseline	National rate per 10,000 Baseline	Waikato rate per 10,000 Year to Dec 2020	National rate per 10,000 Year to Dec 2020
Māori	60.9	65.2	64.4	70.0
Pacific	25.9	33.4	63.8	37.2
Other	66.7	50.1	69.8	50.9
Total	63.1	52	67.5	53.9

Rationale

Self-harm

Poor understanding of current youth service availability and quality. To achieve health equity for youth, primary to tertiary services need to be accessible, appropriate and effective. The Waikato DHB region has no up to date needs assessment for youth in our region. Improved access to quality of care is required for youth in the Waikato region. Focus is on increased collaboration, enhanced understanding of youth needs and youth service provision, and increasing opportunities for alignment.

Improvement milestone:
A 5% reduction in intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year old taking the Waikato DHB rate from 67.5/10,000 to 64.1/10,000.

Waikato activity	Contributory measure	Lead responsibility
Waikato DHB to provide workforce development for school based nurses and GPs to improve their capabilities to appropriately assess, diagnose, support and refer at risk youth for self-harm.	10% increase in referrals to youth primary mental health services.	DHB
Trial and test extended GP consultations for youth (12-24) who are experiencing anxiety.	Number of extended GP consultations by ethnicity (Māori, Pacific, Total).	DHB and PHOs
Youthchatpro is an online screening tool that rangatahi can complete in their own time and space. It will specifically be targeted to rangatahi who may not currently be engaged the in school system as this is often a high need group that will not have access to school based health services. Any health needs that are identified through completion of the screening tool are flagged with a GP who can provide care via phone or telehealth if required.		DHB
Complete further roll out of the Youthchatpro digital screening tool that maps to the HEADDSS assessment screening tool.		DHB

Appendix

2021/22 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP TERMS OF REFERENCE

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for the 2021/22 measure

- An improvement milestone
- Quality improvement activities to achieve system level measure improvement
- Contributory measures that allow monitoring of progress

Specific responsibilities

- Identifying improvement milestone (Where we want to be)
- Identifying activity and provider that will impact the contributory milestones and supporting measures. This could be current, planned i.e. listed in annual plan or new activities ideas (How will we get there?)
- Selecting the most relevant contributory measures
- Identifying wider supporting measures which assist the delivery of the system level measure but are not the nominated contributory measures
- Oversee activity agreed that will impact the milestones

Outside of scope

- Funding related decisions

Linkages

The improvement milestones chosen should take into consideration the strategic priorities across the region, particularly reducing inequity and should aim to:

- Align to current strategic priorities
- Align to current alliance work programmes and activities
- Information that is already collected and readily available; and where possible aligned across the region
- Relevant to family and whānau, clinicians and managers
- Relevant to vulnerable population including but not limited to older people and children
- Impacting on a reasonable sized population
- Desirable with regard to a return on input investment

Terms of membership

Each PHO operating in the Waikato District have been asked to provide a representative. Representatives from appropriate providers and the DHB are also included. Membership may change dependent on each organisations desired attendee. A delegate may represent members on the proviso that the delegate has the ability to report to their own services/organisations and can make informed contribution to discussions.

Accountability

The working group are an expert advisory group and will make recommendations to either the Waikato Child Health Network, Demand Management Advisory Group or Inter Alliance as determined below.

Governance

Waikato DHB's executive leads for SLM are:

- Clinical Director, Primary and Integrated Care (position vacant)
- Executive Director, Strategy and Funding
- Service Development Manager, Primary Care, Strategy and Funding

The Waikato Primary and Community Health Care Alliance will have oversight for Waikato system level measures.

Te Manawa Taki Regional Linkages will be in the form of information sharing. There may also be linkage with the Ministry team around data sources and SLM reporting.

APPENDIX C: Accounting policies

Statement of accounting policies

Reporting entity

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

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

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

Basis of preparation

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board is seeking reassurance from the Ministers of Health and Finance that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

Statement of compliance

Financial statements are prepared in accordance with the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practices in New Zealand (NZ GAAP).

Financial Statements are prepared in accordance with, and comply with, Tier 1 PBE accounting standards.

Presentation currency and rounding

Financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000) unless otherwise indicated.

Changes in accounting policies

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

Standards issued and not yet effective and not early adopted

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the Waikato DHB and group are:

PBE IPSAS 41 Financial Instruments

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

Service Performance Reporting

In November 2017, the XRB issued PBE FRS48, a new standard for Service Performance Reporting. PBE FRS48 is effective for periods beginning on or after 1 January 2022 with early adoption permitted.

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

The Waikato DHB plans to apply this standard in preparing its 30 June 2023 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

Subsidiaries

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

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

Joint ventures

Joint ventures are those entities over whose activities Waikato DHB has joint control and has rights to the net assets of the arrangement. Joint Control is the agreed sharing of control of an arrangement by way of a binding arrangement which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

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

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

Budget figures

The Waikato DHB's budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Waikato DHB in preparing financial statements.

Revenue

Revenue from exchange transactions is measured at the fair value of consideration received or receivable, taking into account the amount of any trade discounts and volume rebates allowed by the Waikato DHB.

Revenue from non-exchange transactions is revenue other than revenue from exchange transactions, such as donations, grants and transfers.

The specific accounting policies for significant revenue items are explained below:

Ministry of Health (MoH) population-based revenue

Waikato DHB is primarily funded through revenue received from MoH, which is restricted in its use for the purpose of Waikato DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder. Revenue from MoH is recognised as revenue when earned. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the funding arrangements.

Ministry of Health (MoH) contract revenue

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

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

ACC contract revenue

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

Revenue from other district health boards

Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. MoH pays Waikato DHB with monthly amount based on estimated patient treatment costs for non-Waikato DHB residents. An annual revenue washup occurs at year end to reflect the actual number of non-Waikato DHB patients treated at Waikato DHB. Inter-district patient inflow revenue is recognised when services are provided or entitlement is confirmed.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donations and bequests

Donations and bequests to Waikato DHB are recognised as non-exchange revenue when control over the asset is obtained. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive revenue and expense. Volunteer services received are not recognised as revenue or expenses.

Vested or donated assets

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

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

Capital charge

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

Finance costs

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

Leases

Waikato DHB as lessee

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased term or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Waikato DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Waikato DHB as lessor

A lease where Waikato DHB, as lessor, has in fact all the benefits and risks of ownership is designated as an operating lease; otherwise, such agreements are recognised as finance leases. Property, plant and equipment made available to third parties by means of an operating lease is recognised in accordance with the accounting standards for property, plant and equipment.

Lease revenue from operating leases shall be recognised as revenue on a straight-line basis over the lease term, unless another systematic basis is more representative of the time pattern in which benefits derived from the leased asset is diminished.

Initial direct costs incurred by Waikato DHB in negotiating and arranging an operating lease shall be added to the carrying amount of the leased asset, and recognised as an expense over the lease term on the same basis as the lease revenue.

Foreign currency transactions

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

Cash and cash equivalents

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

Financial assets recognised subject to restrictions

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

Receivables

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

In measuring expected credit losses, receivables are assessed on a collective basis as they possess shared credit risk characteristics. They are grouped based on the shared credit risk characteristics and days past due. The expected loss rates are based on the payment profile of transaction over a period of 24 months before the financial year end and the corresponding historical credit losses experienced within this period.

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

Derivative financial instruments

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

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

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost and adjusted where applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised as an expense in the period of the write-down.

Consignment inventory is inventory held on behalf of third parties and is not recognised as an asset as ownership has not transferred to the Waikato DHB. The expense is recognised when the goods are distributed or consumed.

Non-current assets held for sale

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

Impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have previously been recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant and equipment

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

- freehold land
- freehold buildings
- plant, equipment and vehicles.

Land and buildings

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairments losses.

Revaluations

Land and buildings are revalued to fair value with sufficient regularity to ensure that the carrying amount does not differ materially to fair value, and at least every five years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and buildings revaluation movements are classified on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense, but is recognised in the expense section of the statement of comprehensive revenue and expense. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, with the remainder then recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Waikato DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost less impairment and is not depreciated. In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefit or service potential associated with the item will flow to Waikato DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Disposal

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as:

Class of asset	Estimated life	Depreciation rate
Buildings	10- 57 years	1.8 – 10%
Clinical assets	2-18 years	5.5 – 50%
General assets	2-20 years	5 – 50%
Motor vehicles	5-11 years	9 – 20%

The residual value and useful life of assets is reviewed and adjusted if applicable, at balance sheet date.

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

Impairment of property, plant, equipment and intangible assets

Waikato DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate commercial return.

Non-cash generating assets

Property, plant, equipment and intangible assets held at cost that have a finite useful life are reviewed for indicators of impairment at balance date and whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If any such indication exists, Waikato DHB shall estimate the recoverable amount of the asset. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in the movement of revaluation reserve in the statement of comprehensive revenue and expense to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised as an expense in the statement of comprehensive revenue and expense. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to movement in the revaluation reserve in the statement of comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised as an expense in the surplus or deficit, a reversal of the impairment loss is recognised as revenue in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised as an expense in the statement of comprehensive revenue and expense.

Intangible assets

Software acquisition and development

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

Information technology shared services rights

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

Amortisation

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

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

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

Impairment of intangible assets

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

Trade and other payables

Short term payables are recorded at their face value.

Borrowings

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

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

Finance Leases

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

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

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

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the group will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken, continuing medical education leave and sick leave.

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

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

A liability and expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond twelve months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within twelve months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The group makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed by the board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus or deficit of the scheme will affect future contributions by individual employers as there is no prescribed basis for the allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

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

ACC Partnership Programme

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future employee remuneration levels and history of employee claims and injuries. Expected future payments are discounted using market yields on New Zealand government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash out flows.

Repairs to motor vehicles provision

A provision is provided for the costs of repairing motor vehicles at the end of their operating lease period before return to the lessor.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components

- Crown equity;
- Retained earnings;
- Revaluation reserves; and
- Trust funds.

Revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

Trust funds

Trust funds represent the unspent amount of unrestricted donations and bequests received.

Income tax

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

Goods and services tax (GST)

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

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

Cost Allocation

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

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

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

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

Critical accounting estimates and assumptions

In preparing financial statements, management makes estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings are as follows:

Land
Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the unencumbered land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensively.

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

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

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

Non-specialist buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value. These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

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

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

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires Waikato DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Waikato DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement gratuities and long service leave

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor is determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Two discount rates for retirement and long service leave are used together with a salary inflation factor.

Critical judgements in applying accounting policies

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

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