Waikato District Health Board

2020/21 ANNUAL REPORT

For the year ended 30 June 2021

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

Statement of responsibility for the year ended 30 June 2021

Waikato District Health Board (DHB), established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD Act), is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services, and disability support services in respect of specified geographically defined populations. Each DHB is a Crown Entity, owned by the Crown for the purposes of section 7 of the Crown Entities Act 2004, and is accountable to the Minister of Health who is the responsible Minister in terms of that Act.

This Annual Report has been prepared to meet the requirements of the Crown Entities Act 2004 (see Section 150 of the Act) and the Public Finance Act 1989 (see Section 43 of the Act). This report presents information on our performance over the 2020/21 year with ratings on the outputs and impacts we intended to deliver in terms of national, regional and local priorities and as stated in the Waikato DHB's 2020/21 Annual Plan.

Name of DHB:
Waikato District Health Board

Address:
Private Bag 3200, Hamilton 3240

Phone:
07 834 3646

Website:
www.waikatodhb.health.nz

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

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

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

In our opinion these financial statements and the performance information fairly reflects the financial position and operations of Waikato DHB for the year ended 30 June 2021.

Signed by

Dr. Kevin Snee
Chief Executive
Waikato District Health Board
15 December 2021

Dame Karen Poutasi
Commissioner
Waikato District Health Board
15 December 2021

Mihi

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

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

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

'Tūturu whakamaua kia tina!'

'Tina!'

'Haumi e; hui e!'

'Taiki e!'

A brief explanation of the mihi

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

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

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

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

'It shall be done!'

'Gather it together; weave everything together!'

'It is accomplished!'

Thank you for your fantastic care, you put me and my fiancé at ease when we needed it most. You listened to us and answered all of our questions.

Theatre

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

Dame Karen Poutasi
Commissioner

Dr Kevin Snee
Chief Executive

E ngā mana, e ngā reo, e ngā karangarangamaha, nei ngā whakamaanawa o te Kiingi, kia amohia ake te ora o te iwi, e whakamaanawa hoki nei kia koutou kia piki te ora, kia piki te kaha, kia piki te maramatanga hei amo tautiaki te iwi.

To all our esteemed delegates from wide and far, we send you our acknowledgements. We send you our acknowledgements with the sentiments of our King's tongikura which states, the wellbeing of our people is paramount. We acknowledge you and hope that you are implementing this value to your personal wellbeing.

We wish to begin by acknowledging and thanking the staff of Waikato DHB and the wider healthcare sector for the incredible dedication, compassion, and professionalism they have shown time and again during the past year. They have ensured our communities remain informed, protected and cared for at all times.

Waikato has a diverse population with a wide range of health needs. The Waikato Health System Plan, Te Korowai Waiora (2019), is our 10-year blueprint for improving the health and wellbeing of the people of the Waikato. This has framed our service development, which focuses on delivering services in the community where people can access care closer to home, with the support of whānau.

This is of increasing importance as we manage an ageing population and more people presenting with high and complex needs across our services. While it is critical to ensure our hospitals have the capacity and capability to respond to acute needs and public health events, a sustainable healthcare system must focus on community-based provision. This, coupled with greater emphasis on keeping well will enable people to achieve their full health potential and reduce reliance on hospital services.

Working in our localities with iwi and local providers has proven invaluable in driving this step-change in how healthcare is delivered. This is evident through the way new services are being co-designed and developed to meet iwi and community priorities. Examples of these initiatives can be found throughout this report.

Our equity report was published this year, illustrating the lifelong impacts of health inequities experienced by Māori and Pacific people, and the urgency with which these gaps must be closed. This work is supported by our Regional Equity Plan, driving partnership between Te Manawa Taki region DHBs and iwi. This milestone project guides our locality work and sets priorities for achieving equitable health outcomes for Māori over the next three years.

Waikato DHB has continued to support the COVID-19 pandemic response. This has required a collaborative and relentless effort from across the health sector and in partnership with our communities, iwi, local authorities and central government. The impact of this pandemic has been felt deeply in our communities and our sympathies remain with all those who have experienced hardship and loss. We thank all those who have worked with us to help protect the people of Waikato, and our community for their warmth and support in following public guidance on how to stay safe and look after one another.

Roll-out of the Waikato vaccination programme began in February 2021. We were honoured with a tongikura gifted to the Waikato

vaccination programme by Kiingi Tuuheitia Pootatau Te Wherowhero te tuawhitu:

"Amohia ake te ora o te iwi, ka puta ki te wheiao"
To protect the wellbeing of our people is paramount

The programme team has embraced this and it guides the everyday operations of this extensive undertaking – the largest immunisation programme in our history.

As with the resurgence response, the vaccination programme is a collaboration with our primary health partners, and kaupapa Māori and Pacific providers, local authorities and iwi. The programme goal is to make it as easy as possible for people across Waikato to be vaccinated, wherever they live.

In May, the organisation experienced a cyber security incident which required the shutdown of systems across the DHB. This outage impacted all areas of our hospital facilities, including systems used to manage patient flows and operate medical equipment. The response of staff was outstanding under very challenging circumstances, introducing manual processes where required to ensure critical care remained available. Where the outage affected delivery of procedures such as radiation therapy, which could not safely be delayed, we were grateful for the support of our national DHB network.

Our Information Services team prioritised restoration of critical clinical services and these were stood up rapidly, while full restoration to the service and application levels prior to the outage were expected to take some months. This team must be commended for their tireless work to restore our full capability. We are also grateful for the ongoing expert support from central government agencies and police.

As we have worked to ensure delivery of services through these extraordinary events, the DHB has also remained focused on our key objectives to improve quality of care and wellbeing in our community. Many measures are recorded in this report which reflect both the growing challenges we face as a community, and successes which have been achieved through the combination of clear objectives and a team of committed and highly skilled DHB staff. We have seen improvements in our clinical quality and patient safety, improved access and efficiency, and grown our partnerships to support a healthcare system which is better integrated, closer to our community and built around the needs of our people.

Closely linked to our delivery of the above objectives was the achievement of our budgeted financial outcome, an improvement of $43 million on the previous year. This was an ambitious target and relied upon a whole of organisation response to find efficiencies and deliver high quality care. As we have noted previously, high quality care produces better outcomes for patients, reducing the need for repeat or long-term acute care, thereby reducing demand on hospital services. Delivering to our budget also supports further investment into services and capital projects, contributing to a sustainable model which reflects our community needs.

The Government has now confirmed that the coming years will be a period of significant change in the healthcare sector, following the creation of Health NZ and a Māori Health Authority. Waikato DHB welcomes the opportunity to focus efforts on building a healthcare service with patients and whānau at the heart of our endeavours to improve access and equity.

Dame Karen Poutasi

Commissioner
Waikato DHB

15 December 2021

Dr. Kevin Snee

Chief Executive
Waikato DHB

15 December 2021

Commissioner interests

Waikato DHB was formed in 2001 and is one of 20 DHBs established to plan, fund and provide health and disability services for their populations.

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

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

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

Agendas and minutes of commissioner meetings are not publically available.

Dame Karen Poutasi

Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Deputy Chair, Network for Learning
- Son, Health Manager, Worksafe
- Chair, Wellington Uni-Professional Board
- Chair, COVID-19 Vaccine and Immunisation Governance Group
- Chair, Taumata Arowai

Mr Andrew Connolly

Deputy Commissioner from July 2020 to February 2021

- Clinical Advisor to the Commissioner, Waikato DHB
- Member, Finance Risk and Audit Committee, Waikato DHB
- Chair, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Acting Chief Medical Officer, Ministry of Health (secondment to 31 December 2021, part-time)
- Board member, Health Quality and Safety Commission (position non-active whilst Acting Chief Medical Officer, Ministry of Health)
- Employee, Counties Manukau DHB
- Clinical Advisor to Chair, Southern DHB
- Member, Ministry of Health Planned Care Advisory Group

Mr Chad Paraone

Deputy Commissioner

- Member, Finance Risk and Audit Committee, Waikato DHB
- Member, Hospitals Advisory Committee, Waikato DHB
- Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB
- Independent Chair, Integrated Community Pharmacy Services Agreement National Review (stepped down from role from December 2020 to June 2021)
- Strategic Advisor (Māori) to CEO, Accident Compensation Corporation
- Māori Health Director, Precision Driven Health (stepped down from role from October 2020 to June 2021)
- Committee of Management Member and Chair, Parengarenga A Incorporation
- Director/Shareholder, Finora Management Services Ltd
- Member, Transition Unit (Health and Disability System Reform), Department of Prime Minister and Cabinet)

Prof. Margaret Wilson

Deputy Commissioner

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

“The nurse and doctor as well as the reception staff were amazingly helpful. Reception staff helped me find the second waiting room and were friendly. The nurse explained informed consent extremely well. Great patient care. The doctor explained the ultrasound results and the next steps for me.”

Waikato Breast Care

Part one: Overview

Introduction

Who we are and what we do

This Annual Report outlines our financial and non-financial performance for the year ended 30 June 2021. In the Statement of Performance (part three), we present our actual performance results against the non-financial measures and targets contained in our Statement of Performance Expectations 2020/21. COVID-19 vaccination figures have been added for 2020/21.

Our focus is on providing services for our population that improve their health and reduce or eliminate health inequalities. We consider needs and services across all areas and how we can provide these services to best meet the needs of the population within the funding available. We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

We have both funded and provided health services this year. For the 2020/21 year, we received approximately $1.5 billion in funding from Government and Crown agencies for health and disability services for the Waikato population. The amount of funding we receive is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status.

During 2020/21 approximately 60 percent of funding received by Waikato DHB was used to directly provide hospital services. The remaining 40 percent was used to fund contracted health services provided by non-government organisations (NGOs), primary healthcare organisations (PHOs), Māori health providers, Pacific health providers, aged residential care, other DHBs, pharmacies and laboratories. These services were monitored, audited, and evaluated for the level of service delivery.

Functions of a DHB

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

We collaborate with other health and disability organisations, stakeholders, and our community to identify what health and disability services are needed and how best to use the funding we receive from the Government. Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the health system to achieve the best outcomes for our community.

Providing health and disability services

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

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

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

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

Our rural hospitals form an important part of Waikato DHB's health service delivery. The hospitals work closely with all health service providers in the area. Some services provided at the rural hospitals include:

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

IS security incident

A cyber attack in May 2021 caused significant disruption which affected systems across our DHB including all five hospitals.

As soon as Waikato DHB became aware of the incident, our incident response plan was implemented to get our digital systems back up and running as quickly and securely as possible.

This included partnering with Government agencies (e.g. the National Cyber Security Centre) and several New Zealand and international incident response specialists to ensure we retained integrity across Waikato DHB's digital environment.

However, the incident response process took time as Waikato DHB is a complex organisation serving over 400,000 patients, providing specialist tertiary hospital services and operating several supporting secondary hospitals and facilities.

For example, Waikato DHB maintains a considerable number of servers, thousands of end point devices and uses a significant number of applications for specialist clinical services. All these systems required cleansing or restoration, despite server operating system patches being up to date at the time of the incident.

While the primary focus of the incident response process was containment and the restoration of Waikato DHB digital systems, later focus will be on reviewing forensic evidence on the sections of Waikato DHB's digital network that were affected.

The findings from this investigation will be used to improve Waikato DHB's information security resilience as we move forward from the incident.

Waikato has been aware of its obligations under privacy laws (including the obligation to notify affected individuals) since it became aware of the incident. For example, Waikato DHB immediately informed the Privacy Commissioner about the incident in accordance with the incident response plan.

A number of support services have been made available to any staff or patients who have questions or concerns relating to their private data.

Following the cyber attack, Minister of Health Andrew Little and local Hamilton East and West MPs Dr Gaurav Sharma and Jamie Strange visited the Waiora Waikato Hospital Campus to meet with staff across services and the Emergency Operations Centre team.

Mental health rebuild – Te Pae Tawhiti

In 2020 the Government approved $100 million funding for a new acute mental health facility for the Waikato. Te Pae Tawhiti programme was established to undertake this project through the build to its completion which is due in 2023.

The programme has been established to achieve the following three objectives:

- To create an integrated and holistic model resulting in reducing significant barriers to timely and appropriate care
- To provide a safe, therapeutic and effective environment for tangata whaiora and staff
- To increase capacity to meet demand and acuity/complexity

The focus for 2020 was on completing the indicative business case for the new adult acute inpatient facility, Ministerial approval was provided in February 2021 enabling us to progress to the detailed business case phase.

Whilst the indicative business case approval process was underway, work to complete procurement of the construction project management and design team was completed resulting in the appointment of:

- Construction project managers – RDT Pacific
- Architects – Klein
- Engineers – AECOM
- Fire engineer – BECA
- BIM manager – Construction Workshop
- Quantity surveyor – Rider Levett Bucknall
- Green Star Accredited professional – AECOM

Iwi engagement has commenced with our mana whenua group – Te Haa o te whenua o Kirikiriroa (THaWK) and work on a site cultural impact assessment is well progressed. Monitoring of the additional geotechnical work was also provided by THaWK.

Additionally, THaWK and our Kaetakawaenga team have worked together to develop a culturally led service plan for mental health, that will now be woven together with the clinical service plan to form a new contemporary model of care.

Working groups from Mental Health and Addictions along with the cultural design team, have worked together with the architectural design team to develop a concept floorplan for the new facility that will support the delivery of culturally appropriate and contemporary clinical services.

The full concept design is due to be completed in October 2022, and provides critical input into the detailed business case. It will also be re-costed to ensure that we can deliver the building within the budget of $100 million.

In parallel, work has started on the first iteration of a system-wide service plan which will identify activities required across the mental health continuum of care to improve health outcomes. This work is also critical to ensure that the new facility is sized appropriately to meet demand.

Work on development of the detailed business case continues and will be submitted for Ministerial approvals in early 2022. Approval of this business case will allow us to progress to implementation business case phase. Meanwhile, the design will progress to preliminary design phase which will see the floorplan elaborated and drawn up to scale, and this will then progress to developed design and then detailed design. During this time the Mental Health and Addictions service will continue work on designing the new ways of working within the facility.

COVID-19 vaccination roll-out

In February 2021, we began delivering the COVID-19 vaccination programme across the Waikato region. Nationally, this is the largest immunisation programme New Zealand has ever seen. This roll-out showed great collaborative work between the DHB, health partners and iwi with a focus on locality and access.

Approximately 350,000 people in the Waikato are eligible to receive the two-dose Pfizer-BioNTech vaccine, which is free to all New Zealanders aged 16 and over. As at the end of June 2021, nearly 74,000 vaccinations had been delivered in the Waikato.

A cornerstone to the Waikato programme was the tongikura gifted by Kiingi Tuuheitia Pootatau Te Wherowhero te tuawhitu: *Amohia ake te ora o te iwi, ka puta ki te wheiao. To protect the wellbeing of our people is paramount*. This has been our inspiration and foundation for shaping the approach we have taken to protecting our community through immunisation.

To ensure priority for those most at risk of catching COVID-19 and those most likely to be seriously ill if infected, the national programme identified four vaccination groups. The Waikato programme has largely followed the order of vaccination set out by the Ministry of Health. We began in February with our key frontline workers, people in long-term residential care and Māori and Pacific people aged 65 and older, their households and carers (Groups 1 and 2).

Te Korowai Hauora o Hauraki, Ngāti Maniapoto Marae Pact Trust, Waikato-Tainui, Raukawa Charitable Trust, Rauawaawa Kaumātua Charitable Trust, K'aute Pasifika, South Waikato Pacific Islands Community Services (SWPICS) and Te Kōhao Health were instrumental in getting the programme underway in the Waikato takiwā.

We built on close working relationships developed through the COVID-19 pandemic to introduce initiatives such as pop-up and mobile clinics. This targeted strategy ensured our vulnerable Māori and Pacific whānau were provided with the earliest opportunity to be protected. By the end of June 2021, 39 percent of Māori kaumātua 65 years and over and 41 percent of Pacific kaumātua 65 years and over of this group had received their first dose.

We also established community vaccination centres across the region to vaccinate in large numbers and worked with the Pinnacle, Hauraki and National Hauora Coalition PHOs and Midland Community Pharmacy Group to bring pharmacies and GP practices into the programme alongside our kaupapa Māori and Pacific providers. Our largest centre is set to open in July 2021 at the Te Awa site in Hamilton where we are able to vaccinate up to 1000 people a day, seven days a week.

As at 30 November 2021 Waikato DHB were at 91 percent first dose and 84 percent second dose with Māori being 82 percent and 68 percent respectively. This was following completion of our largest day of vaccinations, aligning to a national Super Saturday vaccination event with over 10,000 people being vaccinated on that day. Currently the DHB is offering over 70 fixed sites and up to 10 mobile vaccination teams operating on any given day across the district.

For our 2020/21 results as at 30 June 2021 see page 107.

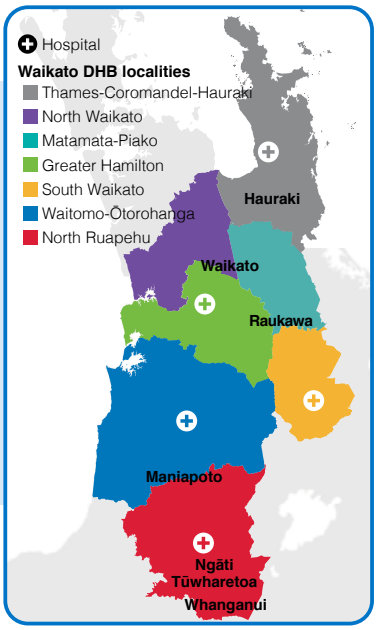
I felt emotional when my injection was done. It's just a sense of relief and realising the opportunity we'd been given.

My main motivator for getting the vaccine was to protect the rest of my whānau and I'm going to let them all know I've had my first shot. I'm looking forward to when they can become part of the roll-out too.

Partnering for vaccine delivery in our localities

Across the Waikato DHB region we worked with iwi, kaupapa Māori providers, PHOs and NGOs to co-design and deliver the vaccine within our communities. It was expected that some providers would do everything themselves while other providers would require additional resource and support to deliver the number of vaccinations that would be required.

The DHB used the co-design process and workshops to develop and implement solutions. Some providers visited our established COVID-19 vaccination centres to get a good understanding of what was involved and how the Pfizer vaccine is administered.



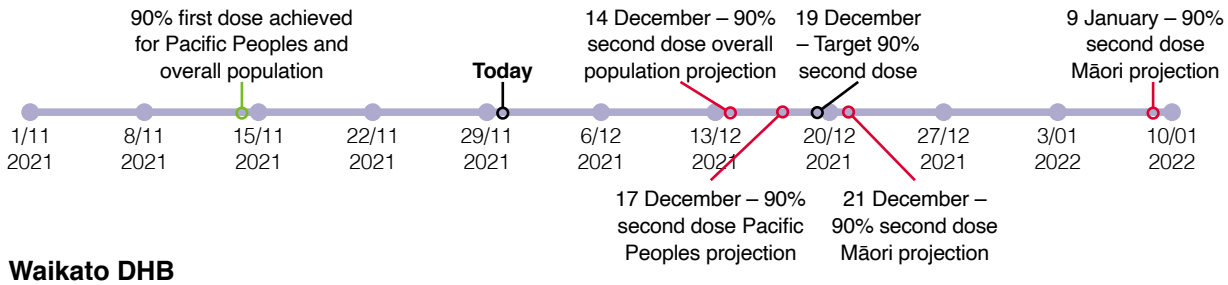
Figures below are unaudited.

Territorial authority doses remaining and percentage vaccination

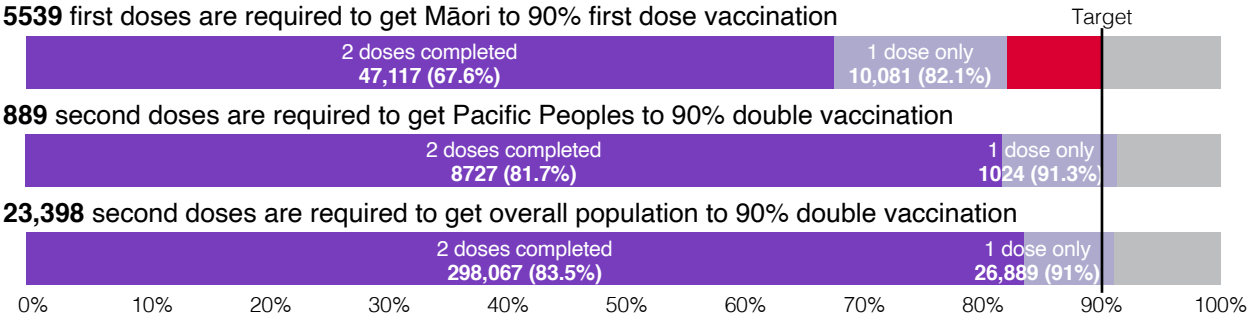
	Māori				Pacific Peoples				All population			
Territorial authority	Dose 1 for 90%	Dose 1 (%)	Dose 2 for 90%	Dose 2 (%)	Dose 1 for 90%	Dose 1 (%)	Dose 2 for 90%	Dose 2 (%)	Dose 1 for 90%	Dose 1 (%)	Dose 2 for 90%	Dose 2 (%)
Hamilton	1539	84.4	5754	69.1	-405	96.7	163	87.3	-5305	93.7	4861	86.6
Hauraki	355	79.0	774	64.7	1	89.5	23	80.3	947	84.5	2384	76.1
Matamata-Piako	617	74.9	1136	62.3	-40	101.8	3	89.0	254	89.2	2507	81.8
Ōtorohanga	400	72.4	703	59.1	18	74.6	25	68.6	676	82.2	1460	73.1
Ruapehu	343	76.1	751	59.6	13	73.4	28	54.4	377	84.3	1090	73.6
South Waikato	103	88.2	1163	69.8	415	68.7	592	59.6	663	86.7	2885	75.5
Thames-Coromandel	705	72.4	1155	61.1	24	82.7	42	77.3	565	88.0	2481	81.1
Waikato	737	83.7	2340	70.0	44	86.0	156	75.9	259	89.5	4097	81.7
Waipa	610	79.5	1214	69.1	-157	132.2	-108	119.0	-1780	93.7	980	88.0
Waitomo	148	85.1	628	69.1	-49	124.8	-35	114.9	-146	91.9	653	81.4
Total	5539	82.1	15,620	67.6	-135	91.3	889	81.7	-3490	91.0	23,398	83.4

Waikato DHB COVID-19 vaccination daily dashboard for 30 November 2021

Projected 90% milestones based on current performance



In Waikato DHB



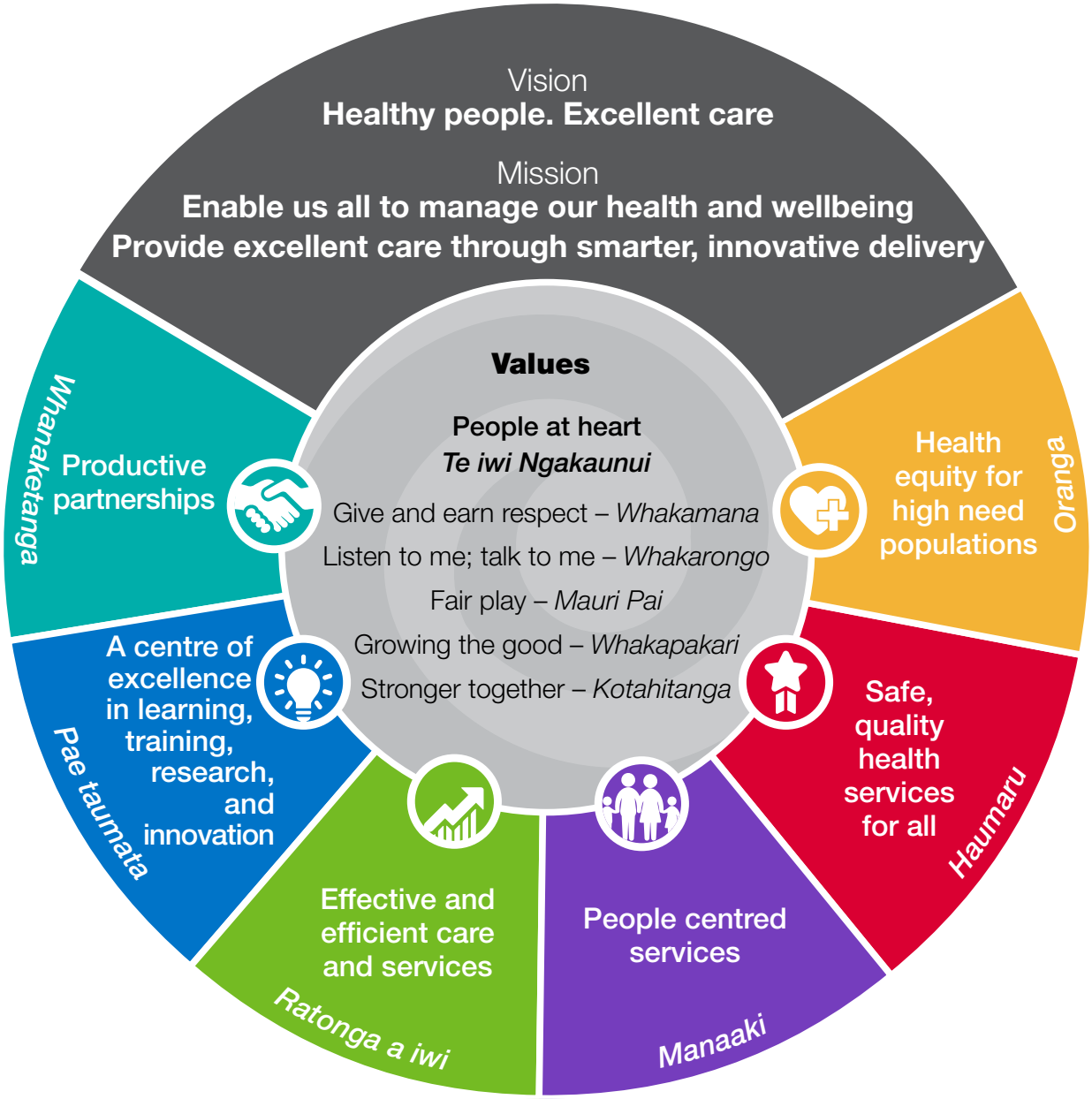
Local performance story

Our vision

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

This vision identified the need for transformative innovation causing significant change. It calls for a move away from thinking about hospitals as the most important part of the health system to thinking about care that meets the needs of people, provided closer to where people live.

To achieve Waikato DHB's vision, health and social care must be well connected, coordinated and cohesive.



Our strategic imperatives and priorities

The strategy describes the organisation as part of a wider health and social system, outlining six key strategic imperatives. Under each strategic imperative are four priorities which connect the strategy with the day-to-day activities of the Waikato DHB. These priorities are areas of work that will be our focus. These are not our only priorities, as we have policy priorities that we deliver on as required by the Ministry of Health and Central Government.

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

WAIKATO
Health System Plan
Te Korowai Waiora

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

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

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

Te Korowai Waiora		
Seven goals		Examples of 2020/21 achievements
goal 1	Partner with Māori in the planning and delivery of health services	A new position 'Director of Māori Workforce Development' was filled. The new director will develop and implement a number of new initiatives to support the current Māori workforce while also increasing the number of Māori across all levels of the DHB. Waikato DHB published Rapua Te Ara Matua Equity Report which contains 20 measures that are useful indicators across the life stages. This report highlights the inequities that exist and provides a baseline to measure success against as new equity initiatives are implemented.
goal 2	Empower whānau to achieve wellbeing	There has been a focus on developing and implementing new service models with funding radically prioritised for Māori. An example is Te Mate Huka, a framework for diabetes that ensures whānau are supported and enabled to be healthy and thriving in their communities with access to screening services. Mate Huka has been co-developed with iwi to find solutions that empower Māori ownership, self-management and care coordination. Waikato DHB has been working with Māori providers in each locality to tailor and enhance whānau ora approaches within their rohe. This includes working in partnership with providers to support whānau to have improved health outcomes.
goal 3	Support community aspirations to address the determinants of health	Waikato DHB and Ministry of Justice launched the Alcohol and Other Drug Treatment Court Te Whare Whakapiki Waiorua (AODTC) in the Waikato. The aim is to break the cycle by treating the causes of offending which are often addiction and dependency. This holistic approach supports rehabilitation, recovery, and is evidence-based best practice after having successful outcomes when trialled in other districts. There are two components from a health perspective, 1) screening and brief-interventions for anyone appearing in the District Court and 2) for those who meet the requirements for AODTC, comprehensive assessment and treatment. The DHB supports and monitors the implementation of the Whānau Pai collaborative a new 'Māori for all' initiative to better meet the needs of Māori, Pacific and young people. Whānau receive or are linked into holistic and culturally responsive primary mental health and addiction services integrated with their local general practice. This will ultimately reduce the number of people who require secondary services (mild-moderate and acute crisis phase) and improve primary health outcomes for whānau with existing mental health and addiction needs.

goal 4	Improve access to services	The 'Ways to Go – Haerenga Pai' survey was undertaken to help Waikato DHB understand and guide changes to the way people travel to and from Waikato Hospital. Ultimately the survey will inform solutions that will reduce the high traffic volumes and ease pressure on current parking facilities so patients, visitors and staff can easily access the hospital campus with minimal stress. Waikato DHB has developed workforce diversity metrics to inform targeted actions that will improve workforce diversity with a focus on outcomes for Māori, Pacific, people with disability and migrants.
goal 5	Enhance the capacity and capability of primary and community health care	Waikato DHB is working towards establishing local leadership groups in each locality to inform ongoing locality planning and health service enhancement. One group has been established in South Waikato, further groups are currently being established in North Waikato and Hauraki. Waikato DHB is leading the implementation of Rapua Te Āhuru Mōwai, locally to be known as He Wāhi Kāinga. This is a cross-sector pilot to prevent homelessness and improve transitions at the point of discharge from the Henry Rongomau Bennett Centre to sustainable housing in the community. The DHB, NGOs, MSD, Kāinga Ora and HUD are working in partnership to develop holistic wrap around plans and intensive supports for 50 tangata whaiora over four years.
goal 6	Strengthen intermediate care	A new four-bed mental health service in Thames will allow Hauraki people to get support closer to home. The service is a collaboration between Waikato DHB, Te Korowai Hauora o Hauraki, Stepping Out Hauraki, People Relying on People. The step-up step-down services will operate from Thames Hospital and provide a level of care between what's available in the community and as a hospital inpatient. Step-up services will help people who need extra support but don't need to stay in an acute inpatient facility. Step-down services allow tangata whaiora to move on from a stay in an acute inpatient facility, giving extra support as they move back into the community.
goal 7	Enhance the connectedness and sustainability of specialist care	Waikato DHB has started and will continue to develop service models that support prevention and early intervention by providing services in the community where clinically appropriate. In 2020/21 this has been successfully completed for: • The skin lesion service • Community referred radiology • Non-surgical COPD, respiratory service • Community prescribing pharmacists are now able to order selected laboratory tests and be accountable for results. A gynaecological theatre list was implemented at Thames Hospital to provide care closer to home, reducing DNA rates at Waikato Hospital while creating additional capacity within the Waikato district to provide care to more women. Clinical pharmacists are now able to better support patients with diabetes with HbA1c ≥80 by carrying out medication reviews, educating patients about their medications management and treatment in consultation with other health care professionals. The Waikato Primary and Community Health Care Alliance meet regularly and continue to work on a programme to implement new integrated models of care to improve access and health outcomes for Māori.

Locality development approach

A localities approach is the mechanism by which the DHB achieves its strategic direction to implement Te Korowai Waiora over a next 10 year period (2019-2029).

The DHB's locality development approach is intentionally consistent with the recommended Tier One networks of services set out in the Health and Disability System Review (Heather Simpson, 2020). The way in which services are provided in each locality and the timing of service development differ according to local need, preference and current levels of engagement.

The locality approach has seven key areas and below are highlights we have achieved in the last 12 months:

1. **Partnership with iwi**
   - In October 2020 Raukawa Iwi and Waikato DHB signed a Mahi Tahi agreement to guide the locality approach in the South Waikato area.
   - Increasingly Waikato DHB has been collaborating with local iwi to co-design and develop new services at a local level that reflect iwi priorities such as Mate Huka (diabetes screening); Whānau Pai (primary integrated mental health services); and Te Pae Tawhiti (mental health rebuild).

L-R: Raukawa Charitable Trust tumu whakarae Maria Te Kanawa, Dame Karen Poutasi, Raukawa Charitable Trust chair Vanessa Eparaima, Dr Kevin Snee signing the Mahi Tahi agreement.

2. **Identify iwi priorities**
   - Equity measures have been identified with seven priority measures agreed.
   - 'Service mapping' is being completed which shows the existing services provided within the locality, compared against the minimum core set of services.

3. **Locality leadership groups**
   - Raukawa Iwi has joined with the DHB to develop a local leadership group.

4. **Confirmation of local development priorities**
   - Sustainability funding has been successfully secured for two projects for Waikato DHB:
     i) Implement a research project with the Whānau Hauora Assessment tool in Waikato Hospital and Tokoroa Hospital to identify the impact social determinants of health have on urgent care demand for children 0-18 years.
     ii) Roll out the first phase of the Mate Huka diabetes screening project for Māori and Pacific in each area.

5. **Design services and networked system**
   - Service development continues while linking in with Te Korowai Waiora; this allows a whānau-centric localities approach which did not occur in the past. This now requires services to consider implementing new initiatives outside of Hamilton. The Planned Care Initiatives programme is a good example.
   - Mental Health and Addictions services have co-developed a number of service transformation projects in two localities – Hauraki and North Waikato – in conjunction with iwi and service users:
     - Creating a bi-cultural mental health and wellbeing service in association with iwi provider Te Korowai Hauora o Hauraki.
     - Participating in the establishment of a community hub in the North Waikato in collaboration with Matawhaanui Trust representing a cluster of marae. The aims are to provide integrated and connected care with other Waikato DHB and local services delivered closer to home.

- Established a step-up step-down service providing short-term sub-acute care in partnership with Thames Hospital. Piri ki te Kainga provides a recovery-focused mental health and wellbeing support to help whānau transition out of the acute mental health inpatient service (Henry Rongomau Bennett Centre) or avoid admission to the Henry Rongomau Bennett Centre.

6. Implement, review and reinvest

- Waikato DHB Rapua Te Ara Matua Equity Report 2020 has been approved and provides guidance on developing relevant outcome measures for the priority services in each locality network.

7. Build local integrated health and social service hubs

- The localities development approach is consistent with the proposed direction of the Health and Disability System Review and informs rural infrastructure planning and it is exciting being part of initial planning for transition.

Health system reform – transition period

Health New Zealand (NZ) will take over the planning, commissioning and other functions of the existing 20 DHBs. A Māori Health Authority will work alongside Health NZ to improve services and achieve equitable health outcomes for Māori.

Planning is underway while the public health sector is anticipating the significant changes in the health system and its operating environment as recommendations from the Health and Disability System Review, 2019 are implemented. The Waikato DHB will continue to support this transition with their staff and external providers until this changeover is fully established as Health NZ.

Community Health Forums

The Community Health Forums (CHFs) have been running for over 16 years and are one of the ways Waikato DHB engages with its consumers and communities. Each year Waikato DHB hold approximately 30 CHFs in 13 different towns across our urban and rural localities from Huntly in the north to Taumarunui in the south.

These public forums are facilitated every three to four months and have representation from our DHB commissioners group. They provide an opportunity to hear about what matters to local communities in regards to health, and enable communities to receive updates on what's happening in terms of Waikato DHB, and health service improvements. Understanding the unique characteristics each community represents is important in order to tailor responses to local needs, and provide true value and support to communities and to respond to their local health and wellbeing aspirations.

A lack of local access to some services, physical access as a barrier (i.e. transport) and mental health and wellbeing matters are regularly identified as issues by participants at forums in rural areas. As an example, in response to a local forum discussion, a mental health training session facilitated in June 2021 for the local rural community workers and families in Taumarunui.

Regional performance story

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

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

Regional Equity Plan

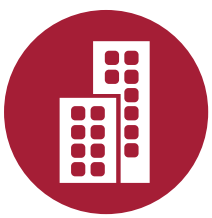
Te Manawa Taki iwi

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

Te Manawa Taki covers an area of 56,728 km^2, or 21 percent of New Zealand's land mass.

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

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



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

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

Transition from Regional Service Plan to a Regional Equity Plan

In October 2020 the Regional Equity Plan was released which enabled the transition from what was known as the Regional Service Plan previously. The Regional Equity Plan was a milestone as it improved the partnership between iwi and five DHBs while incorporating Te Tiriti o Waitangi. The equity plan also outlines a set of values (TAHI) that will guide the way that we work together.

T	**Tautoko** (mutual support) – of each other; supported by our commitment to mahi tahi (a united cause).
A	**Auahatanga** (innovation) – is at the centre of what we want to do; supported by our kaitiakitanga (shared guardianship of our mahi/work) role.
H	**Hauora** (Māori health and wellbeing) – is our priority; supported by our commitment to equity and rangatiratanga (partnered leadership) role.
I	**Ihi** – the power of our integrity towards each other and what we do; supported by manaakitanga (mutual support), whakawhānaungatanga (working together) and whakapakari (strengthening each other).

Establishing a foundation for the Regional Equity Plan begins by reflecting the aspirations and expectations of Māori. The word cloud below is from the DHB Māori health plans, which have been developed in partnership with iwi and demonstrates the common aspirations of whānau in Te Manawa Taki region.

Te Manawa Taki Governance Group comprises the four Board chairs and one commissioner of Te Manawa Taki DHB's as well as the five chairs of Te Manawa Taki Iwi Relationship Board. This 50:50 composition reflects a Te Tiriti o Waitangi-based partership.

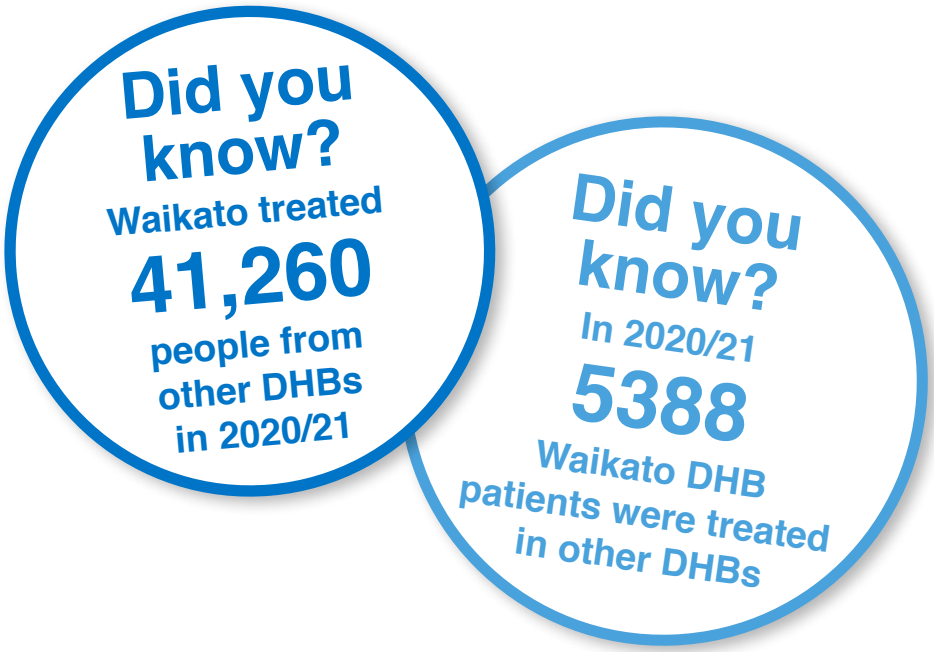
As Waikato DHB's representative the commissioner is responsible for informing the DHB of matters of significance, including risk mitigation strategies, for matters arising from the group's deliberations.

Three-year strategic plan

Te Manawa Taki Governance Group set out priorities and direction for the next three years. The top three service areas which were identified for achieving equitable health outcomes for Māori were:

- Mental health
- Child health
- Cancer

The full plan is published on the HealthShare website – healthshare.health.nz/our-priorities/enablers/planning-support/regional-equity-plan



National performance story

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

Accountability

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

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

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

Our performance story

National performance story

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

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Waikato DHB performance story

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

Service performance

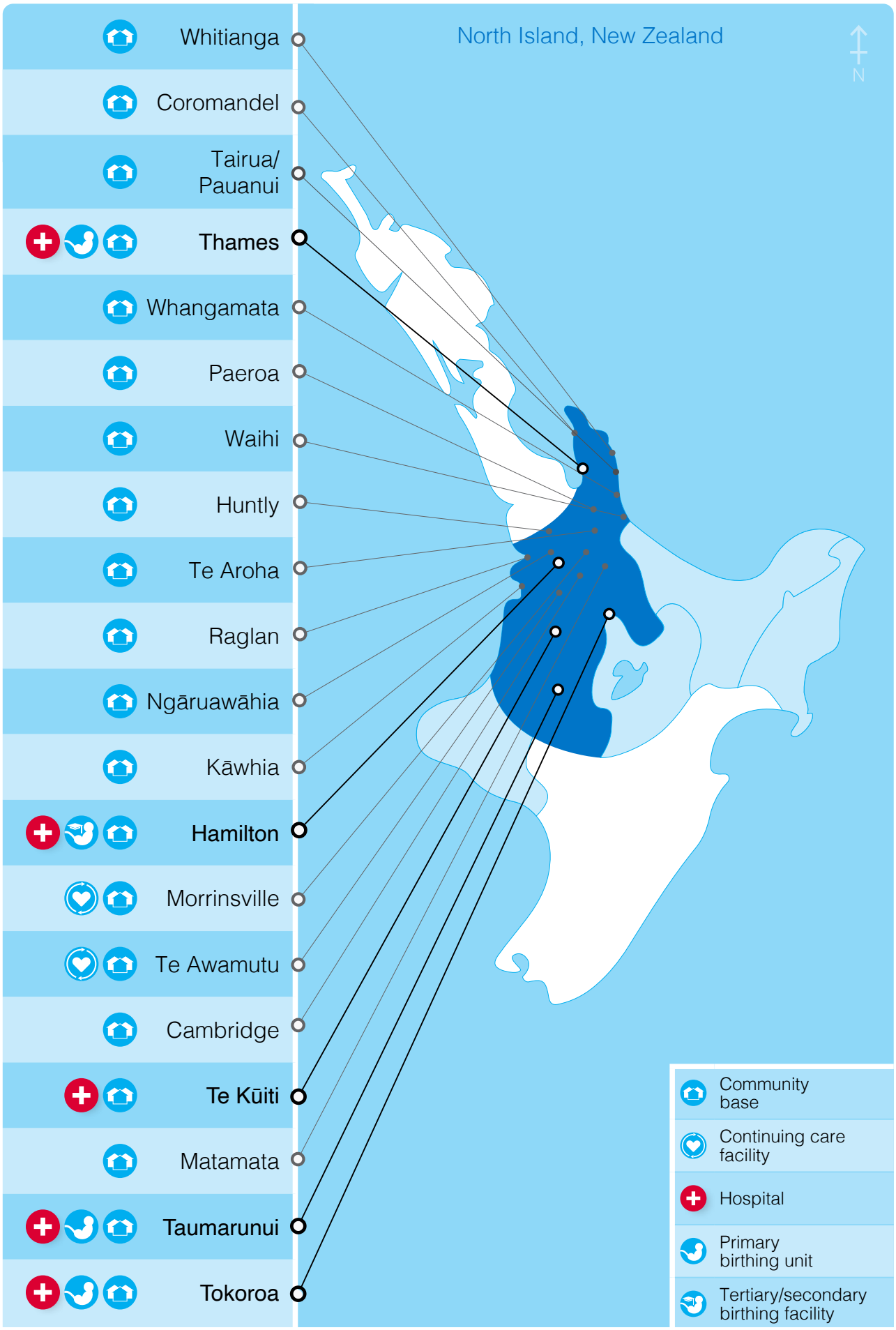
Long-term impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood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

Stewardship

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

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

Waikato DHB profile



Location and population at a glance

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

7 localities within our boundary

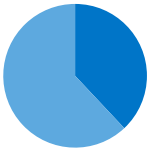
Our population in 2020/21 is 441,869

59% Urban

41% Rural

126,099

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



50,166 40% **Māori**

75,933 60% **non-Māori**

51% Female

49% Male

High deprivation as a percentage of total locality population

- **74%** South Waikato
- **59%** North Ruapehu
- **49%** Waitomo-Ōtorohanga
- **45%** North Waikato
- **35%** Thames-Coromandel-Hauraki
- **22%** Greater Hamilton
- **12%** Matamata-Piako

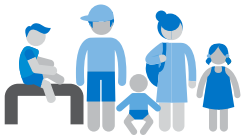
16.8% of our population is aged 65 years or over

25% **Māori population** compared to national average of 17%

Our ethnicity population make up

25% Māori

72% Other



27.4% of our population are under 20 years

3% Pacific

Population growth in the next 10 years

+9% Total

+22% Māori

+36% 65 or older

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

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

Waikato DHB covers almost nine percent of New Zealand's population, from northern Coromandel to close to Mt Ruapehu in the south. There are seven localities that make up our DHB. These are Greater Hamilton, North Waikato, South Waikato, Thames-Coromandel-Hauraki, Matamata-Piako, Waitomo-Ōtorohanga and North Ruapehu. We have a large proportion of people living in areas of high deprivation, the most affected localities being South Waikato, North Ruapehu and North Waikato.

Nearly 17 percent of the Waikato population is aged 65 or over. Our population will continue to get proportionately older (the 65 and over age group is projected to comprise 21 percent of our population by 2031). This, coupled with the increase in chronic and complex health conditions, help to direct strategies and plans being put in place to meet future health needs.

Twenty-five percent of the Waikato population are Māori. The Māori population is significantly impacted by many chronic conditions and are disproportionately represented in adverse health statistics. These facts, alongside the acknowledgement of the status of iwi in the Waikato, gives us a strong commitment to include and engage Māori in health service decision making; and to deliver health information and health services in a culturally appropriate way.

Pacific people represent just over three percent of the Waikato population and are a group that require targeted health initiatives.

Our workforce at a glance

Understanding the workforce composition is essential to delivering equal employment opportunities (EEO). Without such knowledge progress towards a diverse workforce that represents all groups throughout the DHB cannot be accurately measured. The following numbers are as at 30 June 2021 and include all active employees with the exclusion of parked employees (i.e. those on parental leave, yet to start, and those on career break leave) and contingent workers. As at 30 June 2021, Waikato DHB had 8199 employees with 6853.3 full time equivalents.

8199 Total employees

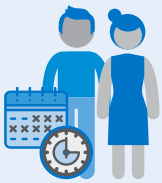
Employee diversity

45.8% NZ European
9.7% Māori
1.8% Pacific
42.6% Other

Employee age range

6.3% <25
25% 25-34
21.8% 35-44
21.4% 45-54
20.1% 55-64
5.4% 65 and over

Employment status



47.8% Full-time
48.4% Part-time
3.8% Casual

Employee type

48.2% Nursing
17.7% Management/ administration
17% Allied health
11.9% Medical
5.2% Support

Employee diversity

New Zealand European is 45.8 percent of the workforce and Māori is 9.7 percent.

Ethnic group	Headcount	Percent
NZ European	3758	45.8%
Asian	2132	26.0%
Other European	1171	14.3%
Māori	795	9.7%
Pacific	149	1.8%
Other ethnicity	84	1.0%
African	55	0.7%
Middle Eastern	36	0.4%
Latin American	19	0.2%
Total	8199	100.0%

Age range

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

Age range	Total	Percent
<25	516	6.3%
25-34	2048	25.0%
35-44	1789	21.8%
45-54	1758	21.4%
55-64	1646	20.1%
65 and over	442	5.4%
Total	8199	100.0%

Employment status

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

Status	Headcount	Percent
Full-time	3918	47.8%
Part-time	3966	48.4%
Casual	315	3.8%
Total	8199	100.0%

Employee type

Type	Headcount	Percent
Senior Medical Officer (SMO)	480	5.8%
Resident Medical Officer (RMO)	497	6.1%
Nursing	3953	48.2%
Allied health	1392	17.0%
Support	425	5.2%
Management/administration	1452	17.7%
Total	8199	100.0%

Employee exiting information

The table below shows the number of terminations for the past 12 months and the reasons for leaving recorded in the system (1 July 2020 to 30 June 2021, source: PeopleSoft). The top five reasons for why people left over 2020/21 are similar to the reasons stated for 2019/20.

The top five reasons people left the Waikato DHB for 2020/21 are:

- relocation
- end of temporary employment
- career progression
- personal reasons
- retirement.

Reason for leaving	Total
Relocation	268
End temporary employment	241
Career progression	208
Personal reasons	208
Retirement	123
Family reasons	108
Health reasons	64
Changed status to casual	40
Dissatisfied with work conditions	31
Further study	27
Resigned from parental leave	10
Career change	10
Reason unknown	8
Offer declined	7
Travel	7
Death	5
Elimination of position	4
Dissatisfied with type of work	3
Mutual consent	2
Unsatisfactory work relationship	1
Dissatisfied with manager/supervisor	1
Externally paid	1
Lack of career path/opportunity	1
Total	1378

Organisational and workforce development

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

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

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

We strive to:

- build a workforce that is representative of our community, with a specific focus on increasing our Māori workforce
- provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- ensure that the values of the organisation are demonstrated at all levels
- provide a healthy and safe workplace
- build the capability for all our employees enhancing their career development.

Leadership, accountability and culture

Waikato DHB continues to take an active role in work at national, regional and local level to implement the State Services Commission's framework for Leadership and Talent Development. Over the last 12 months we have worked alongside our leaders and managers to support them through a significant change process and develop resilience and skills to lead their teams through this change. We have also prioritised the development of specific manager and leadership development programmes based on feedback from the teams across the DHB.

Waikato DHB has an evolving self-service model, starting with myHR (for employee information) and myPeople (for people leader information) intranet pages and work will continue to be undertaken in the next 12 months to simplify and streamline HR business practices further. The Organisational Support directorate is focussed on removing bureaucracy and enabling our leaders and managers to coach and develop their teams.

Recruitment, selection and induction

The DHB has centralised the recruitment function ensuring robust recruitment processes are consistently managed across the DHB. All recruiting managers are required to adhere to the Recruitment and Selection Policy and to attend training on the Waikato DHB recruitment and selection process. This training specifies that those responsible for recruitment within the DHB must make fair, objective and informed selection decisions. Waikato DHB also complies with all relevant legislation when conducting recruitment activities. Our recruitment processes comply fully with safety checking regulations and the recently introduced Public Service Commission Workforce Assurance Standards.

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

Orientation and onboarding are being continuously improved and will be a focus for the next 12 months. Te Hono Whakataki, Our first meeting was launched in 2019 and this warmly welcomes new employees to Waikato DHB.

Te Puna Oranga's Puna Waiora has been developed for Māori secondary school students to facilitate Māori student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. The DHB also works with Kia Ora Hauora to support rangatahi into health.

Employee development, promotion and exit

Waikato DHB has a fair and equitable performance appraisal system in place which has recently been refreshed and will continue to evolve and roll out over the coming 12 months. Whilst the process is well documented and available to all staff the system does enable strength based conversations to occur on a more regular basis, where the staff member is able to identify personal development needs and document career aspirations.

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

SMOs are able to take sabbatical leave for the purposes of strengthening or acquiring clinical knowledge or skills or undertaking an approved course of study or research in matters relevant to their clinical practice. It is also a time for reflection and personal development.

Flexibility and work design

Following COVID-19 alert level restrictions, the need for flexibility across the DHB has increased as has the technology to support increased working from home opportunities. The DHB gives consideration to flexible work practices to accommodate staff wherever practical. Guidelines to assist managers to respond to requests for flexible work arrangements requests are available on the DHB's intranet.

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

Remuneration, recognition and conditions

Employee remuneration

Remuneration	2021 Actual	2020 Actual
Employee remuneration over $100,000 ($10,000 bands)		
100,000 - 110,000	453	365
110,001 - 120,000	230	216
120,001 - 130,000	139	116
130,001 - 140,000	99	94
140,001 - 150,000	77	74
150,001 - 160,000	50	47
160,001 - 170,000	31	38
170,001 - 180,000	30	28
180,001 - 190,000	40	27
190,001 - 200,000	19	18
200,001 - 210,000	14	19
210,001 - 220,000	24	18
220,001 - 230,000	23	28
230,001 - 240,000	22	28
240,001 - 250,000	29	31
250,001 - 260,000	31	23
260,001 - 270,000	23	17
270,001 - 280,000	28	19
280,001 - 290,000	20	15
290,001 - 300,000	15	24
300,001 - 310,000	31	23
310,001 - 320,000	18	21
320,001 - 330,000	17	16
330,001 - 340,000	13	12
340,001 - 350,000	8	9
350,001 - 360,000	16	17

Remuneration	2021 Actual	2020 Actual
Employee remuneration over $100,000 ($10,000 bands)		
360,001 - 370,000	9	10
370,001 - 380,000	15	10
380,001 - 390,000	8	8
390,001 - 400,000	6	2
400,001 - 410,000	7	6
410,001 - 420,000	2	4
420,001 - 430,000	4	3
430,001 - 440,000	5	2
440,001 - 450,000	2	3
450,001 - 460,000	4	3
460,001 - 470,000	4	1
470,001 - 480,000	2	2
480,001 - 490,000	0	2
490,001 - 500,000	0	1
500,001 - 510,000	1	2
530,001 - 540,000	0	1
540,001 - 550,000	1	0
560,001 - 570,000	0	1
570,001 - 580,000	1	0
580,001 - 590,000	1	0
610,001 - 620,000	1	0
620,001 - 630,000	0	1
670,001 - 680,000	1	0
690,001 - 700,000	0	1
860,001 - 870,000	0	1
1,230,001 - 1,240,000	0	1
Total	1,574	1,408

Between the 2020 to 2021 fiscal years the number of employees earning over $100,000 increased by 166, of which 78% related to clinical staff classifications.

Waikato DHB recognises the valuable contribution our employees make to patient care through recognition programmes and/or awards, including long service awards. The DHB has a number of communication channels available to all staff and key local health sector leaders which are effective tools in recognising staff and team achievements. These include telling the stories of success, innovation, achievement and excellence in patient care through our intranet, and within the executive updates sent as all staff emails.

Remuneration and rewards are decided fairly and equitably within the boundaries of the Collective Agreements for the vast majority of employees or in line with relevant employment agreements and the Waikato DHB Remuneration – Individual Employment Agreement Employees policy. The DHB also aligns to the PSC Governments Expectations around Pay restraint, and focussed this year on reducing any equity pay gaps based on ethnicity and gender.

The DHB has regular meetings with its union partners where views are exchanged and information is shared.

Harassment and bullying prevention

The Speaking Up For Safety programme has been running for a couple of years and is designed to support all employees to speak up when they experience or witness behaviour that may harm patient safety. Speaking Up For Safety was developed by the Cognitive Institute and has already been rolled out internationally as well as at other New Zealand DHBs. To date over 75 percent of our workforce have attended the training. This programme along with other initiatives over the next 12 months will ensure that we begin to truly embed and demonstrate the values and behaviours of the DHB.

Safe and healthy environment

In the past 12 months, the DHB has developed a broad Health, Safety and Wellbeing strategy, based on the findings from an assessment undertaken through Safe365 (an innovative online assessment tool aligned to the Health and Safety at Work Act and ISO 30001 and 45001 standards) and its critical risks. The Governance of the DHB is committed to ensuring that health and safety is embedded across the organisation and they have endorsed both the strategy and the action plan that supports its effective implementation.

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

The DHB promotes and provides opportunities for employees to participate effectively in the ongoing management and improvement of health and safety in the workplace via Health and Safety representatives and has recently established the Health and Safety Strategic Governance Group which has a variety of stakeholders including senior leaders, union delegates, Health and Safety representatives and Health and Safety specialists.

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

Systems are utilised by Waikato DHB to ensure that our people, prospective new employees, other clinical personnel, including locums and health care students are assessed, screened and vaccinated against infectious diseases prior to commencing employment or clinical placement. The DHB will be refreshing its current policy in regards to staff vaccinations to ensure that it now includes the requirement for a COVID-19 vaccine.

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

Governance and accountabilities

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

Te Tiriti o Waitangi is New Zealand's founding document and to ensure we, as a Crown entity, are adhering to Te Tiriti we have a governance relationship with local iwi/Māori through Iwi Māori Council, which has representatives from Pare Hauraki, Ngāti Maniapoto, Ngāti Tūwharetoa, Te Runanga O Kirikiriroa representing urban Māori, Pare Waikato, Raukawa, and Whanganui iwi.

Ministerial directions

Directions issued by a Minister during the 2020/21 year, or that remain current are as follows:

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

Some highlights from the year

Hauora project

In 2020 the Waikato DHB obtained sustainability funding for a number of projects within the organisation. These were:

1. **Equity hauora approach for whānau presenting to hospital Emergency Department project**

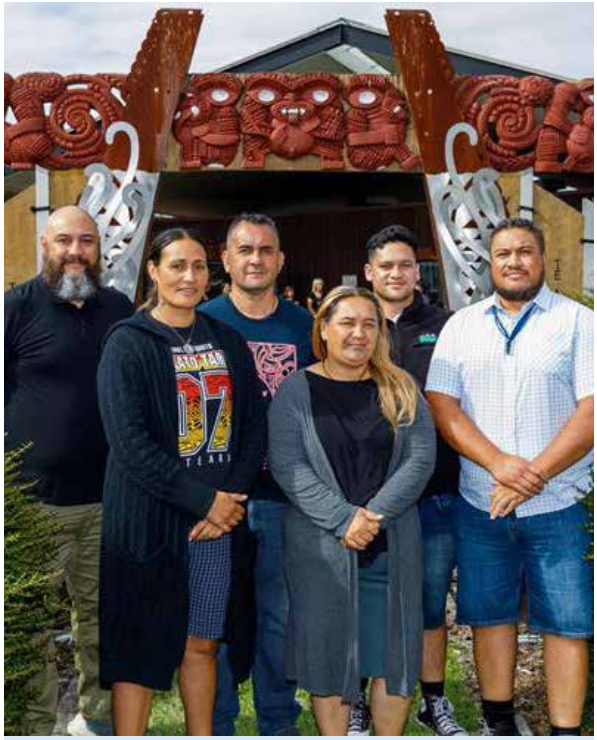
   The aim of this project is to proactively work in both an urban and rural setting to improve whānau access to their local health and social service providers to support and empower whānau to stay well in their local community. The site locations to pilot this are Tokoroa Hospital and Waikato Hospital Emergency Departments working with Māori and Pacific whānau and in particular 0-4 year old tamariki.

2. **Te Ara Hauora – Clinic attendance road map project**

   This Planned Care Initiative (PCI) project looks at increasing attendance at outpatient clinics. This initiative aims to improve the current model of outpatients clinical bookings to ensure that it is patient and whānau centred. This will improve inequities in attendance rates for Māori, improve access to clinics, timeliness and experience for Māori and Pacific whānau in the outpatient clinic attendance setting. This is a 12 month project with the plan to develop into a long term model of care. Added to page 44 of Annual Plan in comments

3. **Whānau Hauora Integrated Response Initiative (WHIRI) project**

   The aim of the Whānau Hauora Integrated Response Initiative project is to proactively increase access for Māori and Pacific whānau, to coordinated primary and secondary healthcare and social services/care and to identify and address unmet need. Our objectives are to rapidly address the inequities in the system for whānau by connecting whānau to appropriate services and reducing unnecessary hospitalisations and deterioration of chronic illness utilising the Whānau Hauora Assessment (WHĀ) and Whānau Hauora Rapid Access Pathway (WHRAP) – Equity clinical nurse specialist (CNS) led.



L-R: Waikato District Health Board psychiatric assistants Dirk Fletcher, Tiana Tuuta, Johno Elliot, Jan Heta, Rangi Stevenson and Vereene Elliot are in their first year of study to become registered nurses thanks to a new partnership with Wintec to upskill Māori healthcare workers.

New scholarships enable Māori health professionals to earn while they learn

Six Māori psychiatric assistants are now studying their way to a degree-level nursing qualification at Wintec that will progress their careers and create potential for better Māori mental health support. They are the first to gain access to 15 fully funded scholarships thanks to a collaboration between Waikato DHB and Wintec.

Waikato DHB knows that if we are to effectively care for the community we serve then it is important we have a workforce that reflects that population. That requires us to have Māori practitioners at every level of the health workforce, including in clinical positions.

The six new students have all been psychiatric assistants for many years and all work for Waikato DHB. While upskilling is attractive, it has never been an option because of their work and whānau commitments. Making time for study while they continue to earn is a priority for these scholarships and Wintec chief executive David Christiansen says the opportunity to earn while they learn was critical in developing the scholarships.

New Waikato Hospital training course to expand endometriosis care across Te Manawa Taki region

Waikato Hospital's Women's Health service continues to lead the way in women's health by establishing a Gynaecological Centre of Excellence which aims to improve the care and wellbeing of women across Te Manawa Taki region.

The major achievement of 2020/21 was the new Midlands Advanced Laparoscopic-Endometriosis Training Programme based at Waikato Hospital.

The aim of the course is to upskill surgeons from Te Manawa Taki region and reduce the need for patients to travel to Waikato Hospital for specialised treatment.

Ultimately women will have improved access to treatment for a condition that causes debilitating pelvic pain.

Participants work through a year-long modular system culminating in individual proctorship and accreditation in Surgical Leadership through Sydney's Macquarie University.

The course includes hands-on skill development in laparoscopic surgery techniques as well as detailed theoretical components which will improve the competency to treat endometriosis.

In addition, Waikato DHB has also increased to three full-time advanced laparoscopic surgeons who focus on women with endometriosis.

New mental health and addiction service for Thames

A new Step-Up Step-Down mental health service is open in Thames, offering mental health and addiction services closer to home. The Hauraki Step-Up Step-Down service, operating from the newly refurbished wing of Thames Hospital, is a collaboration between Waikato DHB, Te Korowai Hauora o Hauraki, Stepping Out Hauraki, People Relying on People (PROP). It enables service users/tangata whaiora to access support while remaining close to their family/whānau and other support networks.

Step-Up services provide support above what is generally available in the community, but where admission to an acute inpatient facility is not needed.Step-Down services allow tangata whaiora to transition following a stay in an acute inpatient facility, providing additional support and assistance as they re-establish themselves in the community. By providing earlier intervention through having services closer to home, the approach aims to reduce acute inpatient admissions and improve outcomes for services users.

Kaumātua lends voice to Waikato's bowel screening programme

A respected senior kaumātua to the Kīngitanga movement, is lending his mana and deeply personal story to support the National Bowel Screening Programme that was rolled out across the DHB takiwā from March for men and women between the ages of 60 and 74. The free programme includes an easy to use bowel screening test kit that can be done at home to help detect bowel cancer.

Survivor David Huti Waitere is urging people to whakarongo, kōrero and ako – listen to his story, open up and talk about changes in your bowels and learn from his experience 22 years ago. Mr Waitere was diagnosed with bowel cancer in 1999, aged 55, while he was still working fulltime in the agriculture industry. He was fit and had no obvious risk factors; he didn't smoke or drink and wasn't overweight. Mr Waitere was cured of his cancer following surgery. Gastroenterologist and Bowel Cancer Screening Programme clinical lead Dr Liz Phillips says she's grateful for Mr Waitere's courage in sharing his story and is thankful he was one of those who survived.

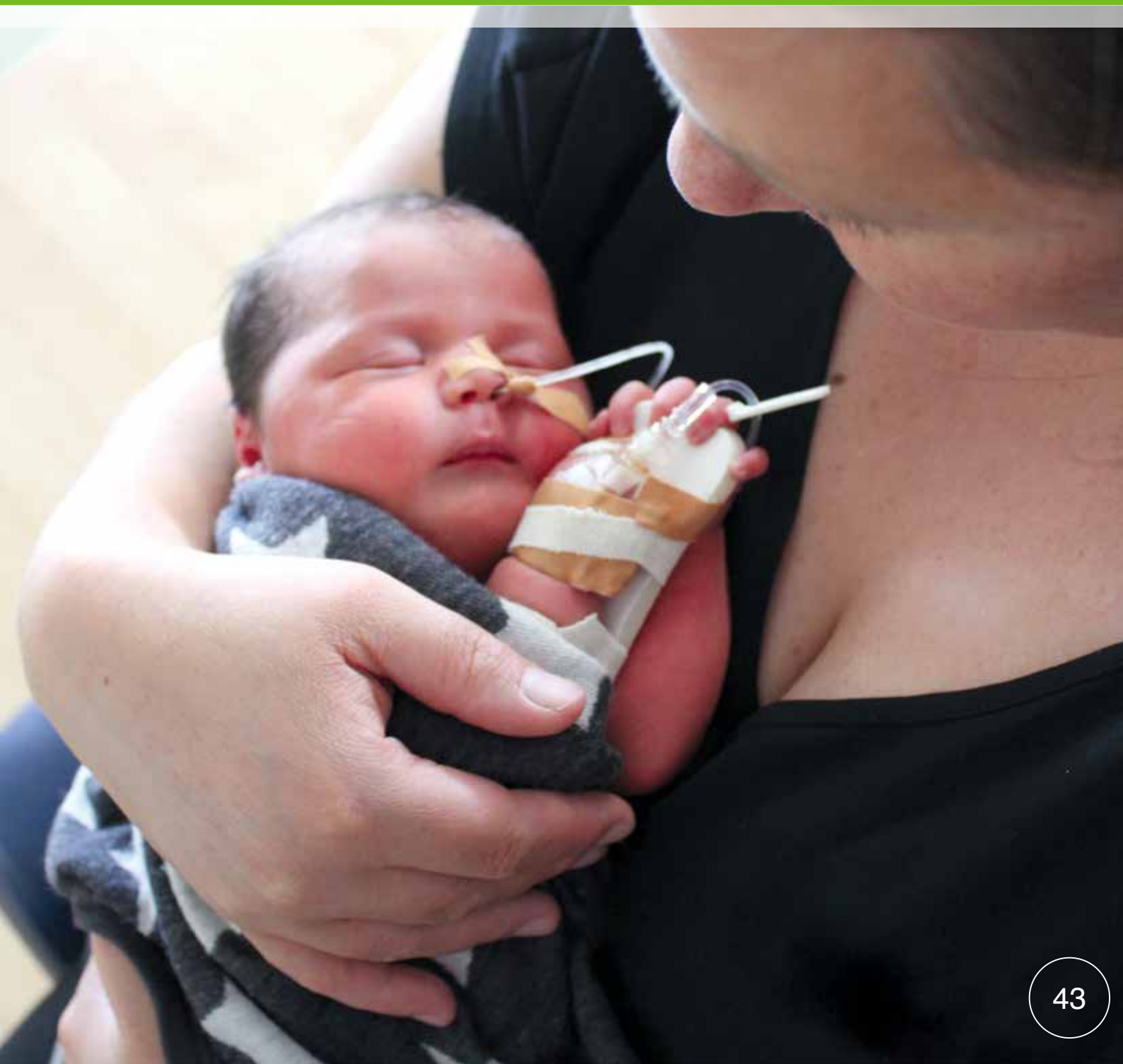
Each year around 3000 Kiwis will be diagnosed with bowel cancer, while more than 1200 will die from it. Bowel cancer, also known as colon, rectal or colorectal cancer, is the second-most common cause of cancer death in New Zealand. Dr Phillips says the programme saves lives by detecting possible signs of cancer early, meaning it can be cured in a less aggressive way than what Mr Waitere went through.

"The whole point of this programme is to raise awareness, to get people talking and to encourage each other to do the kit because while the chance of having cancer is slim the odds of picking up a pre-cancer and treating it is very high and we can prevent further deaths."

> Being the best at what you do best for my little man and giving me the strength to hold my little man when I was scared and insecure. I love and thank you for every day that you have helped him in every way.

Newborn Intensive Care Unit (NICU)

Part two: Quality and patient safety



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

Quality and Patient Safety completed a restructure in the second quarter of 2021 to align the provision of Quality and Patient Safety with the DHB organisational structure. This new structure includes the role of Quality and Patient Safety business partner which will work in partnership with services in the provider arm to enhance quality and patient safety. The business partners who will be employed in the third quarter of 2021 will be supported by the Quality and Patient Safety teams, consumer engagement, clinical effectiveness, risk management and infection prevention and control to ensure that quality and patient safety is an integral part of the business, working in partnership to enhance communication, analyse clinical issues and continue improvements across all DHB services.

Current priorities and achievements

Risk

During the year there has been a focus on communication and consultation to assist the relevant stakeholders to understand risk and the basis on which decisions are made and the reasons why particular actions are required. By providing a range of methods and techniques risks are having the correct treatment options applied to them.

By focusing on the quality of reporting rather than the quantity, there appears to be increased monitoring of risks particularly those 15 and above.

The IS outage in May was an unprecedented event which remains dynamic, very quickly a risk framework was incorporated into the CIMS process and a risk register was created with formalised reviews across multi-disciplinary teams.

The risks feed into the recovery prioritisation plan and are reported through the organisation via the agreed governance structure.

Patient safety

Deteriorating patient programme – year five of five

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

In support of this programme, 'nurse champions' are being established on all inpatient wards. This role will keep nursing staff up to date in all aspects of managing the deteriorating patient as well as supporting data collection to identify improvements needed or track the progress of changes made.

The **National Early Warning Score** for adults has been in use for three years. Quality and Safety Marker data shows that overall the process is effective in recognising clinical deterioration. Ongoing focus is needed to support timely escalation.

The **Maternal Early Warning Score** chart has been rolled out across the DHB and in the rural birthing facilities. Any woman presenting to the hospital, who is pregnant or within six weeks of having given birth, will have this chart used, in the Emergency Department (ED) as well as the inpatient wards. The parameters are designed specifically around the vital signs changes that are relevant to pregnancy and provide a significant safety net to recognising clinical deterioration early.

The **Paediatric Early Warning Score** chart is being developed by a national working group, with Waikato DHB representation included. It is anticipated this will be completed within the coming year.

The **Shared Goals of Care** is the last element of the Deteriorating Patient Programme and is currently in the planning stage.

Sepsis Ready programme

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

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

A Sepsis clinical nurse specialist (CNS) was appointed in January of 2021. Maintaining a focus on sepsis recognition and management is vital to ensuring ongoing success, sustainability and growth. With a strong clinical focus, the role aligns closely with the Infectious Diseases service and Infection Prevention and Control. Patients who suffer a sepsis event are at higher risk of hospital re-admission, mortality and morbidity. The CNS model of care reduces these risks by ensuring clinical expertise are available to support care both during and after a sepsis event. What this means is patients and their whānau have better support and access to outpatient follow up care, resulting in reduced risk and better health outcomes.

Choosing Wisely – year three of three

- This DHB-wide programme works with clinicians and consumers to embed Choosing Wisely; with a focus on reducing low-value care
- Better incorporation of IS solutions for visualisation of tests and investigations is required into this final year. Electronic routine reporting that can be stratified by ethnicity will show where any gaps in equity lie, as well as unexplained volume variances.

Choosing Wisely fits with the Shared Goals of Care model (recommended by the Health Quality and Safety Commission for patients who are deteriorating). While Choosing Wisely focuses on everyday provision of services, the principles of shared goals of care should underlie the basis for clinical treatment plans, thereby reducing patients receiving unwanted or unwarranted treatments. Developing shared goals of care for patients will actively support Choosing Wisely aims.

Patient experience

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

Patients and whānau often say 'something just doesn't feel right' and they are often correct, recognising subtle signs of patient deterioration in hospital, even when vital signs are normal. Failure to respond adequately to concerns raised by patients or whānau is commonly highlighted in Health and Disability Commissioner reports relating to adverse events associated with clinical deterioration.

Kōrero Mai is a communication process that enables whānau to escalate their concerns through a series of steps. It is anticipated that most concerns will be managed at the ward level though the final step is to call a phone number and activate an independent review. The escalation process is being developed with a group of consumers, using co-design principles. The consumer's lived experiences are invaluable to shaping both the process and supporting materials.

A pilot has been completed and the process is being rolled out across the DHB including rural facilities.

Improving communication with trauma patients and their whānau

TE MANAWA TAKI MIDLAND TRAUMA SYSTEM

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

Te Manawa Taki-Midland Trauma System and Quality and Patient Safety have been collecting patient and whānau experience of major trauma patients to identify where improvements in quality of care can be made. Research has shown that patient experience is positively associated with better health outcomes, better use of health resources, better adherence to medications and treatments and better use of preventative services and is now considered one of the central pillars of quality of healthcare alongside patient safety and clinical effectiveness.

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

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

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

Whānau are often the patient's advocate and it was not uncommon for them to feel left out of decision making and unable to advocate in the whānau's best interests. We are working with all stakeholders to improve the experience of our patients and whānau in this area.

We are appreciative of the generosity of time and openness of our patients and families who have been so willing to share their experiences with us.

Consumer engagement

This year the DHB has been developing a Consumer and Community Engagement Framework to define and support the way in which the DHB engages with our consumers and communities. It will set out the importance of partnership with iwi, the role of consumers in service improvement, and the role of communities in determining the delivery of healthcare in their locality, to support Te Korowai Waiora:

Examples of ways that we engage:

- Ensuring the voice of Māori, those with disabilities, and our rural communities are well represented by removing barriers to engagement
- Community Health forums throughout the Waikato where communities can communicate directly with the DHB about the things that matter to them
- Using consumer feedback, compliments and complaints to provide insights and opportunities for improvement
- Gathering patient stories and sharing them so that their experiences start discussions and highlight what matters to our patients and their whānau
- The creation of a 'Friends of the DHB' social media platform to enable productive discussion about things that matter to our community

Consumer voice

Consumer voice and insights are being used in many ways:

- Helping to inform planning for communities in line with Te Korowai Waiora
- Engaging consumer representatives on projects like Chronic Kidney Disease Model of Care and Te Manawa Taki-Midland Trauma projects where consumers are involved in co-designing solutions
- Driving improvement activities through Releasing Time to Care, including changing layouts of some public spaces, and minimising noise disruption in wards
- Using the National Inpatient Survey, conducted quarterly, to highlight where there are opportunities to improve, and where there are positive experiences. Despite the cyber attack preventing participation in a recent survey, in the last 12 months we have obtained information from over 700 inpatients about their experience

Consumer Council

Waikato DHB's Consumer Council is made up of representatives from around the region who have an interest in ensuring consumers have a voice in the design and delivery of health services. The Consumer Council have a priority plan that highlights three main areas of focus centring on equity: healthcare for Māori, rural access, and access for those with disabilities.

The Consumer Council have assisted in the development of a Disability Responsiveness Plan and have provided feedback for the equity plan. Members have standing roles in governance groups such as the Community Public Health Advisory Committees and Hospital Advisory Committee. They are involved in operational groups such as the Māori Equity Clinical Response group, set up to ensure equity is a key factor in the recovery from the cyber-security event, and the Renal Services Plan, aiming to improve delivery of renal services, particularly for rural patients.

Quality Safety Markers for consumer engagement

Waikato DHB continues to value the support from consumers and their whānau in co-designing new services and service improvements. Examples of this in the last year are:

- The Chronic Kidney Disease Model of Care
- Te Manawa Taki-Midland Trauma System development of patient diaries and support for patient transfers
- Closer to Home; working with patients, whānau and Māori providers to ensure mental health services are delivered in the most effective way
- Key Support Person role

Quality improvement around the organisation

Antimicrobial stewardship

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

The focus on antibiotics and related therapies includes:

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

Improving equity

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

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

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

Quality improvement around the organisation

Venous Thromboembolism

Venous thromboembolism (VTE) causes more deaths each year in the US and Europe than breast cancer, HIV disease and motor vehicle crashes – combined (Cohen, 2007). In the general population there is 1 case per 1000 people, however, patients with risk factors increase this rate. 60 percent of all VTE cases occur during or within 90 days of hospitalisation (Jha et al, 2013). Furthermore, active VTE prevention reduces this rate in 11 percent of high risk patients with no prophylaxis compared with 2.2 percent in high risk patients on prophylaxis – a five-fold increased risk (Barbar et all, 2010).

At Waikato DHB given our population and the expected incidence of 1:1000 in the general population we would expect 255 hospital-acquired VTE per annum and up to 8 deaths, of which approximately half are preventable.

VTE prevention is one of the highest ranked safety practices out of 79 practices evaluated and ranks for effectiveness (Shonjania et al, 2001). Using pharmacological or mechanical prophylaxis can reduce the rate in at-risk patients by 30-65% (Geerts et al, 2008, Shojania et al, 2004). Risk assessment can identify high risk groups thus reducing the risk of developing VTE.

A DHB-wide Venous Thromboembolism Risk Assessment and Prophylaxis Policy was reviewed and updated late last year which emphasises that all adult patients should be risk assessed for VTE, including bleeding risk, on admission, with appropriate prevention measures taken, and that this assessment should be repeated within 24 to 48 hours and in response to changes in the patient's clinical condition, and appropriate adjustments made. Waikato DHB is taking a systems-based approach to in-hospital VTE prevention, incorporating a whole of hospital and active multidisciplinary health care professional involvement.

Patient experience – feedback from some of our patients

KARL MUGGERIDGE

INTENSIVE CARE UNIT (ICU), HIGH DEPENDENCY UNIT (HDU) AND CARDIAC CARE PATIENT

> The way they supported me and my family, they couldn't have done any better. Everyone was awesome and so accommodating. I cannot thank everyone enough for saving my life and getting me through a lot of tough times.

CONNAR HOTENE-WILSON

WAIKATO TRAUMA PATIENT – INTENSIVE CARE UNIT (ICU) AND WARD M2 (GENERAL SURGERY) PATIENT

> It has been a real journey – I've come so far and I'm so grateful for the care I received at Waikato Hospital. I'm here now and better than ever thanks to them and the support from my family.

Priorities for 2021/22

Clinical governance

Collaborate with the DHB leadership team on the implementation of a robust clinical governance programme with aligned structures across the DHB to support the provision of high quality services that are consistent with the key principles of clinical governance as described in the HQSC clinical governance guidance for Health and Disability Services (2017).

Listening to our patients and community

Ongoing work to improve the partnership between providers and consumers. Delivery of Consumer and Community Framework and delivery of the Quality Safety Markers for consumer engagement.

Risk focus

To continue with communication and consultation to ensure that all relevant stakeholders understand risk and the basis on which decisions are made and the reasons why particular actions are required. Ongoing improvement of monitoring and reviewing of risks to ensure the effectiveness of the documented treatments and controls. Emphasis will be placed on the equity frame work from the IS outage risk register and ensuring that it is placed across all risks in the DHB.

Venous Thromboembolism (VTE)

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

Kōrero mai / Talk to me

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

Sepsis Ready

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

Choosing Wisely

Year three of three. Working with IS to finalise electronic routine reporting that can be stratified by ethnicity to show where any gaps in equity lie, as well as unexplained volume variances in relation to tests and investigations.

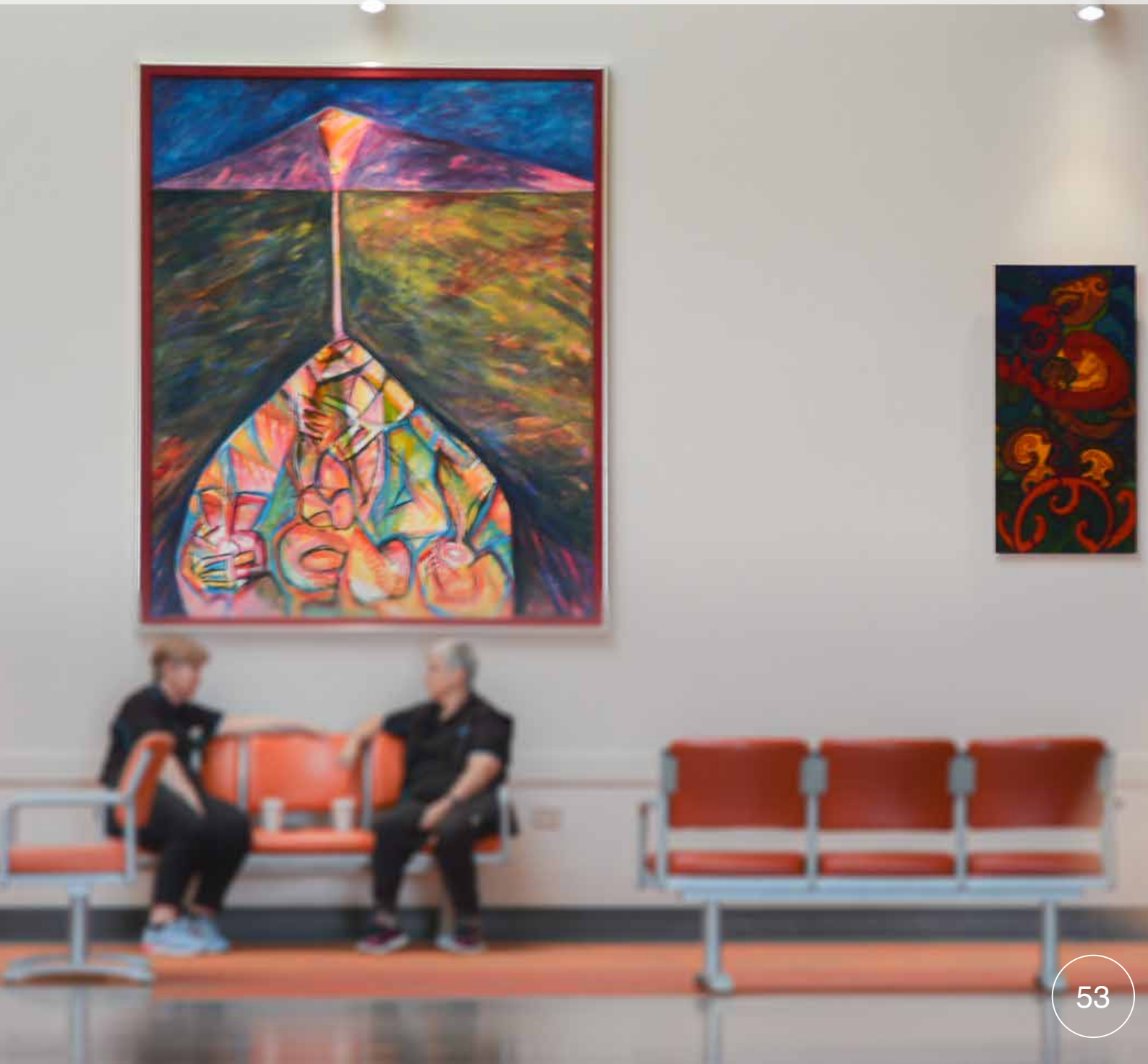
It was a real team effort. They were all exceptionally good and worked so well together to look after us all. They undertook their jobs with no time pressure or to make me feel rushed.

They struck a good balance for me with just the right amount of small talk. I am pretty easy going and like to crack a few funnies and the atmosphere that they have created there meant that I was in my element. It's relaxed, caring and friendly and not clinical at all.

From my 20 visits there, I never experienced a sad or angry face or any indication that someone was having a bad day. They were just so positive. Even the volunteers throughout the hospital were friendly and chat to you. I remember one of them commented on my Chiefs jersey and said 'go the Chiefs!' They made me feel like I wasn't just another number on their register.

Richard – Radiation Therapy

Part three: Statement of performance



Introduction

People are supported to take greater responsibility for their health

People stay well in their homes and communities

People receive timely and appropriate specialist care

Our service performance

The performance expectations reported on in this section articulate Waikato DHB's commitment to make positive changes in the health status of our population. The performance measures chosen are not an exhaustive list of all of our activity, but they provide a good representation of the full range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional, and local outcomes. Where possible, we have included with each measure past performance as baseline data to support evaluation of our performance.

Performance disclosure

2020/21 has been a year of challenges. We are exceptionally proud of the way Waikato DHB faced these challenges and of the way that our staff coped and worked together to overcome these as a team.

The COVID-19 pandemic saw outbreaks within our district and once again we saw our frontline essential service staff working together, committed to help those affected and focused on the delivery of care to our population. The fight against COVID-19 saw the start of the vaccination roll out across the Waikato. Before recruitment began for the vaccination team, existing employees were redeployed to help in both clinical and non-clinical roles.

Impact of cyber-attack

Another big challenge for 2020/21 was the unprecedented cyber-attack that affected our DHB IT system starting 18 May 2021. This prevented staff from being able to access online patient information, system portals, and tools which are all essential to the efficient running of day to day services. The outage also prevented the inputting of information as events occurred. All systems have now been restored and the quality of the data was not effected as an end result.

The data issues were resolved by staff inputting the back log of the manual data collected for patients treated during the system outage. The focus in this work was on ensuring data relevant for patient safety was prioritised. Waikato DHB is confident that the restored data is of the same quality as pre-incident and continued to complete checks while working with the Ministry of Health auditors to provide validity of the data. Waikato DHB engaged with external providers Ernst and Young and Microsoft to undertake an independent assessment on the system recovery activities. This included assessment of current risk management, and what new protocols and implementation guidance the DHB requires to ensure future risks were mitigated. These were managed and reviewed alongside the commissioners, chief executive and chief financial officer and from there we are able to confirm that our back-up was restored, systems are up to date and our results are accurate.

While delivery of some of our services was impacted by the outage this was managed by transferring patients to neighbouring DHBs for treatment where necessary and deferring some non-urgent appointments. Our core services were able to continue during the outage and this is further explored under each of the measures throughout this section.

Our impacts

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

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

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

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

Our outputs

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 of care and are applicable to all DHBs. Identifying a set of appropriate measures for each output class can be difficult as we do not simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. In order to best demonstrate this, we have chosen to present our statement of performance expectations using a mix of measures of timeliness, quantity and quality – all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the expected standard.

The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health impacts we are seeking over the intermediate and longer term. Additionally they cover areas where we are developing new services and expect to see a change in activity levels or settings over the 2020/21 year – and therefore reflect a reasonable picture of activity across the whole of the Waikato health system.

Our service performance – funding

The table shows the revenue and expenditure information for the prevention services, early detection and management services, intensive assessment, and treatment services, and rehabilitation support output classes. These output classes are consistent across all DHBs.

The budget figures are based on the Ministry of Health data dictionary definitions that were used to calculate the budget as presented in the Waikato DHB Annual Plan for 2020/21. Output class allocations are based on specific rules to separate and assign costs resulting in total revenue and total expenses that will be different to the statement of comprehensive revenue and expense.

Output class reporting is a different way of slicing information. We do not have embedded variance analysis in place, making it difficult to explain any variance and/or trends. The output class financial reporting for 2020/21 is built from an allocation of costs by responsibility centre and an allocation of revenue by purchase unit code.

Cost of service statement by output class for the year ended 30 June 2021

	Group 2021 ACTUAL	Group 2021 BUDGET	Group 2020 ACTUAL RESTATED
Revenue			
Prevention	31,680	33,896	28,833
Early detection and management	347,158	347,409	335,216
Intensive assessment and treatment	1,264,188	1,205,835	1,127,575
Rehabilitation and support	144,180	142,009	131,319
Total revenue	1,787,206	1,729,149	1,622,943
Expenditure			
Prevention	30,745	33,649	27,553
Early detection and management	355,115	342,385	331,556
Intensive assessment and treatment	1,281,314	1,224,731	1,253,821
Rehabilitation and support	160,048	157,384	145,425
Total expenses	1,827,222	1,758,149	1,758,355
Share of joint venture surplus/(deficit)	244	-	(14)
Surplus/(deficit)	(39,772)	(29,000)	(135,426)

People are supported to take greater responsibility for their health

Long-term impact	Intermediate impacts	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Babies who live in smokefree homes at six weeks
		Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking
		Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
		Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer (LMC) are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds
		Percentage of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time
		Percentage of two year olds are fully immunised and coverage is maintained
		Percentage of eligible children fully immunised at five years of age
		Percentage of eligible 12 year olds have received HPV dose two
		Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2020)
		The number of people participating in Green Prescription programmes
		Newborn GP enrolment rate at six weeks
		Newborn GP enrolment rate at three months

Why does this matter?

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

The likelihood of developing long-term conditions increases with age and these conditions are more prevalent amongst Māori and Pacific populations. With our higher than average Māori population (25 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.

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

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

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

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

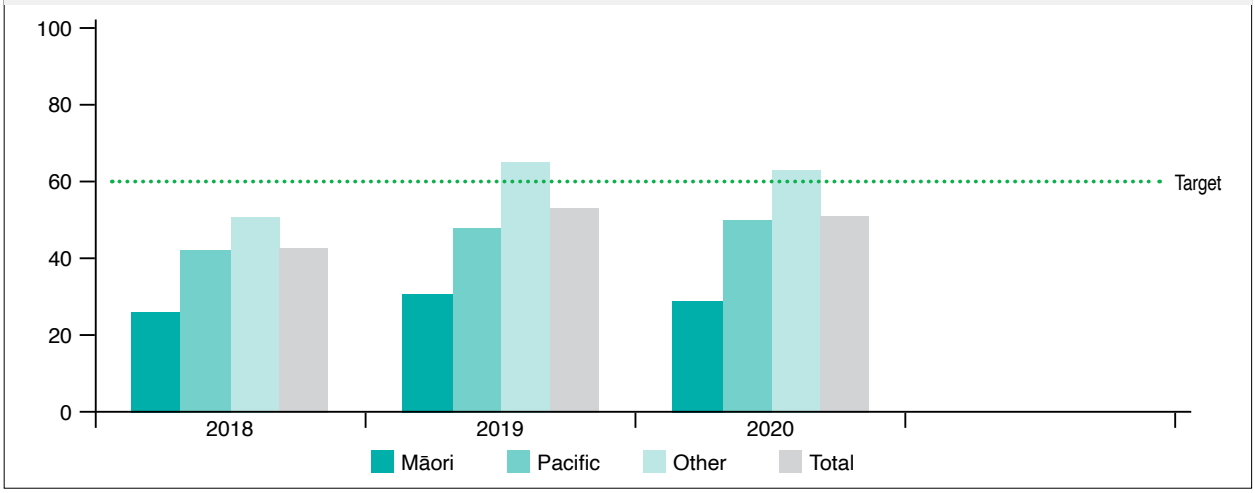
People are supported to take greater responsibility for their health

Fewer people smoke

Impact measure	Baseline 2018	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Babies who live in smokefree homes at six weeks	Māori 26% Pacific 42% Other 51% Total 43%	Māori 31% Pacific 48% Other 65% Total 53%	Māori 60% Pacific 60% Other 60% Total 60%	Māori 29% Pacific 50% Other 63% Total 51%	

Our performance

Percentage of babies who live in smokefree homes at six weeks 



Achieving the babies living in smokefree homes target is crucial in achieving the Smokefree Aotearoa 2025 target and to ensuring our tamariki have the best possible start to life. The data for this measures is based on the 2020 calendar year.

It is disappointing that there remains a high number of babies experiencing avoidable harm that can lead to poorer health outcomes and stubbornly high equity gap. Little change may be the expected outcome in a year where COVID-19 created much extra stress and anxiety for whānau.

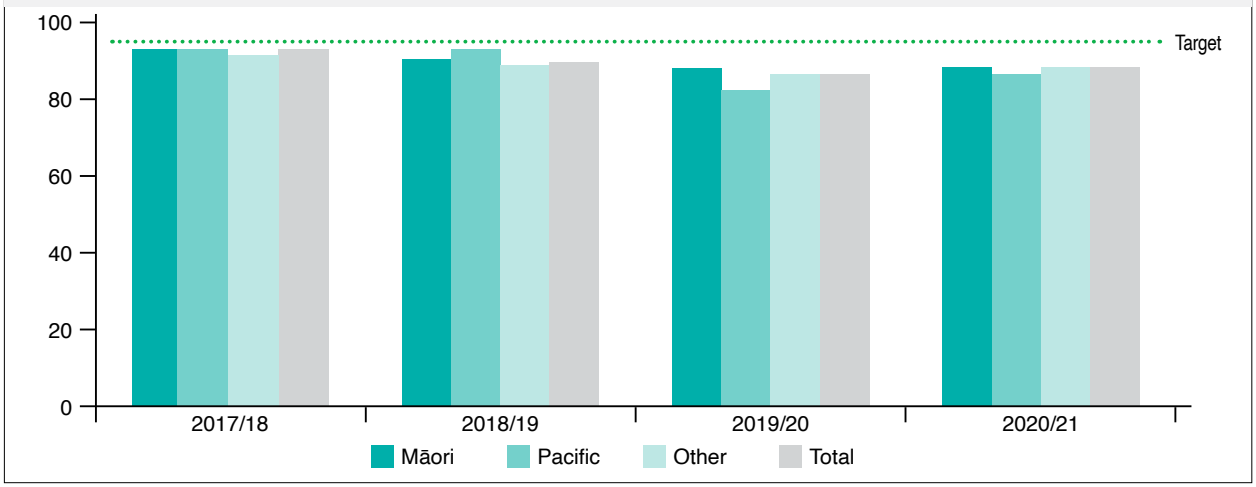
Waikato DHB and our PHO partners (through our System Level Measure plan) continue to target the equity gap that exists for this measure by trialling new initiatives such as Hapu Mama which includes incentivisation to quit smoking. An evaluation of the trial was to take place but has experienced delays due to the cyber-attack.

The focus for 2021/22 is to continue engagement with Lead Maternity Carers (LMCs), general practice and other health care professionals in maternity care to increase the referral rate of pregnant women to smoking cessation services. To stop smoking as early as possible creates the best possible start for newborns.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/April 21	Rating
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	Māori 94% Pacific 100% Other 91% Total 94%	Māori 87% Pacific 82% Other 86% Total 86%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 88% Pacific 86% Other 88% Total 88%	

Our performance

Percentage of hospital patients who smoke offered advice and support to quit



The overall target of 95 percent was not met, as we reached 88 percent of those hospital patients who smoke. Interventions for Māori sit at 88 percent and represent 27 percent of inpatient population. For Pacific people 86 percent received interventions and they represent up 13 percent of our inpatient population over the last 12 months.

There are no obvious gaps in equity for Māori to access smokefree options, with interventions at the same level for Māori as 'Other'. Referrals for Māori to stop smoking services are higher each month as are the referrals of pregnant Māori women. Our ward kaitiaki are trained in ABC smoking cessation and refer Māori directly to the stop smoking services and advocate for nicotine products for whānau on wards. ABC is a tool that nurses can use to help people to stop smoking.

The 'opt off' referral system to encourage pre hospital smokefree admissions continues to work well. From all areas including emergency departments, doctors make 40 percent of referrals, nursing staff 50 percent and allied 10 percent which indicates the ABC guidelines of smoking cessation are followed by clinical staff.

Motivational conversations make it easier for staff to engage with people who smoke, are not ready to quit and might have previously refused referral. The non-judgemental engagement takes pressure off people to commit to quit. Most people will accept the offer of follow up phone call from the 'experts' – community quit coaches, explaining the service and what they are entitled to. Work continues with primary care partners to encourage them to initiate smokefree pre admission using 'stop for your op' process and referrals. Waikato DHB remains the second highest referrer to stop smoking services in Waikato.

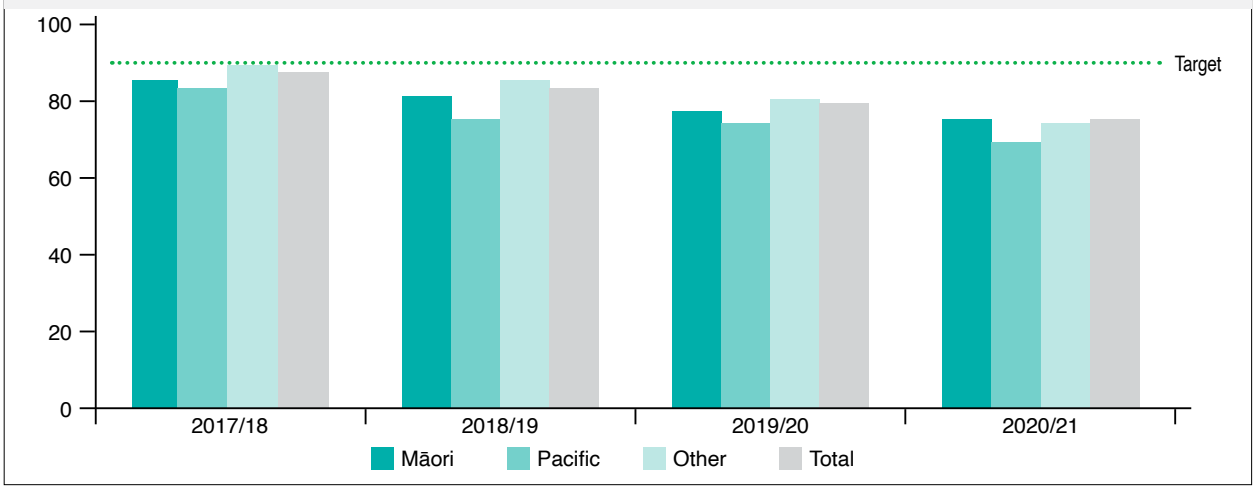
We are excited to build on any/all actions recommended from the Smokefree Aotearoa 2025 Action Plan due to be released by the end of 2021. We understand secondary and primary care has been carrying much of the burden for cessation to meet the 2025 goal of less the five percent of New Zealanders smoking. For this reason we look forward other innovations which will support the goal. With new innovations continuing to denormalise tobacco use, reduced access and the Smokefree Generation, the prevalence could drop rapidly starting in 2022.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	Māori 92% Pacific 91% Other 89% Total 90%	Māori 77% Pacific 74% Other 80% Total 79%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 75% Pacific 69% Other 74% Total 75%	

Our performance

Percentage of PHO enrolled patients who smoke offered advice and support to quit 



It has been disappointing to see results deteriorate from last year. The target remains a priority for Waikato DHB and work is underway with support from the Ministry. A number of actions have been identified as key to improving performance and will be a focus in the 2021/22 year:

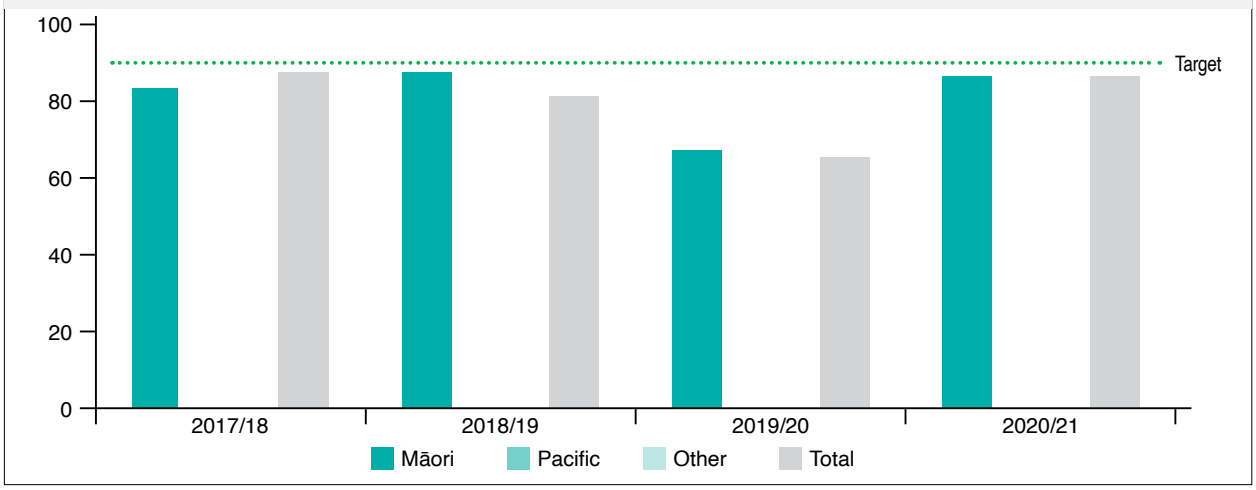
- Supply of NHI level ethnicity data related to prevalence and ABC (this is a reference to a smoking cessation approach to their practices). This will improve the practices' ability to improve cessation rates especially for Māori and Pacific patients
- PHOs will deploy strategies to improve practice engagement with the smoking cessation services
- Community pharmacies will provide brief smoking cessation advice, this approach has been used previously and appears to have good outcomes
- Waikato DHB is engaging with NGOs who work with Māori whānau and Pacific families to ensure they support smoking cessation activities
- All patients in secondary care (outpatient or inpatient) continue to be offered ABC and referral to cessation services

Waikato DHB will closely monitor whether the above actions improve performance throughout 2021/22.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking	Māori 64% Pacific N/A* Other 70% Total 66%	Māori 67% Pacific N/A* Other N/A* Total 65%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 86% Pacific N/A* Other N/A* Total 86%	●

Our performance

Percentage of pregnant women who smoke offered advice and support to quit ●



*The 2020/21 data is for Māori and Total only as this is what the Ministry of Health collates. This is a full picture of maternal smoking rates at the mothers' first presentation to a primary maternity carer.

Waikato DHB continues to prioritise maternal smoking as a key area to improve the health and outcomes for pregnant women and their babies. This is starting to show in our results where a large improvement can be seen when comparing to last year. Overall the rate of smoking during pregnancy has reduced year on year in the Waikato district and we are on track to achieving the target in 2021/22. While results are improving across the board there is still equity gap that remains between Māori and Other.

Maternity staff at Waikato Hospital and the primary birth centres are continuously encouraged to talk with women about maternal smoking and to also refer women to stop smoking services.

In addition a number of initiatives are underway to support improvements in maternal smoking rates with a particular focus on eliminating the equity gap.

One new initiative is the maternal smoking training that was delivered to LMCs in 2020/21, this training has been co-designed with Māori women and covers key topics such as: talking to women about maternal smoking, providing advice and Nicotine Replacement Therapy and referral to stop smoking services.

The training commenced covering two geographical areas with high rates of maternal smoking and will continue in 2021/22.

Both Waikato Plunket Whirihia and Waikato Hapū Wānanga include tobacco and pregnancy in their pregnancy and birth education programmes. These programmes include Kaupapa Māori led specialist stop smoking support for women and their whānau to be smoke free.

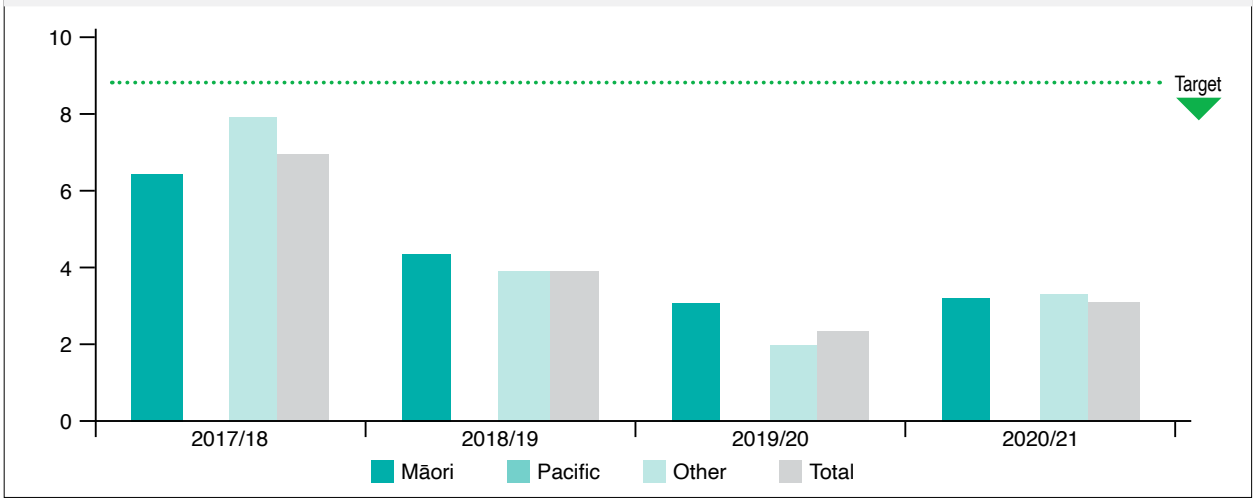
People are supported to take greater responsibility for their health

Reduction in vaccine preventable diseases

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds	Māori 19.4 Pacific 0.0 Other 4.5 Total 8.8	Māori 3.1 Pacific 0.0 Other 2.0 Total 2.3	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8	Māori 3.2 Pacific 0.0 Other 3.3 Total 3.1	● ● ● ●

Our performance

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



The rate of vaccine preventable disease continues to be low with the three year counting period seeing an increase of only one case.

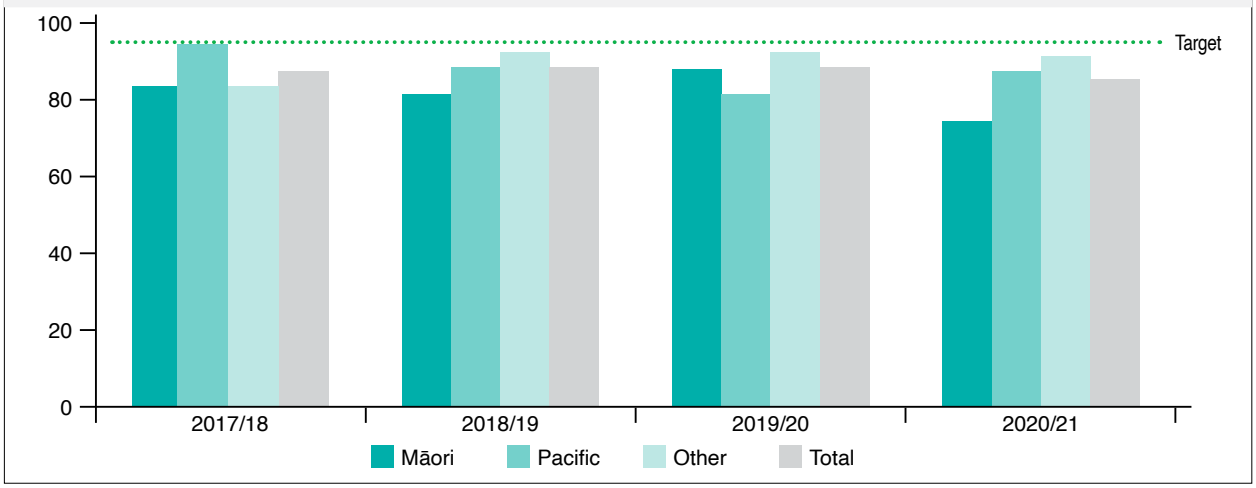
Although the low rates are very pleasing, it must be seen against a background of relatively low immunisation rates in the Waikato and across New Zealand particularly for Māori where there has been a sustained decline in immunisations rates at the eight month milestone since April 2020. The reason for the Pacific result showing 0.0 percent is that this is a very small population and they have a high immunisation rate which is pleasing to see.

Significant work continues with all major partners to help raise the immunisation rates and reduce the risks of serious diseases which can have deadly consequences for particularly the young, elderly and immune compromised in our community.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Māori 90% Pacific 95% Other 83% Total 91%	Māori 82% Pacific 91% Other 92% Total 88%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 74% Pacific 87% Other 91% Total 85%	

Our performance

Percentage of eight months olds will have their primary course of immunisation on time 



Though we have not met the target Waikato DHB continues to work with health partners to identify all areas in the system that can be improved to reduce barriers and increase the chances of timely immunisation. This starts with information for parents before birth, through enrolment with general practices, support and monitoring of every immunisation event.

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

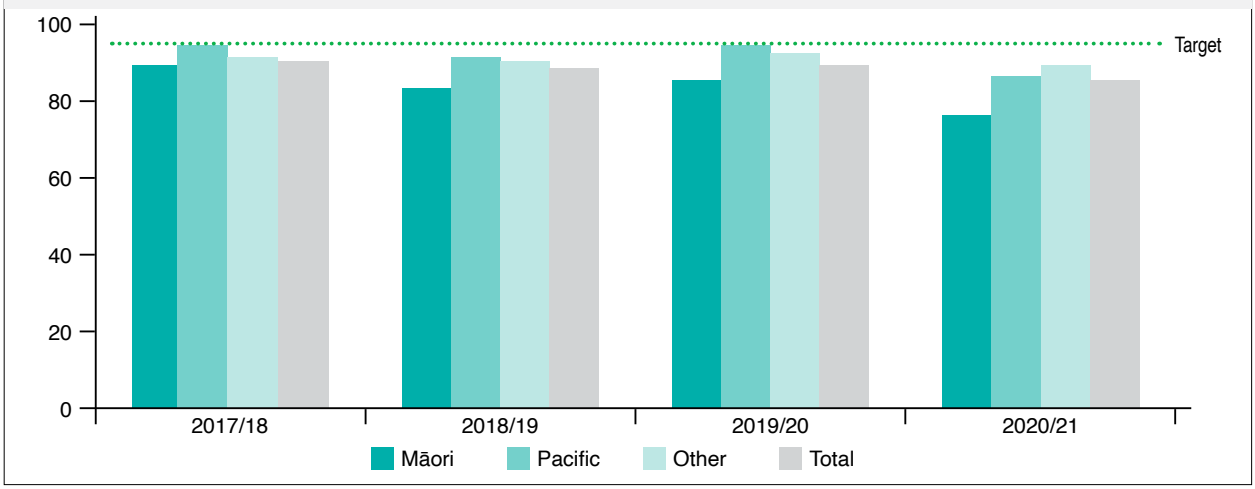
Our approach will continue to focus on general practice as the most significant provider of immunisation. However, we will investigate alternative approaches to immunise children where general practice has not been able to engage. Moving services to become more local and responsive will be key to engaging whānau and increasing immunisation rates.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of two year olds are fully immunised and coverage is maintained	Māori 91% Pacific 95% Other 91% Total 90%	Māori 85% Pacific 94% Other 92% Total 89%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 76% Pacific 86% Other 89% Total 85%	

Our performance

Percentage of two year olds are fully immunised 



Our performance remains lower than we wish to see, with an increasing equity gap, particularly for tamariki Māori.

The impacts of COVID-19 appear to be spreading into all vaccinations. Increasing misinformation is creating hesitancy and scepticism towards a wide range of proven safe vaccines. Coming years will require programmed and targeted communication to offset unfunded, unscientific social media commentary.

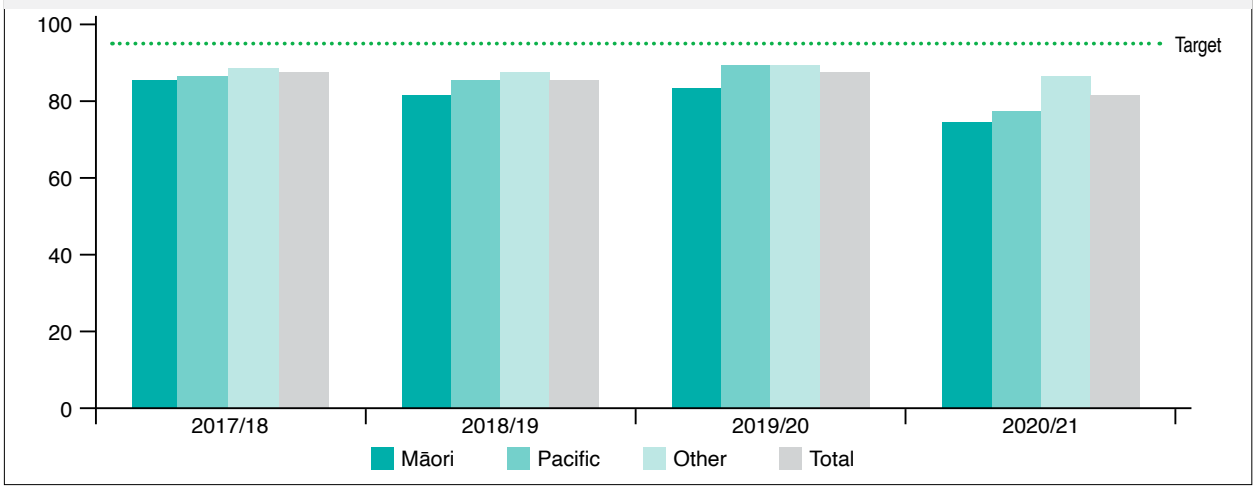
The focus remains on timely immunisation of eight month olds. The activities in the eight month immunisation target are designed to protect our most at risk as early as possible to reduce vaccine preventable diseases and the risks associated.

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

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eligible children fully immunised at five years of age	Māori 73% Pacific 78% Other 76% Total 73%	Māori 83% Pacific 89% Other 89% Total 87%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 74% Pacific 77% Other 86% Total 81%	

Our performance

Percentage of five year olds are fully immunised 



Our immunisation rates continue to decline across the whole population, particularly in the Māori and Pacific communities.

New Zealand is not unusual in this global trend as the anti-vaccination movement on social media coupled with the COVID-19 response has frequently been cited as impacting health sectors and adding pressure to systems around the world.

Our key partners in this work are our three PHOs through which we work with all the general practices to provide the first option for immunisation. Outreach immunisation services are also provided by the PHOs to assist whānau that have not had immunisation through primary care. We are working hard with these organisations to improve both primary care, outreach services, and the integration between the services to improve immunisation rates at each milestone (eight months, two years, and five years).

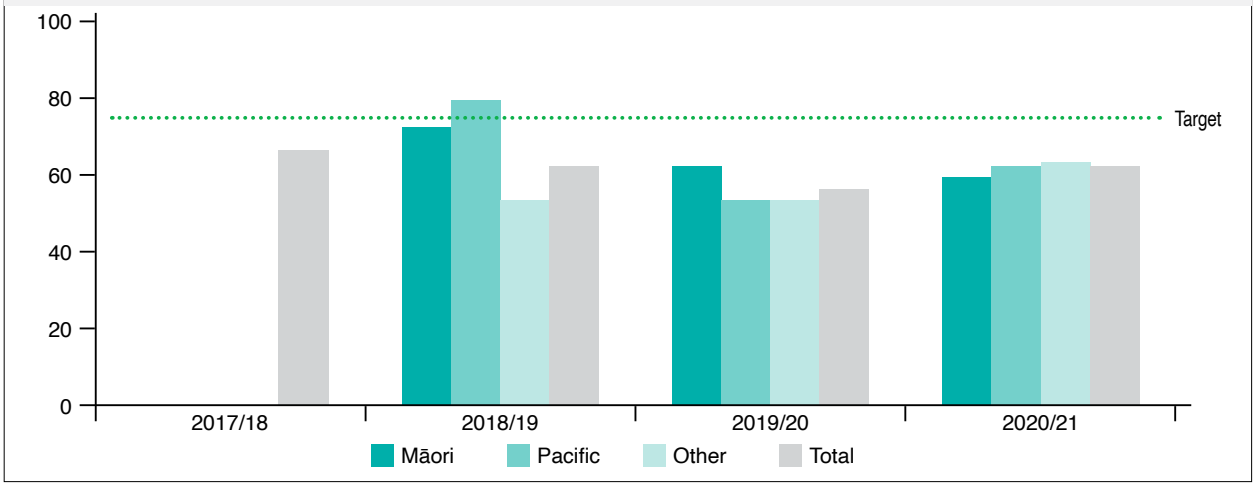
We will develop our Immunisation Improvement Plan to better meet the needs of Māori whānau by providing outreach immunisation services within a more holistic community based service model.

People are supported to take greater responsibility for their health

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eligible 12 year olds have received HPV dose two	Māori 70% Pacific 106% Other 62% Total 66%	Māori 62% Pacific 53% Other 53% Total 56%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 59% Pacific 62% Other 63% Total 62%	

Our performance

Percentage of eligible 12 year olds have received HPV dose two 



While we did not achieve the target this year it is positive to see significant improvement in the rate of Pacific and Other uptake. This year (2021) the fourth quarter Human Papillomavirus Vaccine (HPV) has been delivered over a longer timeframe with a smaller Public Health Nurse team due to half the public health nurses being in the COVID-19 vaccination teams. This will also have had an impact on our HPV results.

In June 2020 after the COVID-19 lockdown the public health service were able to engage with schools to complete the first dose of HPV and then again to complete the second dose before the end of the year. This required permission to give the vaccine with the minimum gap of five months and for the schools to agree to a change from normal. Schools were very supportive with the urgency of dose one at a later date this year and understood we needed to complete dose two prior to the end of the year.

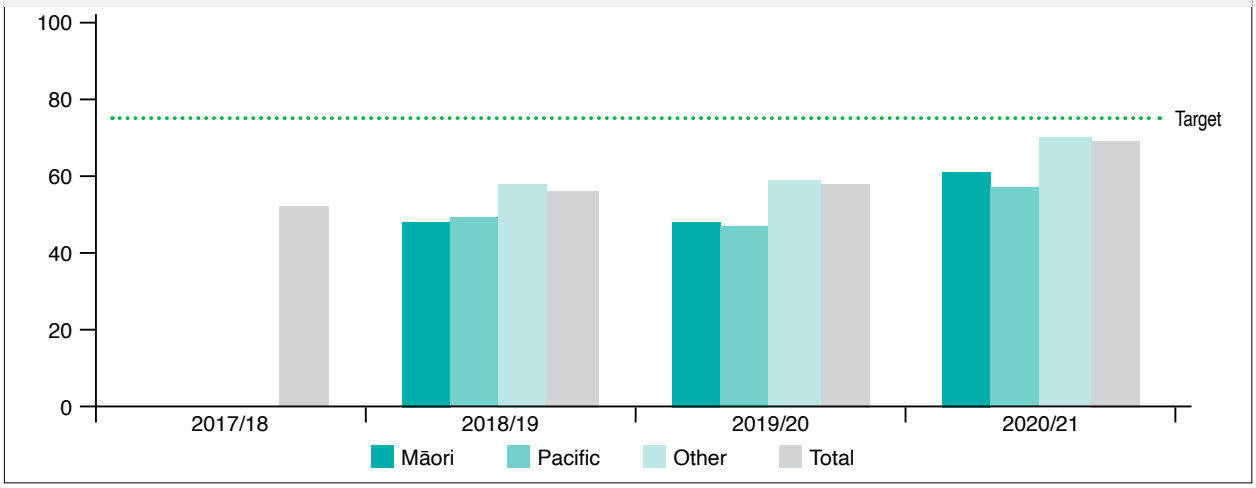
The school scenarios are similar around increased numbers of pupils so in some schools there are limited facilities for the service to use. This year in one large school, for dose one the Ministry of Education ordered a marquee which was placed on the school grounds so there was a vaccination venue. This support from the Ministry of Education was crucial to the students receiving their vaccination and much appreciated. We will use this method again for dose two in this facility.

There are still three small schools that do not participate in the HPV programme. They are encouraged to reconsider each year. It is important to do this annually as school staff and Board of Trustee changes can make a difference in the decisions made.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Seasonal influenza immunisation rates in the eligible population (65 years and over)	Māori 46% Pacific 49% Other 53% Total 52%	Māori 48% Pacific 47% Other 59% Total 58%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 61% Pacific 57% Other 70% Total 69%	

Our performance

Percentage of eligible population older than 65 years who have received the seasonal influenza immunisation



While we did not meet the target for 2020/21 it has improved from 2019/20. This was due to the extra activities taken place from the effects of COVID-19 from Māori and Pacific providers, Māori NGOs, PHO, pharmacy partners and age related residential care services to increase uptake.

Influenza is a significant public health issue causing ambulatory sensitive (avoidable) hospital admissions and significant work force disruption. The data for this measure is from the six month period from 1 March to 30 September as this is the 2020 influenza season.

Around 70 percent coverage of influenza immunisations is needed to reduce the incidence and spread of the virus in the community especially for those most at risk. Immunisations are provided by general practices and most Waikato pharmacies. All PHOs have annual recall and reminders in place and the pharmacies have national television advertising campaigns.

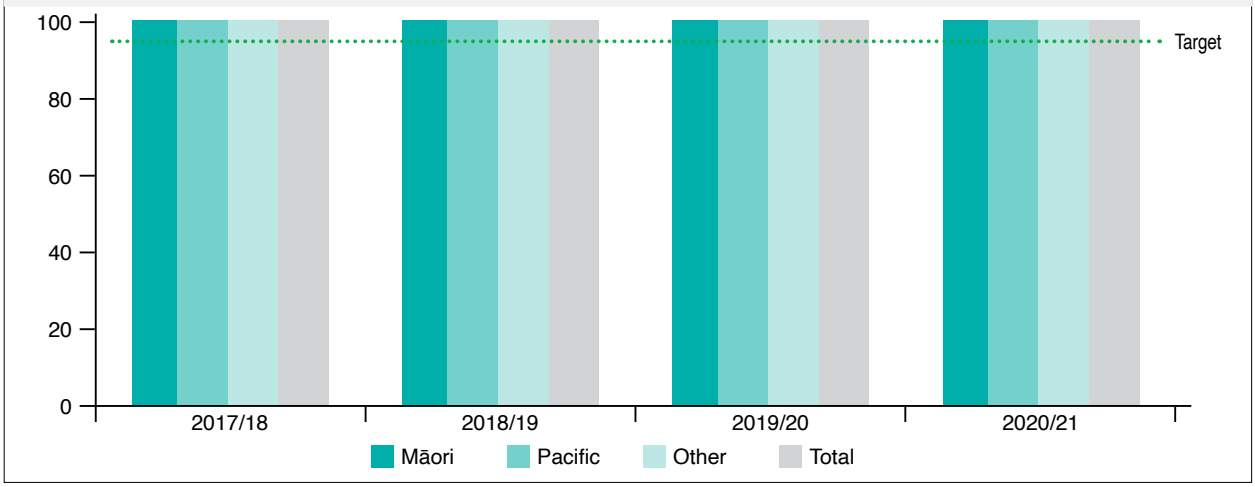
People are supported to take greater responsibility for their health

Improving health behaviours

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	Māori 7% Pacific 19% Other 8% Total 9%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 100% Pacific 100% Other 100% Total 100%	●

Our performance

Percentage of obese children identified in B4 School Check offered a referral ●



Waikato has consistently achieved this target with a 100 percent referral rate across all ethnicities. New Zealand has the second highest rate of child obesity in the world (UNICEF, 2019), with an estimated 31 percent of children aged between two to 14 years in the overweight and obese range (Ministry of Health, 2019). Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of premature onset of illness. It can also affect a child's immediate health, educational attainment and quality of life. In 2018 Waikato DHB implemented an Active Families programme suitable for younger children who are identified as having an unhealthy weight. The programme is called Whānau Kori Tamariki Ora – Active Families, Healthy Kids (WKTO) and focuses on supporting whānau to make healthy changes including food options, ideas to keep kids moving and active, reducing screen time and improving sleep. The programme ended in December 2020 following confirmation that funding would end. Referrals for tamariki identified as obese continue to be made, largely to general practitioners and practice nurses for ongoing care and advice.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
The number of people participating in Green Prescription programmes	5802	3196	On hold for re-scoping	N/A	

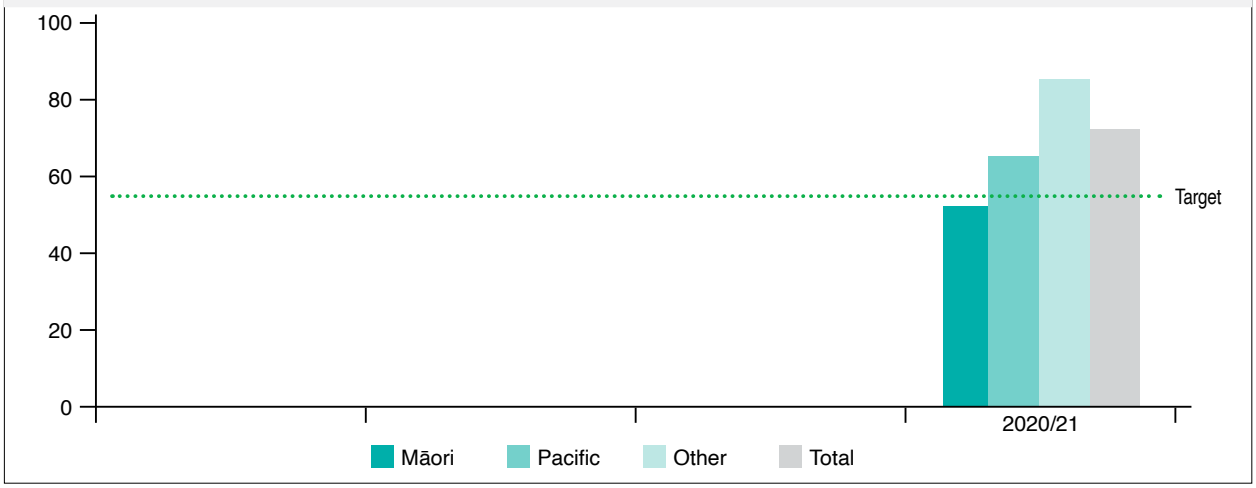
Our performance

Green prescriptions service was provided by Sport Waikato until December 2020. A service has not been offered in 2021 which has reduced the number of clients that have taken part in a Green Prescription. Waikato DHB worked closely with Sport Waikato to redesign how Green Prescriptions are delivered. From October 2019 Sport Waikato provided three levels of Green Prescription based on client needs and their support requirements. This allows longer engagement with the service, but for much fewer patients. The previous short intervention was not always long enough to embed habit changes into everyday life and make on-going and lasting health and nutrition improvements. This has particularly been identified as an issue for Māori clients. During 2021 Waikato DHB has been working with the Tainui waka iwi of Waikato-Tainui, Hauraki, Raukawa and Maniapoto to co-design replacement services that will better meet the needs of our communities.

Output measure	Baseline 2019/20	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Newborn GP enrolment rate at six weeks	Māori 7% Pacific 19% Other 8% Total 9%	New measure for 2020/21	Māori 55% Pacific 55% Other 55% Total 55%	Māori 52% Pacific 65% Other 85% Total 72%	

Our performance

Percentage of newborn GP enrolment rate at six weeks



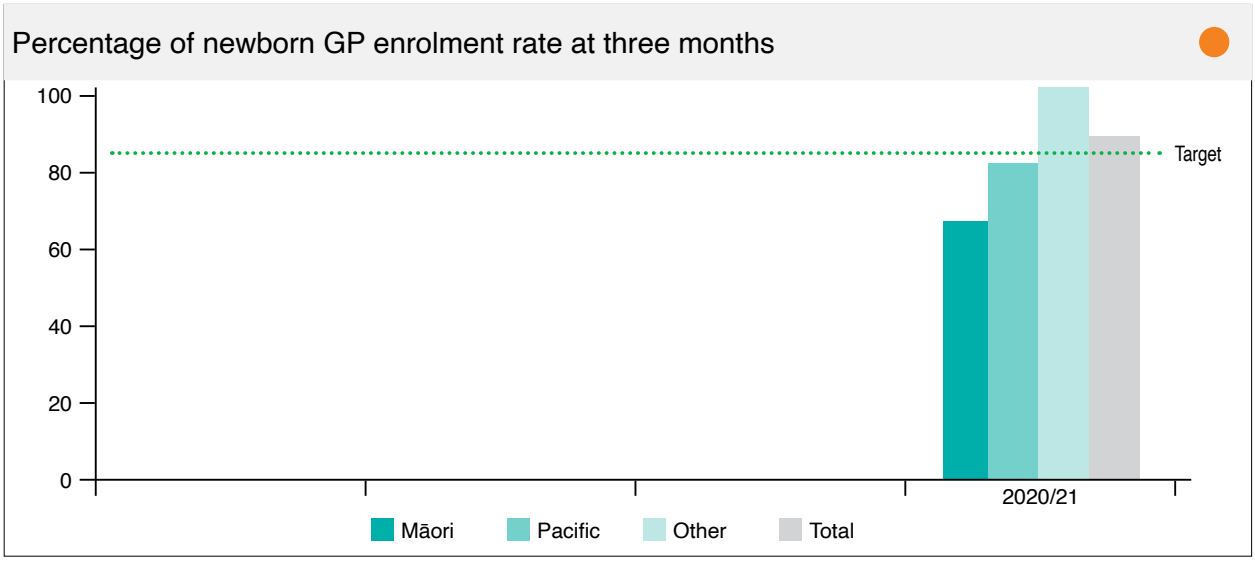
While we have achieved the target overall and improvements have been made across all ethnicities compared to last year, there is still an equity gap that exists for Māori and Pacific with enrolment rates being significantly lower than for 'Other.' In real terms this means to achieve the target for Māori an additional 65 Māori tamariki needed to be enrolled with a GP at six weeks.

The focus for 2021/22 is to work closely with our three Primary Healthcare Organisation partners to improve early enrolment for Māori and Pacific children and reduce the equity gap that is so clearly demonstrated by this data. Early enrolment is a key to getting access to healthcare and in particular early immunisation to give greater protection to the most vulnerable in our communities.

People are supported to take greater responsibility for their health

Output measure	Baseline 2019/20	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Newborn GP enrolment rate at three months	Māori 62% Pacific 78% Other 106% Total 86%	New measure for 2020/21	Māori 85% Pacific 85% Other 85% Total 85%	Māori 67% Pacific 82% Other 103% Total 89%	

Our performance



The results above are based on two data sets received from the Ministry of Health. Due to specific requirements of each of these data sets there are differences in when data is extracted. This can lead to the perception of more children being enrolled than are in a population group.

It is pleasing to see that improvements have been made from the previous year during a period that has continued to be impacted by COVID-19. Increasing the number of tamariki being enrolled early with a GP helps to provide the best start possible and allow our little ones to thrive.

The focus for 2021/22 is to continue working with our primary health care partners to develop the good work already underway with a focus on reducing the equity gap experienced by tamariki Māori.

People stay well in their homes and communities

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

Why does this matter?

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

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

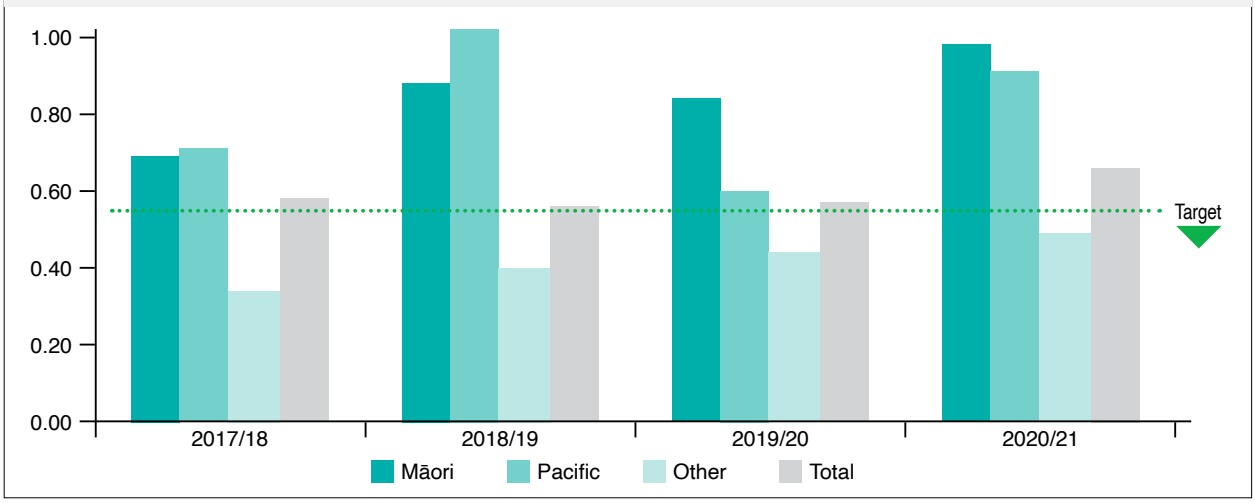
● We achieved the target	● We almost met the target (within 10 percent)	● We have not met the target

Children and adolescents have better oral health

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Mean decayed missing and filled teeth (DMFT) score of Year 8 children	Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.84 Pacific 0.60 Other 0.44 Total 0.57	Māori <0.55 Pacific <0.55 Other <0.55 Total <0.55	Māori 0.98 Pacific 0.91 Other 0.49 Total 0.66	 

Our performance

Mean decayed missing and filled teeth (DMFT) score of Year 8 children 



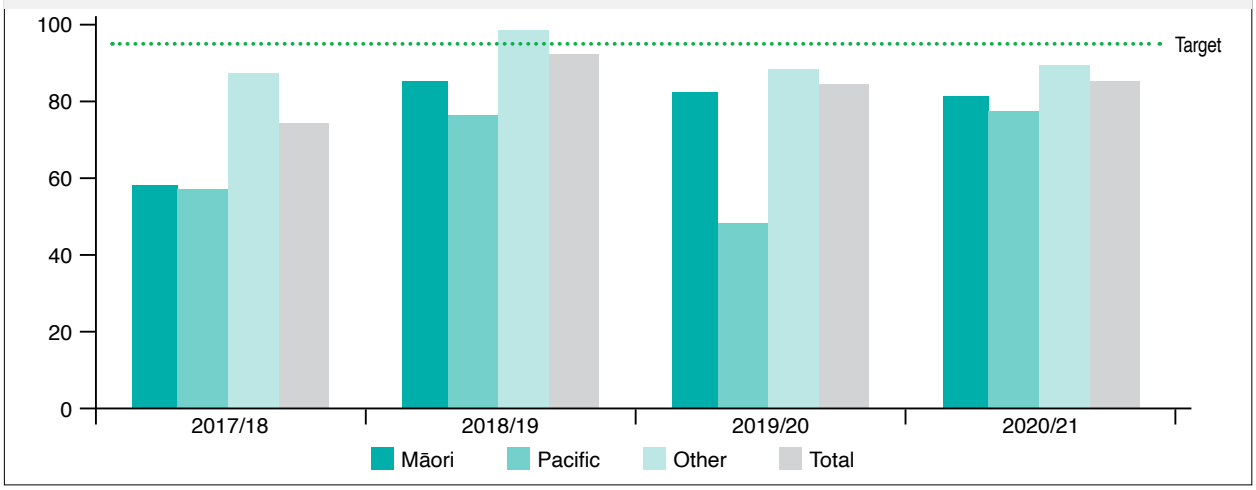
The above results are based on the 2020 calendar year and represent the measure of the mean number of decayed, missing and filled permanent teeth for 12-13 year olds. The cohort of Pacific children is relatively small therefore a small change in actual numbers can result in what appears to be a significant percentage change from year to year.

The increase in the mean DMFT for year eight children in 2020 compared to 2019 is largely due to the impact of the COVID-19 response which reduced dental care to emergency treatments only and closed schools during the higher alert levels. The growing inequality for Māori and Pacific children is of concern and will remain a focus during the coming year as the service moves to better meet the needs of children and their whānau.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of children (0-4) enrolled in DHB-funded dental services	Māori 72% Pacific 72% Other 72% Total 72%	Māori 82% Pacific 48% Other 88% Total 84%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 81% Pacific 77% Other 89% Total 85%	

Our performance

Percentage of children (0-4) enrolled in DHB funded dental services 



The above results are based on the 2020 calendar year and represent the number of children (0-4) enrolled in the DHB funded dental service. The cohort of Pacific children is relatively small therefore a small change in actual numbers can result in what appears to be a significant percentage change from year to year.

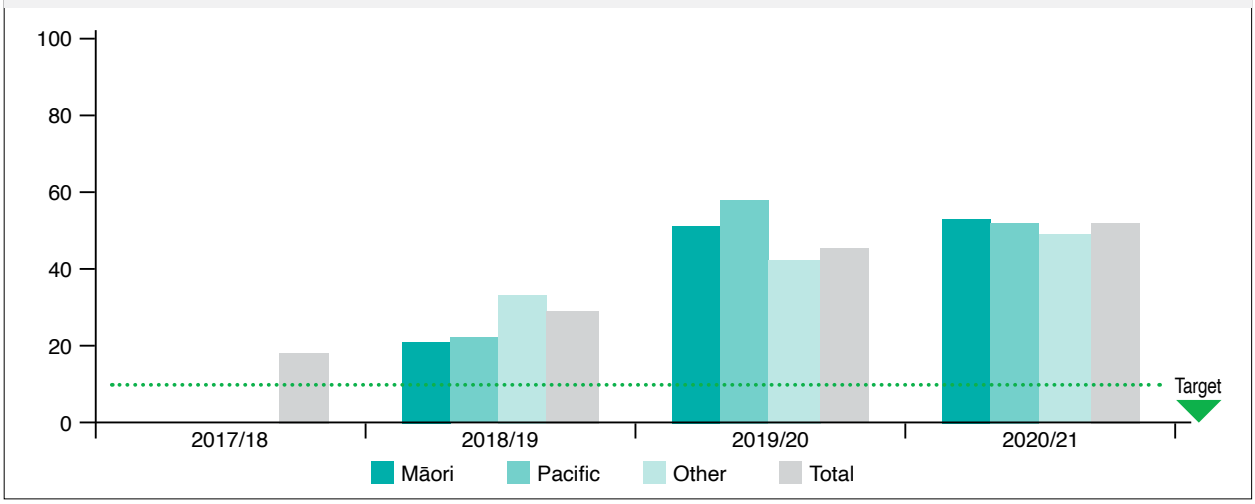
Waikato DHB has not achieved the targets against this measure in 2020 with a disappointing small decrease in Māori enrolments. However, the Waikato dental service has continued to make improvements to the rate of arrears through better service design and successful recruitment of staff who specifically target 0-5 year olds and getting whānau engaged with dental services early on. This early engagement provides opportunities to provide good quality education, prevention and treatment which will improve the oral health of tamariki in the long term. Improvements in enrolment rates will remain a focus for 2021/22 as early enrolment is key to prevention and early intervention.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori 18% Pacific 20% Other 25% Total 18%	Māori 51% Pacific 58% Other 42% Total 45%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori 54% Pacific 52% Other 49% Total 52%	● ● ● ●

Our performance

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



The above results are based on the 2020 calendar year and represent the number of children aged 12 and under who are overdue their scheduled dental examination. The cohort of Pacific children is relatively small (approximately 200 children) and can produce wide variation from year to year. It is disappointing to see the results have deteriorated further in 2020 against results in 2019.

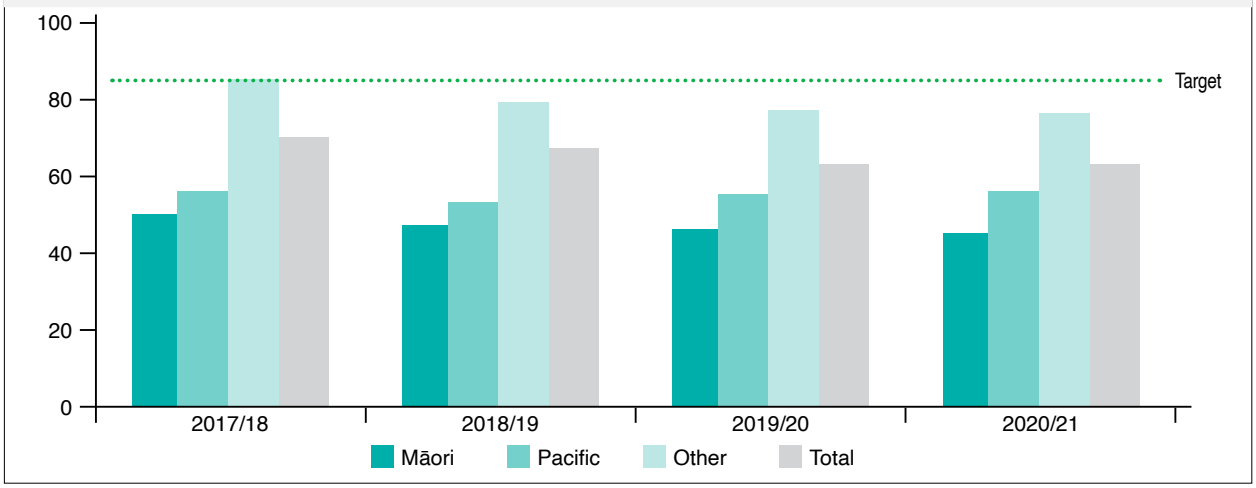
The COVID-19 response had a significant impact on the oral health service. Significant time was lost during alert levels three and four where dental treatment was restricted to emergency treatment only. This reduced the number of children that were able to be seen and increased the number that were overdue a check.

Significant planning and restructuring of the service is underway to provide better education and prevention that will allow resources to be better targeted for whānau where children have a higher risk of poor oral health.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of adolescent utilisation of DHB-funded dental services	Māori 45% Pacific 53% Other 80% Total 70%	Māori 46% Pacific 55% Other 77% Total 65%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 45% Pacific 56% Other 76% Total 63%	

Our performance

Percentage of adolescent utilisation of DHB funded dental services 



The results are based on interim data for the 2020 calendar year to line up with the school year. While Waikato's rates remain above the national New Zealand average it is disappointing that there has been a decline in adolescents who received dental care and the equity gap for Māori remains high. Adolescent engagement with dental services remains a challenge across New Zealand. This has been particularly so during 2020 with the COVID-19 lockdown disrupting dental services.

Effective partnerships are also an essential part of providing the best service possible. Waikato DHB take part in regional and national forums which provide opportunities for sharing approaches, successes, challenges, and opportunities to learn from each other about how uptake can be improved.

We remain committed to increasing adolescent utilisation of DHB funded services knowing good oral health during childhood and adolescence is an important indicator for good lifelong oral health and will continue to focus on improving our results in the coming year.

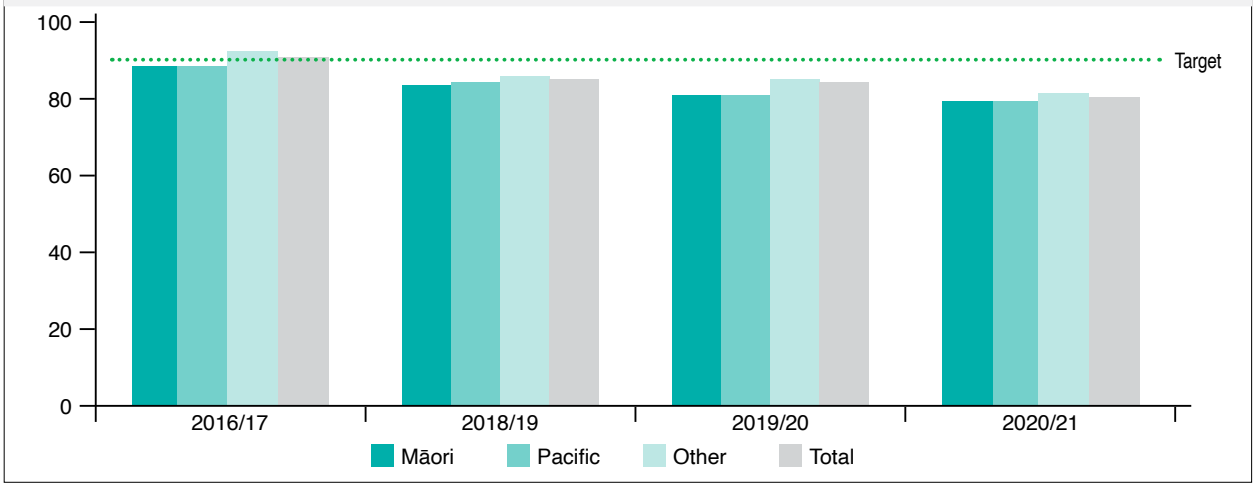
People stay well in their homes and communities

Long-term conditions are detected early and managed well

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percent of the eligible population who have had their cardiovascular risk assessment in the last five years	Māori 87% Pacific 88% Other 91% Total 90%	Māori 81% Pacific 81% Other 85% Total 84%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 79% Pacific 79% Other 81% Total 80%	

Our performance

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



It is disappointing the target has not been met and that results have declined compared to the previous year. Throughout 2020/21 there were significant events that required a shift in focus away from some system level measures of which this is one. COVID-19 testing and vaccination programme took priority and when Waikato DHB suffered the cyber-attack systems were inaccessible for several weeks with disruption still ongoing at the end of 2020/21. It cannot be underestimated how much these events affected planned activity through the requirement to re-prioritise workforce and resources.

In the Waikato district cardiovascular disease accounts for a high proportion of amenable mortality (avoidable deaths) rates, particularly for Māori. This is why it has been a key focus for PHOs and general practices to work alongside Te Puna Oranga (Waikato DHB Māori Health), local iwi and the wider Waikato network to reach high needs populations, especially Māori whānau to achieve the 90 percent CVDRA target. This collaborative approach will remain the focus in the coming year as it is well known that supported general 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.

To help improve CVDRA rates all PHOs now have IT systems including interactive dashboards, Mohio, patient prompts, and up to date performance statistics to assist them to identify current and new eligible patients and offer a CVDRA.

Further to this all Waikato PHOs are now using the national cardiovascular disease (CVD) risk calculation tool which was launched by the Ministry in March 2021.

To help improve results in the future Waikato DHB will continue to fund all Māori and Pacific providers with a range of agreements which support wellbeing and people with long term conditions. These include amongst others, Whānau ora services, Long term conditions nurses, Pacific nursing services, Mobile nursing and kaiāwhina services.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past five years	74%	65%	90%	61%	●

Our performance

Māori men aged 35-44 are the most at risk population group for CVD. 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 therefore ensuring this high risk group have access to and complete regular CVDRA is of great importance. The result for this measure continues to be disappointing and will require a whole of system approach to improve.

While two PHOs reported results of 82 percent and 72 percent, one PHO reported a significantly reduced result of 31 percent despite their efforts which include incentivising their general practices to complete CVDRA checks for Māori men aged 35-44. To improve results and care for this target population in 2021/22, this PHO will be shifting the measure of CVDRA performance to align with the clinical guidelines around follow ups. This includes; patients with a CVD risk score of greater than 15 percent should be followed up annually compared to someone who scores less than three percent should be followed up every ten years.

The overall focus on this target will remain and be monitored through the System Level Measure plan which is co-developed by Waikato DHB and the PHOs and reported against quarterly. A number of activities have been agreed for 2021/22 including:

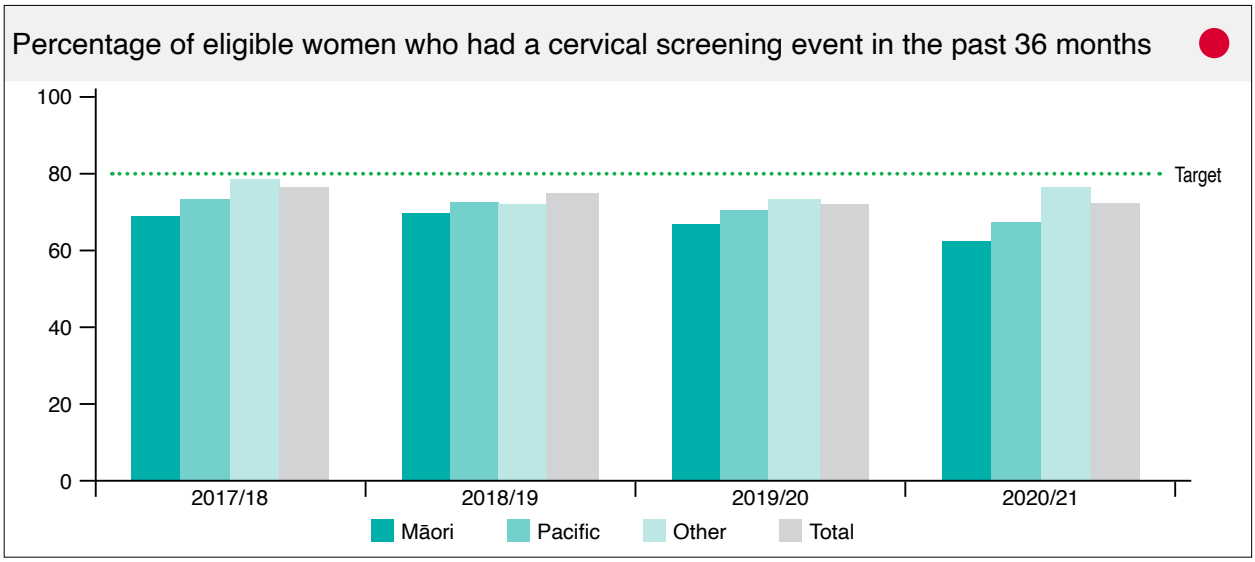
- linking with local iwi to identify Māori males in the 30-44 age group
- PHOs will provide proactive information to their practices that this high risk group need contact and follow up
- increased opportunistic screening
- PHOs will continue to educate general practice teams in the Equally Well approach to improve access to CVDRA for Māori men with serious mental health issues
- ethnicity based reporting will be completed to monitor and improve equity gap

It is expected that by working together Waikato DHB and our PHOs partners will be able to improve services for Māori men in this high risk group and significantly improve performance in 2021/22.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	Māori 60% Pacific 65% Other 80% Total 74%	Māori 66% Pacific 70% Other 73% Total 71%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 62% Pacific 67% Other 76% Total 72%	

Our performance



While we have not achieved the target we are in line with the national average.

Many opportunities have been identified for 2021/22 despite the challenges faced with COVID-19 lockdown and COVID-19 vaccination roll outs. Some of the challenges that continue to impact the result for this target include the COVID-19 lockdowns and vaccination roll out requiring resource to be re-prioritised.

To improve results over the past year our three PHO partners have had a focus on increasing screening participation, particularly for Māori and Pacific where a significant and persistent equity gap exists. To assist PHOs Waikato DHB has been and will continue to provide monthly data reports and support general practices on the use and benefits of these reports. Through the use of social media targeted awareness, education and clinic information is being communicated. The story from one of our young local wāhine and her cervical cancer journey has been captured and will help spread the message on the importance of screening and will go live on social media in early 2021/22.

The DHB and PHOs have also been working in partnership to ensure that wāhine who are overdue for screening are identified and supported to access screening services. Collaborative screening opportunities with PHO and DHB screening services have seen us more in the community which is essential to limit access and cost barriers and to normalise the importance of screening and prevention. We will be extending our support to regional and rural practices in 2021/22, in collaboration with our PHO partners, with a dedicated plan on providing opportunistic cervical screening alongside the breast screening mobile visits in areas with high target populations.

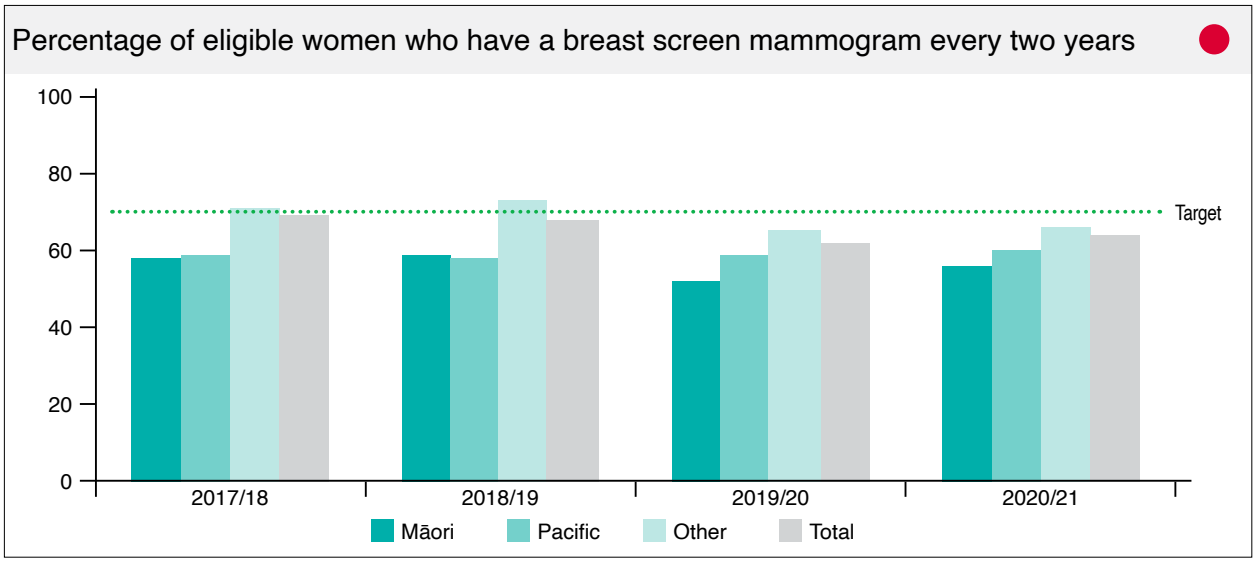
Community events where opportunistic screening was provided include Waka Ama 2021, Fieldays and marae. Waikato DHB also partnered with K'aute Pasifika to hold a weekend screening clinic and plan to hold more in the future while also holding more events in 2021/22 with the Smear Your Mea campaign. Further initiatives to increase screening include a bi-monthly newsletter for practice staff, screen-takers and health promotion, which is proving popular. This covers refresher of information around support to screening, claiming, data match reports, regional and national awareness, tips and advice.

With our joint approach and many initiatives, we expect to see improved results in 2021/22.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eligible women aged 50-69 who have a Breast Screen Aotearoa mammogram every two years	Māori 58% Pacific 60% Other 70% Total 68%	Māori 52% Pacific 59% Other 65% Total 62%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 56% Pacific 60% Other 66% Total 64%	

Our performance

Percentage of eligible women who have a breast screen mammogram every two years



While we have not achieved the target this year many activities have taken place to improve results and many opportunities have been identified for 2021/22 despite the challenges faced with COVID-19 lockdown and recovery.

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

To try and increase screening targets a number of engagement activities took place including the coordination of well attended Mana Wāhine days, staff attendance at public events to promote breast screening, supporting targeted awareness campaigns to improve screening participation and strengthening of community engagement in South Waikato. BreastScreen Midland also worked on improving Kaitiaki support during the mobile visits in Te Kūiti and Tokoroa, which saw an average of five percent increase in Māori screening participation than the last visit.

Opportunities to make the service more accessible were also identified and implemented. Some of the key actions include implementing a pro-equity BreastScreen Midland invitation process, providing opportunistic screening through the Hauora iHub, increasing Saturday dual screening clinics (breast and cervical screening), scoping up other possible mobile sites around Hamilton to improve Māori screening, and more convenient parking facilities outside the Breast Care Centre.

To help eliminate the equity gap BreastScreen Midland is seeking to recruit into a new equity lead position to lead and support improving Māori breast screening coverage, with a focus on Waikato DHB. BreastScreen Midland will also continue to work closely with the Ministry of Health on strategic policies for breast screening, focusing on opportunities to improve rescreening rates for priority women and strengthening vulnerable workforces. Collaboration with, and the providing of training and support to PHOs for their Support to Screening service contracts has been successful and will continue.

The focus for 2021/22 will be to work on increasing community engagement in areas of highest need and improving the service from enrolment to screening for wāhine Māori.

People stay well in their homes and communities

Fewer people admitted to hospital for avoidable conditions

Impact measure	Baseline 2018	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Ambulatory sensitive hospitalisation rate per 100,000 for 0-4 year olds	Māori 10,531 Pacific 10,942 Total 9260	Māori 8387 Pacific 8852 Total 7008	Māori 9927 Pacific 10,924 Total 6423	Māori 6591 Pacific 7008 Total 5662	● ● ●
Impact measure	**Baseline 2018**	**Previous year 2019/20**	**Target 2020/21**	**Result 2020/21**	**Rating**
Ambulatory sensitive hospitalisation rate per 100,000 for 45-64 year olds	Māori 9081 Pacific 7446 Total 4451	Māori 8726 Pacific 9000 Total 4335	Māori 9384 Pacific 9999 Total 3858	Māori 7914 Pacific 7258 Total 3770	● ● ●

Our performance

It is pleasing to see that we have met all of our targets. It shows that working with communities, general practice and hospital services is helping to achieve these targets. Early intervention and a reduction in risk factors help ensure patients who need services can have these provided in community settings rather than in hospital.

It appears our community based interventions targeting rural, remote and high risk populations of Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe are making some contribution to prevent ED presentations and hospitalisations. DHB and primary care have developed a partnership to further improve and promote referrals to healthy housing options. We have implemented interventions such as collaborating with Kainga Ora to instigate referrals through the patient's practice for immunisation and hauora checks. With also the redirection of referrals to general practices which provides care closer to the person's home.

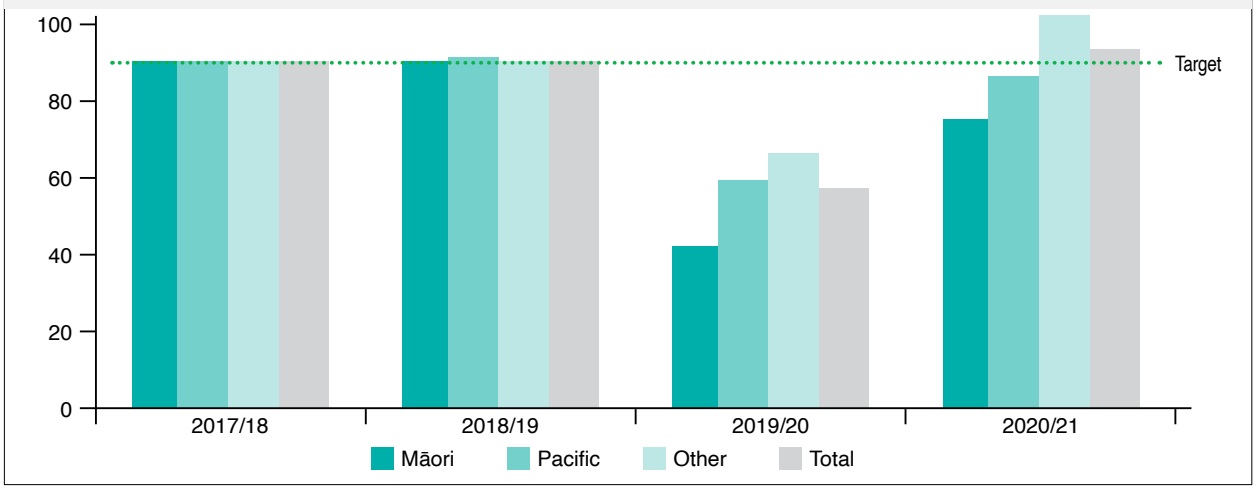
For the 45-64 age group, we have successfully implemented a number of services to provide care closer to home and to redirect the patients to their GPs or urgent care clinics. For example, community based nurse led COPD clinics. We have revised the POAC service which was implemented in July 2019, this allows the GPs to manage the patients in the community. The POAC volumes have continued to grow. The redirecting acute referrals received by General Medicine back to the GPs with the patient treatment plan was implemented immediately after the COVID-19 lockdown in 2020. It is also assisting the DHB to redirect the patients to GPs to avoid admission to the hospital.

The Waikato Hospital ED's EmergencyQ app based patient redirection service volumes have continued to grow for Triage category 4 and 5 presentation. This service was also introduced at Thames Hospital in November 2020. Both of the EDs, redirect a significant proportion of their ED presentations to urgent care clinics or local GPs.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of eligible population who have had their B4 School Check completed	Māori 77% Pacific 83% Other 98% Total 90%	Māori 42% Pacific 59% Other 66% Total 57%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 75% Pacific 86% Other 107% Total 93%	

Our performance

Percentage of eligible population who have had their B4 school Check completed



While the target was achieved with 93 percent of total children receiving a B4 School Check a large equity gap exists for Māori and Pacific and when considered in isolation the target was not met for either of these population groups. The performance for 'Other' has exceeded 100 percent and this is because the population target is based on estimated populations and people can self-identify their ethnicity or ethnicities.

Comparing against last year's result does not provide an accurate comparison. A significant amount of the B4 School Check programme is undertaken in the second half of the financial year which in 2019/20 coincided with the COVID-19 lockdown and ongoing response which prevented the normal 'catching up' phase of the programme and resulted in abnormally poor result. Comparing this year's result to 2018/19 provides a more accurate story of performance and while there has been improvement for the Total population there has been a significant deterioration by 15 percent of tamariki Māori receiving their B4 School check and a three percent drop for Pacific.

Declining results could be contributed to COVID-19 and the ongoing pressure this has created in the health system. This was compounded at the end of the year by the cyber-attack which resulted in a full systems outage at Waikato DHB in May and June 2021.

The B4 School Check is an important Ministry of Health programme which aims to identify health, behavioural and developmental issues before a child starts school. This is a crucial check to allow children to have the best possible start to their formal education. The focus for 2021/22 will be to once again eliminate the equity gap for this measure to ensure tamariki start school well set for formal education and lifelong learning.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	3.9/100,000	3.5/100,000	1.2/100,000	3.3/100,000	●

Our performance

During the 2020/21 reporting year, there were 14 notified cases of acute rheumatic fever in the Waikato district – this includes all confirmed, probable, and under investigation cases so may be subject to modification following clinical review. This is a slight decrease on last year's number. Acute rheumatic fever remains one of many disease of inequity – with our numbers reflecting ongoing inequities in health care quality and access, and also varying social determinants of health.

While 14 cases may not seem like a large number, the impact an episode of acute rheumatic fever has on an individual and on their whānau is immense and lifelong, which is why it is important to resource rheumatic fever prevention and management initiatives sufficiently. Current Ministry of Health directed funding is coming to an end shortly. It is directed at increasing rheumatic fever awareness, providing free sore throat swabbing services to eligible populations (pharmacies), and supporting the administration side of the Whare Ora programme to improve housing conditions.

Waikato DHB is in the process of exploring how rheumatic fever prevention can remain a priority and receive the funding it requires. We are also re-establishing our stakeholder governance meetings, and working with the Ministry of Health on our action plan.

More people maintain their functional independence

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Average age-of-entry to aged residential care:					
• Rest home	85 years	84 years	>84 years	86 years	
• Dementia	83 years	81 years	>80 years	82 years	
• Hospital	86 years	85 years	>85 years	84 years	

Our performance

The Waikato DHB targets for entry to all levels of aged residential care between have been achieved. They have tracked consistently with the prior year.

The Waikato DHB has a focus on the overarching goal that aligns to the Healthy Ageing Strategy – older people will live well, age well and have a respectful end of life in age friendly communities

Alongside being able to offer aged residential care in people's locations of choice, alternative options are available to allow people to remain in their community for as long as they are able with the right supports.

The Waikato DHB delivers a supportive model of care Supported Transfer and Accelerated Rehabilitation Therapy (START) that provides individuals with targeted rehabilitation in their home up to four times a day, seven days a week. Alongside this if a person experiences an acute episode a transition to home initiative has been developed with aged care facilities and the community with a focus on quality of short stay residential care and increasing rehabilitation opportunities for individuals through the START programme.

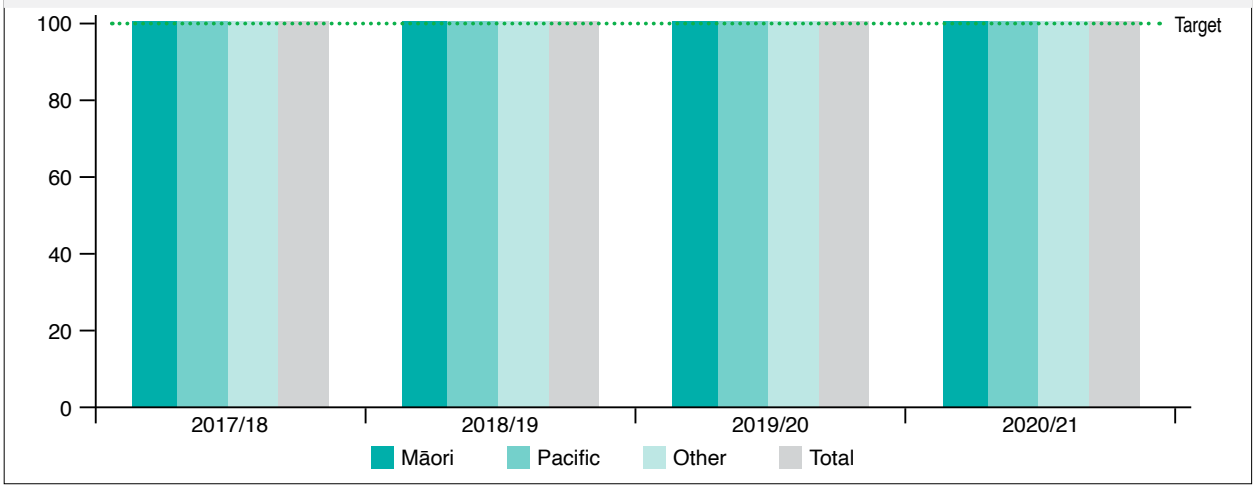
Although residential care will continue to be needed by a proportion of the older population, these alternative options can delay the need to leave their homes, a wish often expressed during assessment, and contribute to matching available residential care with the needs of the growing older population as the "baby bulge" generation approach this stage of life.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of older people receiving long-term home-based support have a comprehensive clinical assessment and an individual care plan	100%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	Māori 100% Pacific 100% Other 100% Total 100%	●

Our performance

Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan ●



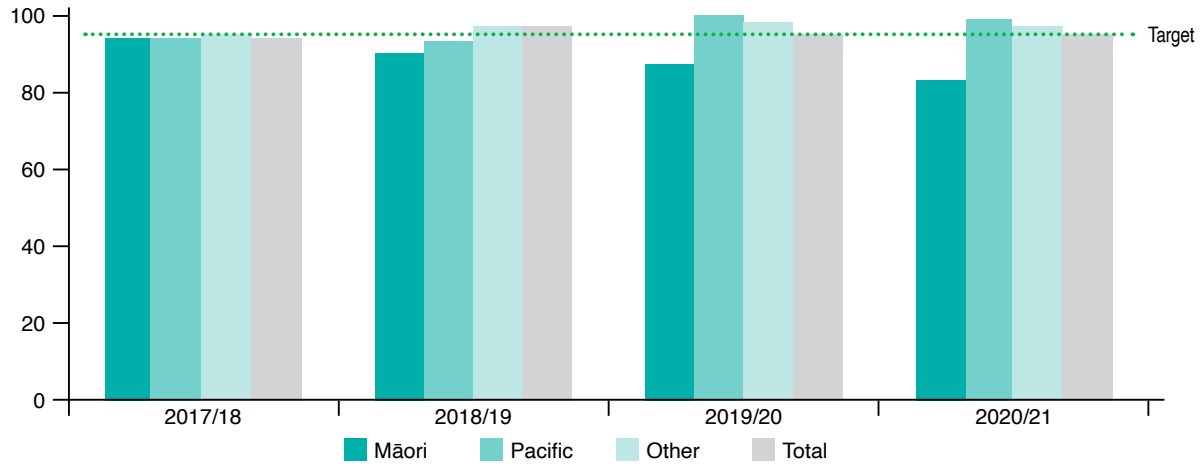
We continue to maintain the target of 100 percent of clients having a care plan in place. This target is based on the outcome of an International Residential Assessment Instrument (InterRAI) with the minimum data-set homecare assessment tool (MDS-HC).

With the direction of the new national model of care being implemented in the Waikato, clients are screened using the Screening Assessment Tool to determine a pathway for assessment. Non-complex clients have a contact assessment completed. If deemed complex an InterRAI comprehensive clinical assessment is undertaken for all clients. Both assessments enable staff to select appropriate support requirements for older people needing home-based support services. Any care plan that is put in place is tailored to the individual needs and enables the older person to access the assistance they need while maintaining their independence.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of people enrolled with a PHO	Māori 91% Pacific 88% Other 96% Total 95%	Māori 87% Pacific 100% Other 98% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 83% Pacific 99% Other 97% Total 95%	

Our performance

Percentage of people enrolled with a PHO 



Overall the target has been achieved. While it is pleasing to see high rates of enrolment overall and for Pacific and Other populations there is a consistent equity gap that exists for Māori. In 2020/21 706 more Māori enrolled in a PHO compared to 2019/20. While this is positive this growth equates to 0.78 percent and is less than the projected population growth of Māori for Waikato DHB of 1.16 percent.

Increasing enrolment rates are important because access to primary care has been shown to have positive benefits in maintaining good health. It can also reduce the economic cost of ill health through prevention and early intervention.

Enrolment will remain a focus of Waikato DHB in 2021/22 and we will continue to work with local iwi and Te Puna Oranga to encourage Māori to enrol with a PHO. Further to this two new general practices (with a focus on Māori equity) will be opening in the first and second quarter of 2021/22 and it is expected that this will have a positive impact on next years results.

People stay well in their homes and communities

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days	62%	94%	Māori 100% Pacific 100% Other 100% Total 100%	90.5%%	●

Our performance

We did not meet the target for 2020/21 due to the COVID-19 lockdown and the cyberattack that Waikato DHB had experienced. This impacted significantly on Needs Assessment Services Coordination (NASC) completing assessments. We cannot report via ethnic group since the cyber-attack due to the unavailability of the database. This is currently being worked on so we can provide this data in future reporting.

Assessing face to face was not possible and therefore clients were reviewed rather than assessed. Receipt of referrals was slower throughout the cyber-attack and recovery. During the Waikato DHB cyber-attack vital tools such as the interRAi needs assessment tool, clinical portal, patient notes and Service Coordination Internal Database were unavailable, this meant the service had to adopt a paper process.

Inequities continue to be addressed by the dedicated Māori NASC assessment and coordination team. Assessing for Māori is being completed using the assessment tool Te Aromatawai. This tool was consulted over several years with all of the iwi and Māori NGO providers across the Waikato. This needs assessment can take place in a variety of locations including local marae. It is a comprehensive process and helps show whānau how they can support their older relative. It has been successful in improving access as DSL use a Māori needs assessor, Māori service coordinator and Māori service provider. This has resulted in the service doubling the number of Māori accessing disability support services.

In line with the National Framework for 'Home and Community Support Services, Community Health, Transitional and Support Services', NASC has almost completed the transition of non-complex clients to the NGO providers to service manage this cohort. This uses the case-mix model to determine complexity. This has involved developing new referral processes, establishing a shared training programme across all providers, establishing a Māori working group led by our Māori service providers in partnership with Disability Support Link's dedicated Māori NASC team.

Moving forward the service will be using its newly developed model of care that encapsulates how the NASC team works in partnership to deliver an inter-service approach that improves outcomes and efficiencies while also reducing costs. This model covers the patient journey from admission avoidance through emergency, inpatient stay and post-hospital discharge.

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 Number of planned care interventions completed Did-not-attend percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Percentage of clients discharged from community mental health and addiction services with a transition/wellness plan Average length of acute inpatient stay (mental health) Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives Number of new patients seen by the Waikato Hospital Palliative Care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days) Percentage of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days) Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

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

People receive timely and appropriate specialist care

Why does this matter?

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

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

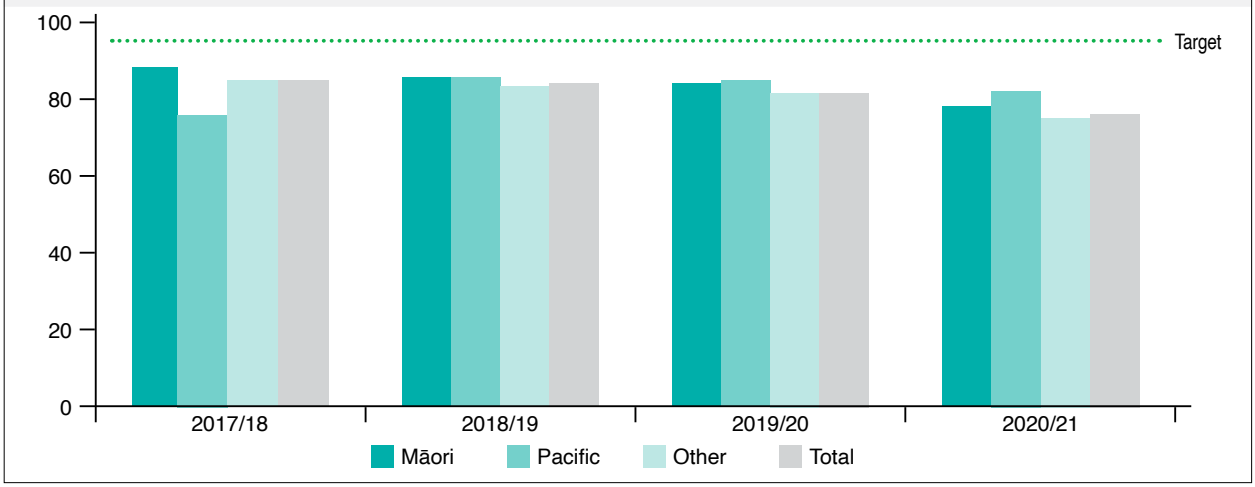
Achievement of this long-term impact will improve the quality of life for our population through early diagnosis and intervention to avoid further deterioration, timely corrective actions to relieve pain or illness, and appropriate supports to manage end stage conditions.

People receive prompt and appropriate acute and arranged care

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	Māori 92% Pacific 91% Other 91% Total 94%	Māori 84% Pacific 85% Other 82% Total 82%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 78.1% Pacific 81.8% Other 74.8% Total 76.0%	● ● ● ●

Our performance

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



Our EDs continue to face a very high demand for their services and this has been reflected in our results.

ED presentation numbers have been inconsistent for the past year due to a number of disrupters. This includes lower presentation numbers over the July and August period due to COVID-19. Unfortunately, the need for additional personal protective equipment (PPE) within the COVID-19 zone of the department caused delays and reduced demand did not result in reduced wait times.

During the cyber-attack the ED was unable to complete timely electronic data entry. However, the rapid change to manual processes as part of our critical incident management plans meant that we were still able operate the department. This resulted in slow performance with delays for diagnostics, no access to medical records and no electronic communication across the hospital.

As per the past year admitted patients are more likely to breach the Ministry of Health six-hour target than non-admitted patients. This reflects the higher complexity of patients that convert to an inpatient admission.

To improve performance Waikato DHB have been working on a whole of organisation approach with the ED an integral part of the programme of activity. The projects in this programme run through and connect with community services, inpatient teams and rehabilitation:

1. 'Emergency Q' helps reduce the volume of patients through the ED and has been extended to other accident and emergency clinics in Hamilton and Thames.
2. Automatic referral and movement of patients to the surgery, medicine, women's and paediatrics units by the emergency medicine specialist using a standardised pathway to improve timeliness and utilisation.
3. Internal medicine is actively developing services with a view to providing a consistent pathway via the Acute Medical Unit and a general physician review 24 hours a day and seven days a week. Senior doctors are holding the General Medicine phone to enable faster response to GP queries and prevent unnecessary hospital presentation.
4. The Qlik database tracks the patient journey in the ED and has been used to effectively demonstrate where delays are occurring and identify what needs to be done to improve patient flow.
5. START are actively diverting frail elderly patients from the ED to support them at home, preventing an unplanned and unnecessary admission.
6. An admission avoidance pathway has been established for general practice – GP's can ring a central triage point who will admit patients directly into community teams or short-term respite options to prevent an admission.

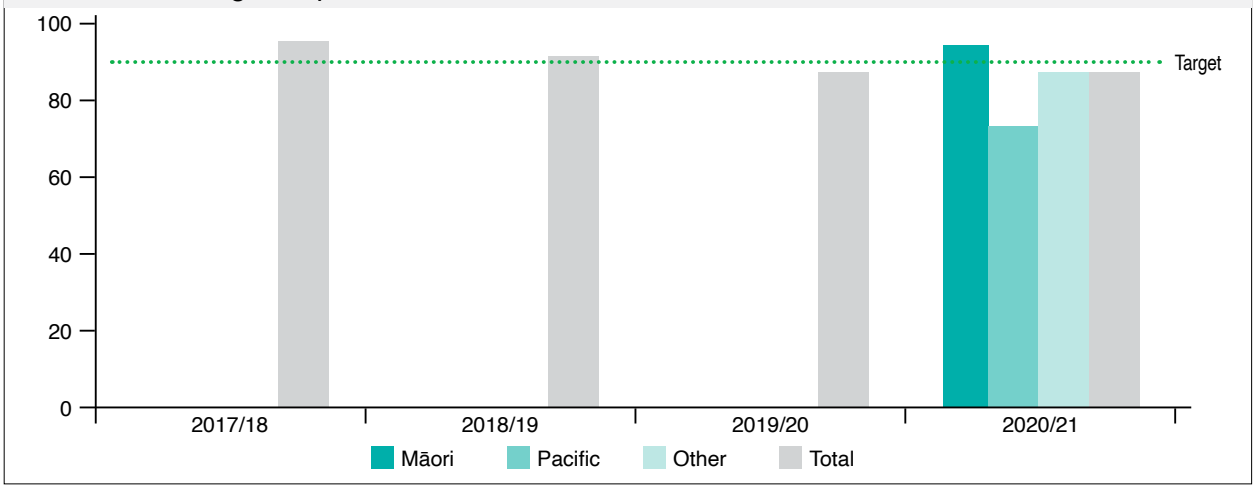
For 2021/22, a Whānau Hauora initiative has been launched to wrap services around our Māori and Pacific presentations. This service supports patients and whānau in a holistic manner. Whānau as well as the patient in ED care are provided support to access community services that support the whānau to be healthier reducing their ED needs.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	56%	87%	90%	Māori 94% Pacific 73% Other 87% Total 87%	

Our performance

Percentage of patients to receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks



It is pleasing to see that we achieved the target for Māori and almost achieving for Other ethnic group.

A number of initiatives have been improving results, including the implementation of the regional clinical pathways and Multi-Disciplinary Team (MDT) meeting solution for the lower gastrointestinal tumour stream to enable better management of clinical data.

Pathways have been established for newly diagnosed or suspected Lymphoma patients to get early referrals to diagnostics prior to first specialist appointment (FSA). This ensures FSA's are booked in a timely manner.

Waikato DHB has also implemented a fast track process for cancer patients needing surgery to go to the Anaesthetic Assessment Clinic after their clinic appointments, which eliminates the waiting time for the anaesthetic assessment.

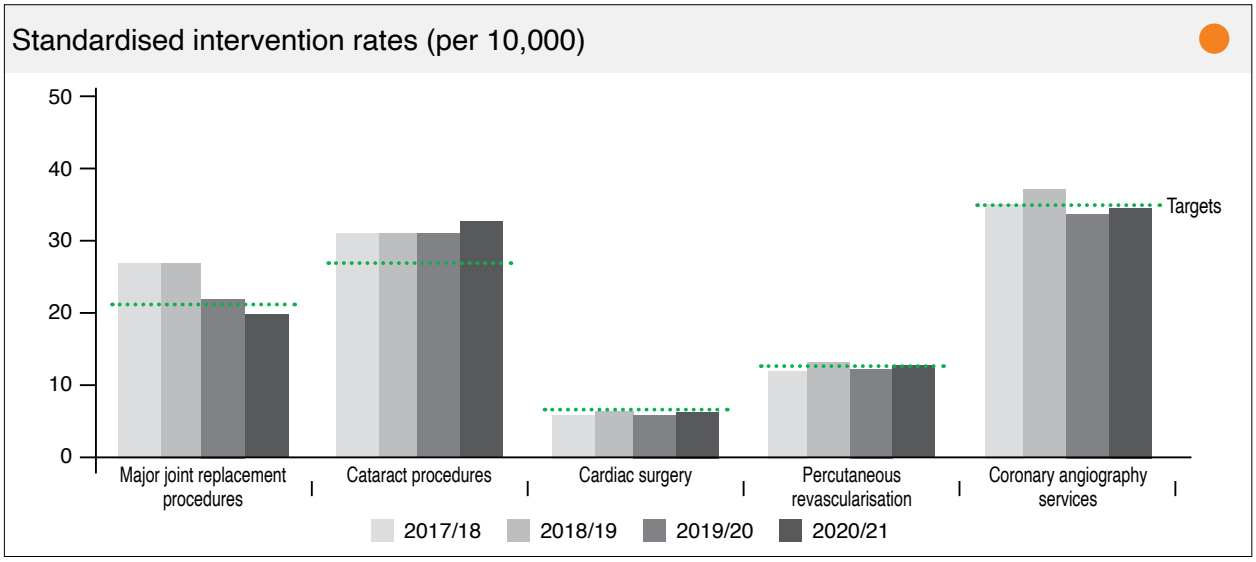
Lastly, Respiratory Medicine and Cardiothoracic Surgery are working on a dual purpose facility for breaking bad news and having Cardiothoracic Surgery FSA for lung cancer patients who are recommended for surgical treatment.

To address equity we have engaged with the Clinical Equity Leadership Group to identify barriers to clinical or hospital care. We have also engaged with Te Puna Oranga to minimise inequity in Faster Cancer Treatment (FCT), including addressing DNAs and identifying any barriers to improve better health outcomes. The clinical nurse specialist for equity continues to work on access issues for Māori and Pacific patients, monitoring DNAs and assisting patients to attend hospital appointments. A dedicated Radiation Oncology Equity Group was initiated with the aim of enabling the Radiation Oncology service to improve health outcomes for Māori and other priority groups to achieve health equity.

People have appropriate access to elective services

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Standardised intervention rates (per 10,000):					
• Major joint replacement procedures	27	22	21	19.8	
• Cataract procedures	25	31	27	32.6	
• Cardiac surgery	7.3	5.9	6.5	6.4	
• Percutaneous revascularisation	11.4	12.4	12.5	12.8	
• Coronary angiography services	33.9	33.8	34.7	34.5	

Our performance



Timely access to the above specialist services is considered an effectiveness measure of the health system. Elective surgery, now referred to as Planned Care is important to the wellbeing of the population and in reducing pain and discomfort to improve independence. This is particularly the case for surgical interventions such as cardiac, cataract, and major joint replacement procedures. SIR targets are set taking into consideration volume of patients seen relative to the Waikato DHB population base and health needs. Waikato has attained two of the five targets is just shy of two and has not attained one.

Prior to the cyber-attack we are aware the results this year had been impacted by a number of industrial actions and COVID-19 related events that have taken place during 2020/21. There have been Planned Care Initiative (PCI) recovery plans put in place to further assist the patient journey where there has been a wait longer than the prescribed wait times (four months). This pertains to not just the surgical intervention but the FSA too.

In addition to the above, Waikato DHB has enacted the PCI three year plan. 2020/21 was the first year of the three year plan, which saw a number of the milestones set being met. Waikato DHB has focused on a locality based model aligned to Te Korowai Waiora. An example of this has been improving access to diagnostics that enhance patient pathways. This has increased primary care access and options for care without referral to secondary and or tertiary services. The PCI plan year two will be further developed and implemented into the continuum of health services in 2021/22.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of patients waiting longer than four months for their first specialist assessment	2.7%	19.2%	0.0%	32.7%	

Our performance

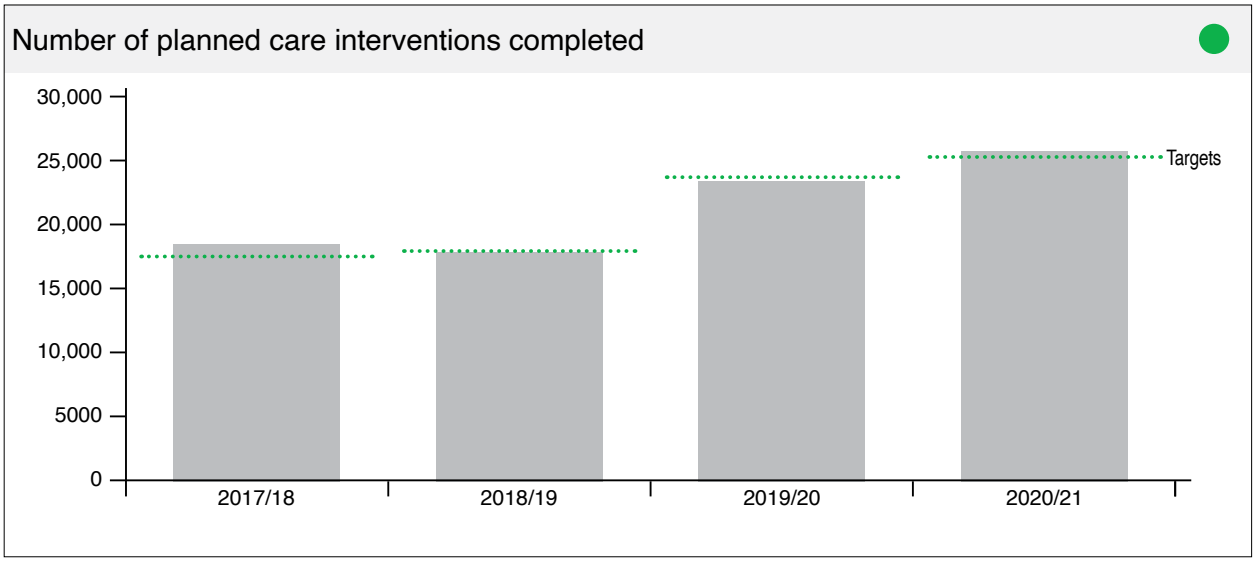
We did not meet the target as FSA was significantly impacted by the national response to COVID-19 followed by the Waikato DHB cyber-attack in May 2021. Initial recovery is focused on prioritising in line with clinical requirements. By working through the backlog of the initial manual entered data this is the best result at the end of quarter four.

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

The production planning team are continuing to work on reporting and models that provide the ability to model and monitor demand against capacity. The Production Planning team have plans to develop these, which are critical to managing demand more effectively.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Number of planned care interventions completed *Previously: Improved access to elective surgery, health target, agreed discharge volumes*	15,693	23,257	25,459	25,758	

Our performance



It is pleasing to see we achieved our target for 2020/21 despite the cyber-attack in May 2021.

Theatre capacity was significantly affected from mid-May to July, with only acute and time critical patients receiving elective procedures in the first instance. We continue to work through the back-log and reschedule these appointments.

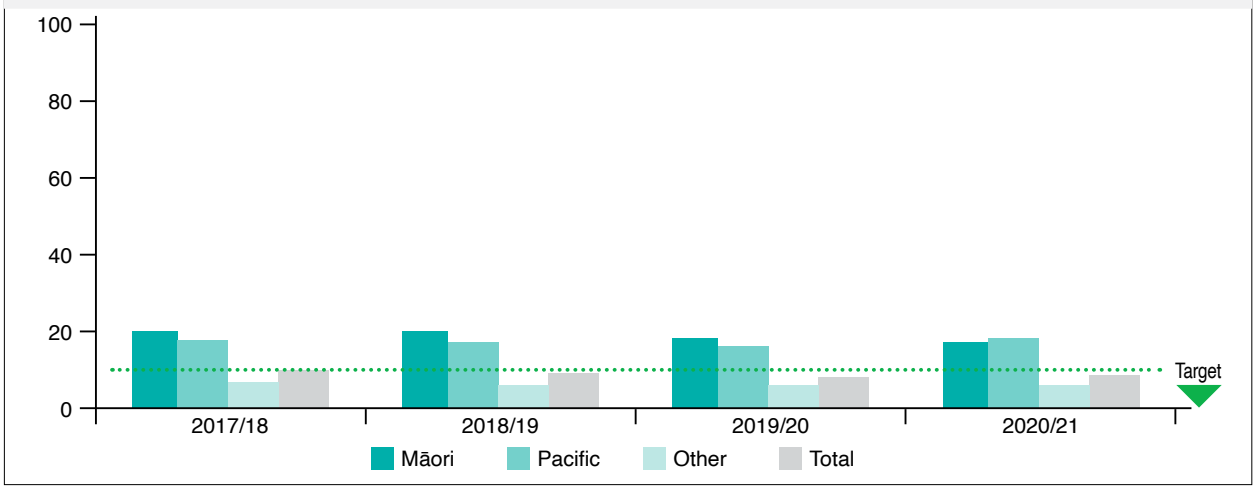
Transition and recovery plans are being developed at service level and additional funding to support recovery is currently being finalised with the Ministry of Health.

The production planning team are continuing to work on reporting and models that provide the ability to model and monitor demand against capacity. The production planning team have plans to develop these, which are critical to managing demand more effectively.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Did-not-attend (DNA) percentage for outpatient services	Māori 21% Pacific 18% Other 7% Total 10%	Māori 18% Pacific 16% Other 6% Total 8%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 17% Pacific 18% Other 6% Total 8.5%	

Our performance

Percentage of did-not-attend (DNA) for outpatient services



We have been tracking well for our did-not-attend considering the cyber-attack in May 2021. The Outpatients Automated Reminder System (OARS) has gone live (text messages reminding of appointments) post cyber-attack and is attributing the higher than normal DNAs down to the lack of reminders previously. Now that this function is up and running we will incorporate this with the Equity programme of work and we will hopefully see reduced DNAs.

All Māori and Pacific patients as part of the equity programme of work get telephoned for their upcoming appointments.

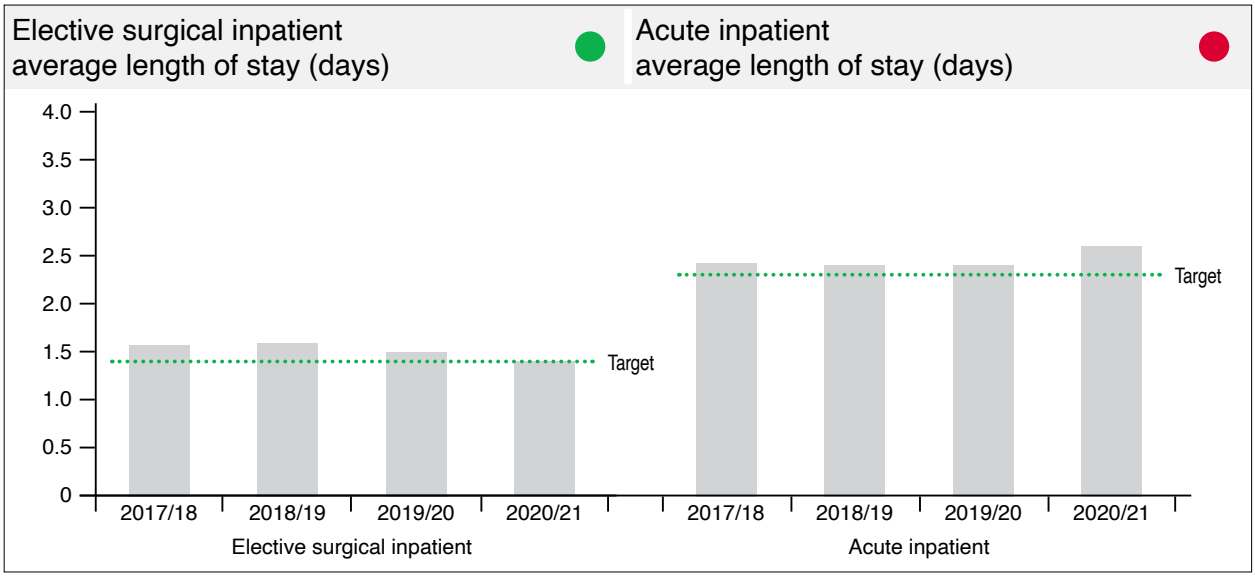
We remain committed to reducing DNAs and will continue to implement initiatives that will drive progress towards achieving the target for Māori and Pacific in 2021/22. Achievement of this target will improve health outcomes, access and ensure we make best use of clinicians' time.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Elective surgical inpatient average length of stay	1.71 days	1.50 days	1.50 days	1.50 days	

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Acute inpatient average length of stay	3.89 days	2.50 days	2.30 days	2.69 days	

Our performance



Overall there has been a slight reduction in elective Length of Stay (LOS). The year was impacted by the ongoing effect of the April 2020 COVID-19 lockdown and the cyber-attack in May 2021. While difficult to quantify the impact on elective LOS, these events did result in complex work being re-prioritised and may have had some impact across certain specialties.

Maxillofacial surgery elective LOS reduced by 0.4 days. This is due to significant vacancies in SMO full time equivalent (FTE) resulting in reduced volumes of complex surgeries done by the service. Orthopedic surgery LOS reduced by 0.2 days, returning to the level achieved in 2019. Thoracic surgery reduced by a further 0.2 days continuing a trend of reducing elective LOS.

The most significant increase in LOS was in elective cardiac surgery with a 1.7 day increase. Extended wait times for surgery combine with an increasingly comorbid patient population impacts on the complexity of elective cardiac surgery.

The Internal Medicine acute average LOS has increased from last year. Whilst a number of initiatives to address this continue it reflects growing complexity, with increasing numbers of patients presenting with chronic health conditions.

Waikato DHB is undertaking research and analysis in partnership with Waikato University to examine the growth in complexity through the patient journey. The Patient Clinical Complexity Levels (PCCL) are currently being mapped through community supports, emergency medicine, general medicine, older persons and rehabilitation and back through community. This will inform some targeted approaches supporting an admission avoidance and case management approach. The Respiratory service continues to show a drop in the average LOS. There has been some increase in complex patients treated who have had longer stays which has led to the current research being undertaken.

The positive initiatives introduced this year include General Medicine hot clinics, with Community Chronic Obstructive Pulmonary Disease (COPD) services continuing to be reviewed in order to manage patients more effectively. The trial of a Respiratory Pleural clinic 1-2 times per week has also been undertaken to allow procedures to be done in an outpatient setting that would normally involve inpatient stays.

Two successful admission avoidance pathways have been established. The first one being direct access to a SMO in General Medicine. This includes 10-15 consults per day providing advice on patient care to prevent admissions and on occasion facilitate a planned admission to Acute Medical Unit. Secondly, direct access to community supports (frailty/admission avoidance pathway) which is 30 calls per month that facilitate same day home support/urgent respite/geriatrician input. Waikato DHB will continue to focus on early supported discharge with 140+ patients being supported with rehabilitation in their own home.

The focus by the Renal and Oncology inpatient services to remain within their bed allocation has resulted in the combined patient LOS remaining similar to last year. The cancer and regional directorate has compared its average LOS to other DHBs using Health Round Table data, which has demonstrated that these specialties perform better or comparably to other large centres.

The Endocrinology service has reduced LOS compared to the previous year, reflecting the clinical complexity involved. The small number of admissions for this specialty means results can vary greatly year-to-year.

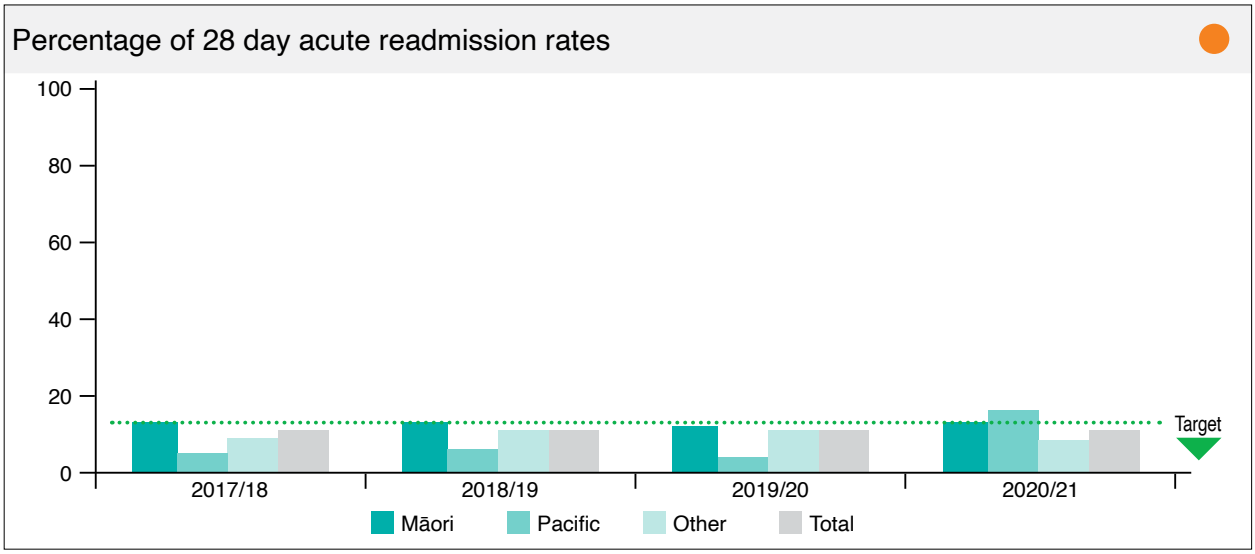
There are no issues with LOS for electives and acutes in women's and children's sector service. We have increased the number of non-invasive procedures enabling a quicker recovery and discharge home for women.

People receive timely and appropriate specialist care

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

Impact measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
28 day acute readmission rates	Māori 14% Pacific 8% Other 12% Total 12%	Māori 12% Pacific 4% Other 11% Total 11%	Māori <13% Pacific <13% Other <13% Total <13%	Māori 13.2% Pacific 16.13% Other 8.5% Total 10.9%	

Our performance



The 28 day readmission rate for 2020/21 was 11 percent however we did not meet the target for Māori and Pacific.

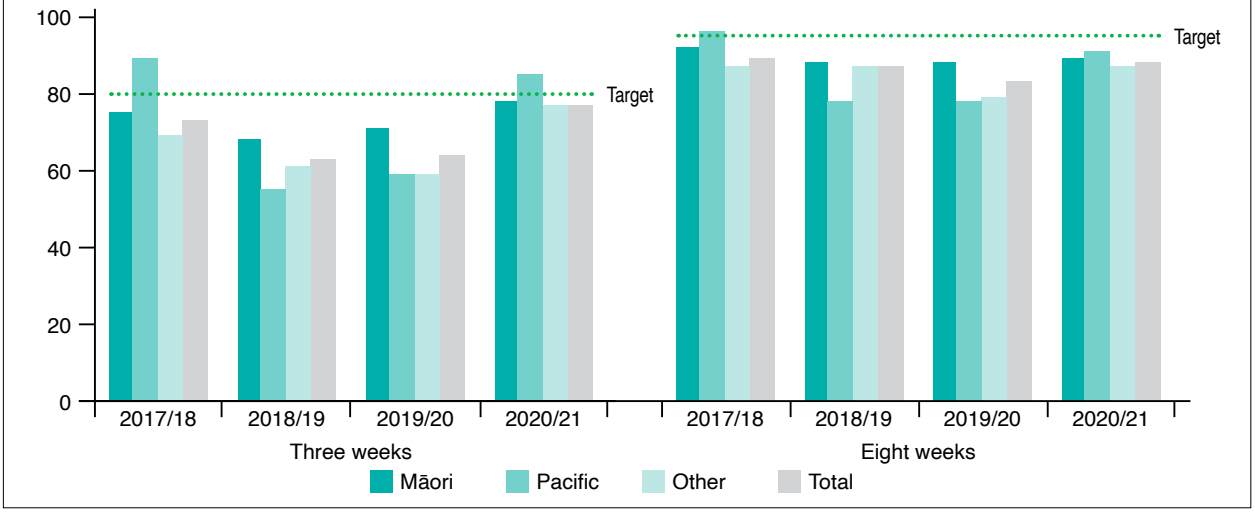
Demand for mental health and addictions services has continued to increase. A targeted plan to reduce and manage occupancy levels in our acute adult inpatient facility was implemented in 2019. This included a focus on supporting post-discharge recovery for our service users with work to ensure sustainable housing and a number of specific wrap-around resources were available to support tangata whaiora on discharge from hospital. While there was some initial success in this area, occupancy and length of stay have again increased to significant levels through 2020/21.

We are continuing to develop models of care that better support tangata whaiora in the community post-discharge, such support includes housing and enhanced residential support services. The housing crisis does create challenges in securing sustainable housing in our district however Waikato DHB is currently working with community providers (NGOs) and other key stakeholders to find local solutions to these issues.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks	**3 weeks** Māori 82% Pacific 86% Other 72% Total 75%	**3 weeks** Māori 71% Pacific 59% Other 59% Total 64%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80%	**3 weeks** Māori 78% Pacific 85% Other 77% Total 77%	
	8 weeks Māori 93% Pacific 95% Other 90% Total 91%	**8 weeks** Māori 88% Pacific 78% Other 79% Total 83%	**8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**8 weeks** Māori 89% Pacific 91% Other 87% Total 88%	

Our performance

Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks



Child and Youth Mental Health services continue to face very high demand for their services and this is reflected in the wait times reported by the provider arm for three and eight week categories. While there is improvement in 2020/21 from 2019/20, Waikato continues to work towards the targets being set.

A number of the recommendations from the review of the Infant, Child and Adolescent Mental Health Service (ICAMHS) cluster have been implemented, in either part of full. The services and the sector continued to work on these during 2020/21 and are committed to this for the out years 2021/22 and beyond.

Waikato DHB has had difficulty providing timely access to service and the wait lists have been growing to levels not previously experienced. Ministry of Health and Waikato DHB Mental Health and Addictions service executives have worked together to find additional resources to address this concern. During quarter four, one of the three clusters, the Hauraki cluster, trialled a collaborative approach to assess waitlist, rapid triage and access to appropriate services. This additional capacity has worked well and reduced the waitlist. Based on this piece of work, this will be rolled out to the other two clusters as soon as possible. The Greater Hamilton cluster has a significant waitlist that is currently being prioritised.

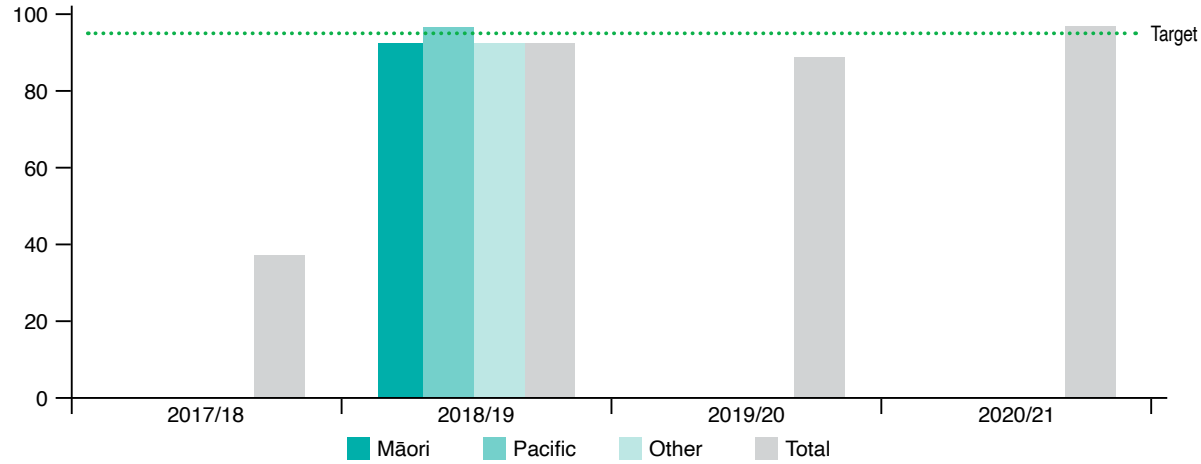
Primary mental health options are extended during 2020/21 to help reduce pressure on secondary services by offering alternative access points for youth. One such investment has been the distressed youth in ED approach that has been worked on in quarter three and quarter four. We continue to work with our third party psychology service providers to extend this into group sessions, creating capacity in the currently overloaded system.

People receive timely and appropriate specialist care

Output measure	Baseline 2017/18	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Mental health clients discharged have a transitional (discharge) plan	37%	Māori N/A Pacific N/A Other N/A Total 98%	Māori 95% Pacific 95% Other 95% Total 95%	Māori N/A Pacific N/A Other N/A Total 96.4% *Please note: Q4 data unavailable due to a third party provider who did not provide results*	●

Our performance

Percentage of clients discharged from community mental health and addiction services with a transition/wellness plan ●



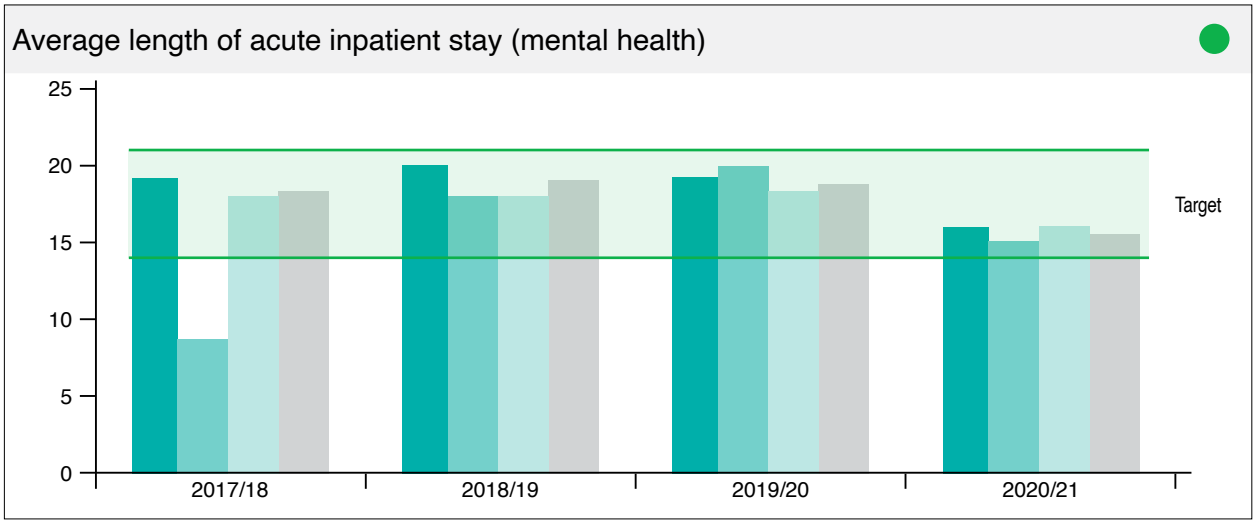
The most recent data from quarter three has shown 96.4 percent of community clients and of inpatient clients discharged have a transition wellness plan upon exit from services (100 percent of inpatient clients discharged).

There have been challenges during the fiscal period to obtain and report the planning by the three identified ethnic groups. Accessing Q4 data from a third party provider has proven difficult due to staff changes in their organisation and therefore have not been able to send through results. While these are challenges, Waikato DHB remains committed to report this measure with an equity approach to specifically identify the ethnicity of the client plan.

This is also aligned to the Waikato DHB's over-arching strategy, Te Korowai Waiora, equity strategy and Rapua Te Ara Matua Equity Report to eliminate equity gaps for all whānau.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Average length of acute inpatient stay (mental health)	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 19.19 days Pacific 19.91 days Other 18.28 days Total 18.74 days	Between 14 and 21 days	Māori 15.95 days Pacific 15.10 days Other 16.05 days Total 15.55 days	● ● ● ●

Our performance



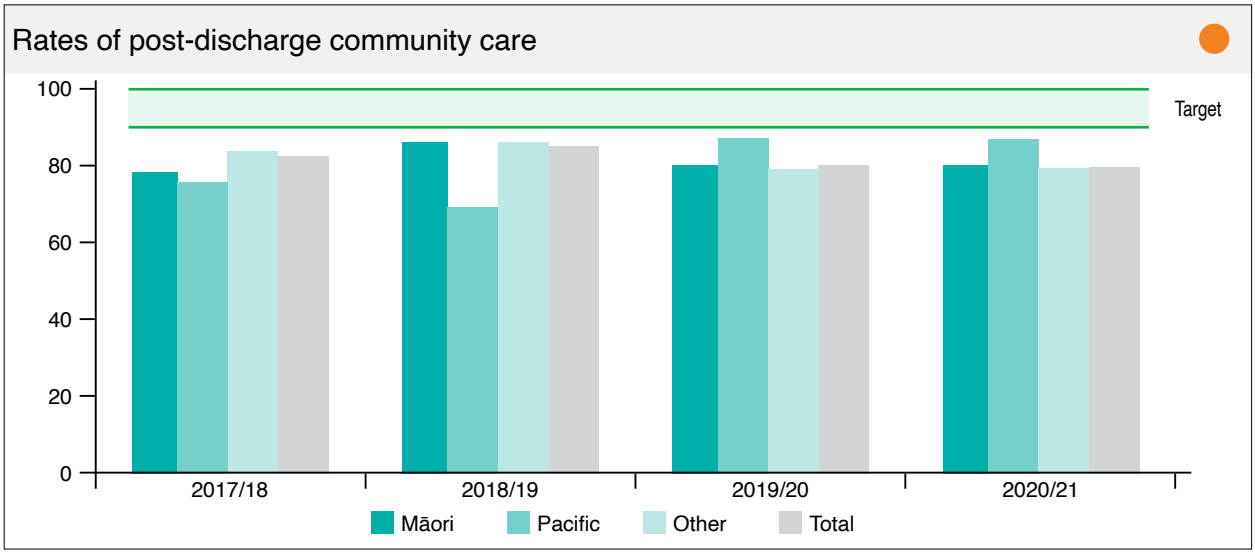
Waikato DHB Mental Health and Addictions services does not turn away people in need of hospital admission or discharge people to homelessness. For many of our tangata whairoa there are barriers to safe, recovery focused, community living and recovery. The work we undertook in 2019 to ensure improved access to housing, specific wraparound support packages and individualised placements in supported accommodation, where appropriate, allowed for many people with long hospital stays to be discharged. However we are now seeing length of stay growing again, as there remain a number of tangata whaiora, for whom appropriate discharge options from hospital are limited, even with these new initiatives.

We continue to work toward alternatives to hospital admissions and are working closely with our colleagues in strategy and funding to explore solutions for some of the long stay inpatients for whom housing and accommodation options are limited.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Rates of post-discharge community care	Māori 69% Pacific 73% Other 72% Total 87%	Māori 80% Pacific 87% Other 79% Total 80%	Between 90% and 100%	Māori 80.1% Pacific 86.7% Other 79.1% Total 79.6%	● ● ● ●

Our performance



Overall there has been a reduction in our results compared to last year, we continue to closely monitor and report on any issues specifically impacting the ability to follow up within the agreed period.

Throughout early 2020/21 Mental Health and Addictions focused on working to improve face-to-face follow up with those people recently discharged from hospital (within seven days of discharge). We saw success and positive progress in this area, achieving our highest rates of face to face, post seven day discharge follow up at 96 percent. Where face to face contact was not achieved within the specified seven days, we followed up to understand the barriers, made telephone contact with tangata whaiora and reviewed our discharge processes.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97%	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 4.78%	**0-19 years** Māori 5.17% Pacific 3.36% Other 4.72% Total 4.82%	**0-19 years** Māori 5.07% Pacific 3.21% Other 4.72% Total 4.78%	
	20-64 years Māori 7.12% Pacific 4.34% Other 4.34%* Total 4.33%	**20-64 years** Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12%	**20-64 years** Māori 10.05% Pacific 5.17% Other 4.05% Total 5.31%	**20-64 years** Māori 9.67% Pacific 4.59% Other 3.92% Total 5.12%	
	65+ years Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**65+ years** Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	**65+ years** Māori 2.65% Pacific 3.43% Other 2.39% Total 2.43%	**65+ years** Māori 2.44% Pacific 3.10% Other 2.35% Total 2.37%	

Our performance

Specialist mental health and addictions services are funded for those people who are most severely affected by mental illness or addictions. Waikato DHB continues to place a focus on continually improving access and increases the annual target accordingly. Previous results continue to be well above the baseline of 2014/15. The actual results for 2020/21 fiscal year indicate 18,790 individuals have engaged with our services, (2019/20, 19,522). This is a minor reduction, a direct result of current workforce challenges and associated COVID-19 impacts compared to the prior year. Of the 2020/21 total, 5192 were 0-19 years, (2019/20, 5560).

The sector continues to face very high demand within both the DHB provider arm and NGO services. Interface/s between the providers within the service continuum remain critical to ensure access continues to improve.

Following on from the programme of work Te Pae Tawhiti, Waikato DHB has developed key strategic directions for Mental Health and Addictions that seek to improve timeliness and access to services by delivering care closer to home using the locality approach. A focus moving forward will be the continual enhancement of the child, youth and adult models of care to support care pathways. The mental health service review findings will also be a key focus as the DHB works towards implementing the recommendations that aim to improve the patient journey through our system.

Primary mental health options have been extended during the 2020/21 fiscal year to reduce future secondary mental health presentations. Investment into community based psychology services and Access and Choice 'Whānau Pai' has continued and will be extended in the 2021/22 fiscal period.

People receive timely and appropriate specialist care

More people with end stage conditions are supported appropriately

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of aged residential care facilities utilising advance directives	100%	100%	100%	100%	●

Our performance

An advanced directive is a statement signed by a person setting out in advance the treatment they do or don't want if they become unwell in the future and are considered unable to give consent. The Health and Disability Standards require that an advanced directive is on file for every person in a long-term residential care facility and is used when indicated.

Waikato DHB achieved 100 percent with all long-term residents of residential care having an advanced directive in place. This is reviewed through the auditing process.

Waikato DHB also promotes and utilises the Advance Care Plan (ACP) service model. Te Kōhao Health will support aged care facilities to facilitate and complete plans. The ACP is an alternative to an advanced directive and provides greater detail on a person's wishes. The ACP includes what is important to someone in their life: religion, whānau, being at home as much as possible, quality of life etc.

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Number of new patients seen by the Waikato Hospital Palliative Care service	1085	740	727	741	●

Our performance

The Palliative Care team at Waikato Hospital is a consult liaison service that provides care for patients with life limiting or life threatening illness. We provide physical, psychosocial, spiritual and cultural care for patients, their whānau and other significant caregivers. The team work very closely with Hospice Waikato (third party provider) in a one service two provider model.

The consult liaison service has seen 740 new patients during the year, (22 percent Māori and 78 percent 'Other') with a total of 4946 face to face patient visits. The Renal conservative care clinic continues and there has been a strengthening of links between teams for the management of motor neuron disease.

The service has developed a midland training group (including Waikato, Bay of Plenty and Taranaki) to support Palliative Care advanced trainees and SMOs across the region. This provides regular weekly specialist education sessions via Microsoft Teams and fosters close working relationships.

An independent Palliative Care Review was completed in late 2020 to inform future models of care. There is ongoing consideration of these recommendations and the Palliative Care strategic leadership group continue to work towards improving workforce prioritisation and service specification with the goal of improving living and dying in our community.

Support services

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	94%	49%	95%	59%	

Our performance

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

People receive timely and appropriate specialist care

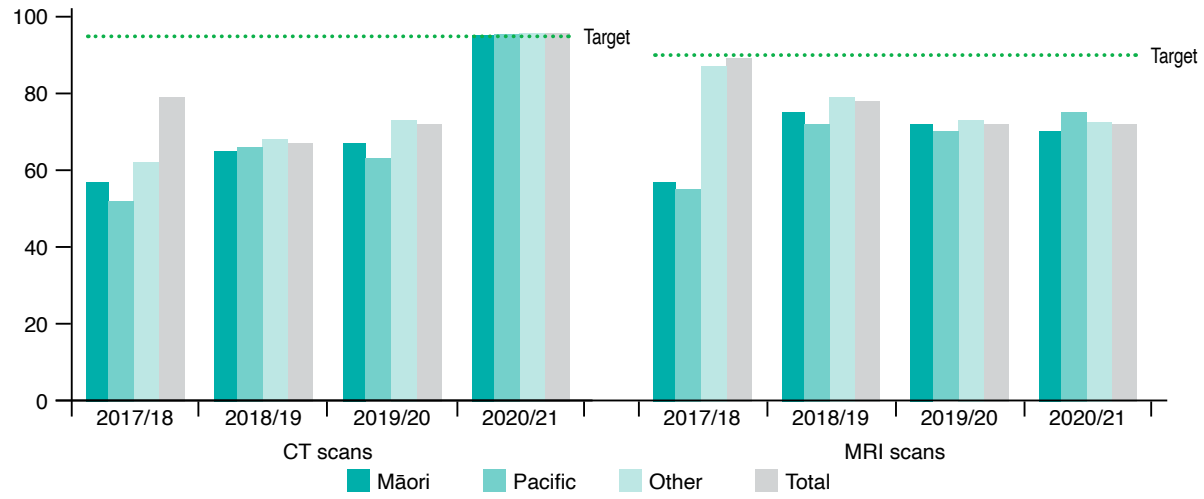
Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	Māori 92% Pacific 100% Other 90% Total 90%	Māori 67% Pacific 63% Other 73% Total 72%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95.03% Pacific 95.36% Other 95.64% Total 95.53%	●

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of accepted referrals for MRI scans will receive their scan within six weeks (42 days)	Māori 55% Pacific 53% Other 52% Total 48%	Māori 72% Pacific 70% Other 73% Total 72%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 70.11% Pacific 75.0% Other 72.5% Total 72.0%	●

Our performance

Percentage of accepted referrals for CT scans will receive their scan within 6 weeks ●

Percentage of accepted referrals for MRI scans will receive their scan within 6 weeks ●



It is pleasing to see that we have achieved our targets for CT scans but have not been able to in the MRI scans.

Throughout the year we have scanned approximately 2200 patients per month through the CT scanners. Since October 2020, we have received additional planned care funding to allow us to outsource patients to meet the ministry target of 95 percent. This outsourcing will continue to allow us to meet the output measure until we have a third CT scanner installed at Waikato Hospital which will increase our available capacity for scanning and continue to meet target.

We have consistently scanned approximately 1000 patients through MRI, but the ministry target of 90 percent has not been met. Capacity in April 2021 was increased with the commissioning of another magnet and the percentage scanned is steadily increasing. The cyber-attack has impacted volume of patients scanned.

The lack of radiologists has resulted in some CTs and MRIs going unreported for longer. A range of mitigations are in place ranging from active recruitment through to the use of offshore reporting for CT and basic radiology to ensure the target for CT can be maintained.

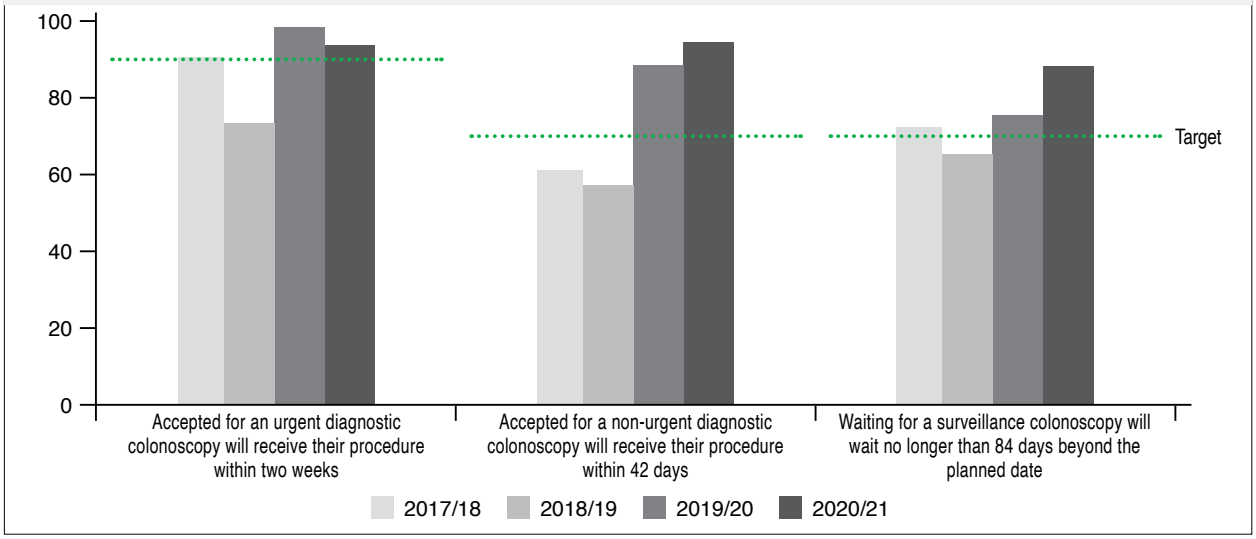
Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	78%	98%	90%	95.4%	●

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	49%	88%	70%	95.9%	●

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date	70%	75%	70%	97%	●

Our performance

Percentage of people waiting for colonoscopy procedures ●



Waikato DHB has achieved compliance across all three output measures in 2020/21. Management of the colonoscopy waiting times has continued to achieve the required targets following the changes made to system processes in 2019/20.

During the cyber-attack in May 2021 the Endoscopy unit's ability to deliver services was reduced to 70% of its usual capacity for a period of 10 weeks. During this time alternative solutions, such as outsourcing 120 patients to private providers, were put in place to ensure our population continued to receive the services needed.

Since then, data has been restored and restrospectively put into patient management system (iPM) with cross checks and upload provation reports into Clinical Work Station (CWS). This information has also been transferred to the National Booking Reporting System to the Ministry.

We continue to work with patients who choose to come in later or they have DNA to be rebooked. We offer them another appointment instead of returning to the GP especially if they are "urgent" patients. We continue to manage lists according to Ministry guidelines while looking after our vulnerable populations.

People receive timely and appropriate specialist care

Output measure	Baseline 2014/15	Previous year 2019/20	Target 2020/21	Result 2020/21	Rating
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	100%	100%	100%	100%	●

Our performance:

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

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

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

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

Implementing the COVID-19 vaccine strategy

As at 30 June Waikato DHB were at 9.41 percent and just starting the wider roll out of the COVID-19 vaccination programme in line with the Ministry of Health eligibility framework. At 30 June Waikato DHB had 41 fixed sites operational and were just starting the roll out to primary care. The focus was on getting Māori vaccinated and to do this there were four mobile teams working every day in locations with higher Māori populations, in addition our kaupapa Māori providers were already operating with large volumes. See tables below for results for 30 June 2021.

Vaccine doses administered by DHB

DHB	Dose one	Dose two	Total
Waikato	44,066	29,842	73,908

Eligible population fully vaccinated by DHB of residence (note 1) (note 4)

DHB of residence	Proportion fully vaccinated (note 1)
Waikato	9.41%

Vaccine doses administered by age group (note 4)

Age group	Dose one	Dose two	Total
Unknown	1	0	1
12 to 15	2	1	3
16 to 19	567	361	928
20 to 24	1817	1365	3182
25 to 29	2570	1972	4542
30 to 34	2781	2194	4975
35 to 39	2414	1896	4310
40 to 44	2289	1814	4103
45 to 49	2561	2019	4580
50 to 54	2928	2282	5210
55 to 59	3265	2469	5734
60 to 64	3652	2585	6237
65 to 69	4694	2538	7232
70 to 74	4874	2563	7437
75 to 79	3801	2075	5876
80 to 84	2860	1670	4530
85 to 89	1705	1129	2834
90+	1285	909	2194
Total	**44,066**	**29,842**	**73,908**

**Unknown age refers to a dose being captured but insufficient other information being captured to identify the recipients age.*

Eligible population fully vaccinated by age group (note 5)

Age group	Proportion fully vaccinated (note 1)
12 to 15	-
16 to 19	1.95%
20 to 24	5.24%
25 to 29	7.04%
30 to 34	7.83%
35 to 39	7.61%
40 to 44	7.76%
45 to 49	8.17%
50 to 54	9.32%
55 to 59	9.84%
60 to 64	11.08%
65 to 69	12.32%
70 to 74	14.08%
75 to 79	16.00%
80 to 84	19.47%
85 to 89	23.31%
90+	33.77%
Total	**9.41%**

Vaccine doses administered by ethnicity (note 4)

Ethnicity	Dose one	Dose two	Total
Māori	7229	4577	11,806
Pacific	1502	963	2465
European or other	28,167	18,891	47,058
Asian	6305	4868	11,173
Unknown	863	543	1406
Total	**44,066**	**29,842**	**73,908**

Eligible population fully vaccinated by ethnicity (note 5)

Ethnicity	Proportion fully vaccinated (note 1)
Māori	7.65%
Pacific	10.42%
European or other	8.99%
Asian	15.23%
Unknown	10.91%
Total	**9.41%**

Vaccine doses administered by sequencing group (note 4)

Sequencing group (note 3)	Dose one	Dose two	Total
Group 1	1495	1275	2770
Group 2	28,491	21,495	49,986
Group 3	12,201	6020	18,221
Group 4	1879	1052	2931
Total	**44,066**	**29,842**	**73,908**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every five years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 430,306. This is 8244 below the Stats NZ total projected population of 438,550 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total population	HSU	Stats NZ	Difference
Māori	94,395	106,400	(12,005)
Pacific	13,855	13,350	505
Asian	42,865	50,400	(7535)
Other	279,191	268,400	10,791
Total	**430,306**	**438,550**	**(8244)**

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

“Every total care was shown to me –
I have so much praise for everyone.”

Tokoroa inpatient

Part four:
Asset management

Asset performance information

Asset numbers

Our fixed assets

Fixed assets play an integral part in Waikato DHB achieving better health outcomes for patients.

Managed under the three asset portfolios; property, equipment and information and communication technology, Waikato DHB has in place robust asset management processes and programmes with a key focus to:

- identify what and why fixed assets are required, when to purchase or replace and from whom we should purchase such assets
- ensure existing fixed assets comply with local and international standards around operation, performance and servicing
- ensure fixed assets are fit for purpose and the appropriate preventative maintenance programme is in place across all portfolios; and
- manage the risk profiles of all fixed assets.

The following table summarises our three portfolios:

Asset portfolio	Assets class within portfolios	Asset purpose	2018/19 Net Book Value	2019/20 Net Book Value	2020/21 Net Book Value
Property	Land, buildings, plant and equipment, fixture and fittings, vehicles	To facilitate the delivery of hospital services through the establishment of purpose-built infrastructure	$725 million	$701 million	$896 million
Equipment	Clinical equipment	To facilitate the delivery of hospital services through the provision of fit for purpose clinical equipment	$49 million	$57 million	$56 million
Information and communication technology	Computer hardware and software, other communication systems and devices	To facilitate the delivery of hospital services through the establishment of fit for purpose Information technology and communication systems	$28 million	$35 million	$29 million

The 2020/21 asset performance indicators (APIs) identified for each portfolio are set out below along with targets which have been agreed at clinical, management and commissioner level.

Asset performance indicators

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

Property portfolio performance

Asset performance indicators	Indicator class	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Rating
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%	6%	6%	0%	7%	●
Waiora Waikato hospital campus building core services down time as a percentage of total operating hours, per annum. Note 2	Utilisation	99%	99%	100%	<99%	100%	●
Waiora Waikato campus disabled carparks as a percentage of total public car parking. Note 3	Functionality	5%	13.3%	13%	>13%	14%	●
Waiora Waikato hospital campus building energy efficiency savings as a percentage of targeted energy consumption. Note 4	Functionality	16%	14%	21%	>7%	7%	●
Percentage of Waiora Waikato hospital campus buildings with vaild Building Warrant of Fitness (BWoF)	Condition	N/A	N/A	N/A	100%	100%	●
Percentage of Waikato DHB rural hospitals and community facilities with valid BWoF	Condition	N/A	N/A	N/A	100%	94%	●

Clinical portfolio performance

Asset performance indicators	Indicator class	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Rating
Percentage CT scanners (Radiology) compliant with the requirements of the Radiation Safety Act 2016	Condition	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%	●
Waikato Hospital Radiology department, actual CT scanned patients versus planned patient scans	Utilisation	103%	100%	120%	>90%	113%	●
Percentage of the available time Linear Accelerators (Oncology) are used to carry out radiation treatment on patients	Utilisation	92%	85%	72%	>86%	65%	●
Waikato Hospital, planned theatre usage versus actual usage. Note 5	Utilisation	76%	73%	73%	>75%	74%	●
Waikato Hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	100%	98%	94%	>90%	107%	●
Waikato Hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. Note 6	Utilisation	92%	88%	86%	>85% and <95%	101%	●
Waikato DHB, elective surgery completed as a percentage of Ministry of Health elective surgery targets for last 12 months. Note 7	Utilisation	105%	99%	92%	100%	103%	●
Waikato DHB, weighted average age of clinical fixed assets versus suppliers weighted average life expectancy	Condition / Functionality	N/A	8.9 years	8.9 years	<7 years	7.2 years	●
Percentage of Diagnostic Monitors meeting Quality Assurance (QA) requirements	Functionality (fit for purpose)	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 (fit for purpose)	N/A	N/A	N/A	100%	76%	●

Information communication and technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2017/18 Result	2018/19 Result	2019/20 Result	2020/21 Target	2020/21 Result	Rating
Percentage of computer hardware used by staff less than five years old. Note 8	Condition	82%	62%	66%	100%	83%	●
Availability of critical clinical systems (iPM, CWS, iSL, PACS) to the Emergency Department. Note 9	Utilisation	99.8%	99.7%	99.4%	99.5%	90.6%	●
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 to 10 scale. Note 10	Functionality	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	>=85%	75%	●
Percentage of server devices with critical and security patches, to latest vendor-provided level. Note 12	Condition	N/A	N/A	N/A	100%	65%	●

Addendum

1. Measuring earthquake risk against current building design and detail
2. Usage of core building services, including Lifts and Boilers
3. There are 146 carparks designated for disabled parking at the Waikato DHB (30 June 2021)
4. Measured as Kwh /m2 per annum
5. For theatre day session Monday to Friday and includes acute list
6. Includes all inpatient wards within CCTV/IM/Surgery/Orthopaedics/Oncology/Paediatrics/Women's Health but excludes Critical Care
7. As defined by the Planned Care Initiatives, Waikato facilities only, excludes Waikato domiciled patients receiving treatment at other DHBs
8. Includes PCs/laptops/tablets. Win10 project will have an impact on age of items
9. Change in measure specifically identifies critical clinical systems at ED only
10. Based on customer survey
11. IS System security effectiveness
12. IS System security effectiveness. Covers owned assets only.

“The eye clinic gave me back my sight and I am extremely grateful.”

Ophthamology outpatients

Part five:
Financial statements

Statement of comprehensive revenue and expense for the year ended 30 June 2021

	Note	Group			Parent	
		2021 Budget	2021 Actual	2020 Restated Actual	2021 Actual	2020 Restated Actual
		$000	$000	$000	$000	$000
Revenue						
Patient care revenue	2	1,707,350	1,757,850	1,600,355	1,757,850	1,600,355
Other revenue	3	21,471	28,676	22,067	27,736	22,208
Finance revenue	4	328	680	521	560	288
Total income		**1,729,149**	**1,787,206**	**1,622,943**	**1,786,146**	**1,622,851**
Expenses						
Personnel costs	5/38	752,610	759,225	772,813	759,225	772,813
Depreciation	6	51,303	52,330	50,862	52,330	50,862
Amortisation and impairment cost	7	9,059	6,632	5,935	6,632	5,935
Outsourced services		69,692	94,610	85,545	94,610	85,545
Clinical supplies		170,367	187,809	168,074	187,809	168,074
Infrastructure and non-clinical expenses		67,331	84,448	78,768	84,448	78,768
Other district health boards		69,288	68,346	65,303	68,346	65,303
Non-health board providers		520,945	531,152	484,982	531,152	484,982
Other operating expenses	8	10,669	11,765	11,770	11,747	11,753
Finance costs	9	464	81	796	81	796
Capital charge	10	36,421	30,824	33,507	30,824	33,507
Total expenses		**1,758,149**	**1,827,222**	**1,758,355**	**1,827,204**	**1,758,338**
Share of joint venture surplus/(deficit)	11	-	244	(14)	-	-
Surplus/(deficit)		**(29,000)**	**(39,772)**	**(135,426)**	**(41,058)**	**(135,487)**
Other comprehensive revenue and expense						
Increase/(decrease) in revaluation reserve	12	-	240,318	(51)	240,318	(51)
Other comprehensive revenue and expense for the year		**-**	**240,318**	**(51)**	**240,318**	**(51)**
Total comprehensive revenue and expense for the year		**(29,000)**	**200,546**	**(135,477)**	**199,260**	**(135,538)**

Explanations of major variances to budget are provided in note 39.

The accompanying notes form part of the financial statements.

Statement of changes in equity for the year ended 30 June 2021

	Note	Group			Parent	
		2021 Budget	2021 Actual	2020 Restated Actual	2021 Actual	2020 Restated Actual
		$000	$000	$000	$000	$000
Balance at 1 July		**624,492**	**561,455**	**579,404**	**560,484**	**578,659**
Total comprehensive revenue and expense for the year						
Surplus/(deficit) for the year		(29,000)	(39,772)	(135,426)	(41,058)	(135,487)
Other comprehensive income/ (expense)		-	240,318	(51)	240,318	(51)
Total comprehensive revenue and expense for the year		**(29,000)**	**200,546**	**(135,477)**	**199,260**	**(135,538)**
Owner transactions						
Capital contribution		58,000	-	120,000	-	120,000
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other equity movement	23	97	(1,014)	(278)	-	-
Correction – prior year equity accounting joint venture		-	-	-	-	(443)
Balance at 30 June	**12/38**	**651,395**	**758,793**	**561,455**	**757,550**	**560,484**

Explanations of major variances to budget are provided in note 39.

Prior year figures were restated as detailed in note 38.

The accompanying notes form part of the financial statements.

Statement of financial position as at 30 June 2021

	Note	Group			Parent	
		2021 Budget	2021 Actual	2020 Restated Actual	2021 Actual	2020 Restated Actual
Assets		$000	$000	$000	$000	$000
Current assets						
Cash and cash equivalents	13	9,416	28,034	27,058	18,170	18,218
Receivables	14	54,189	91,019	51,218	90,981	51,199
Prepayments	15	5,970	7,846	7,676	7,846	7,676
Inventories	16	12,261	12,516	12,649	12,516	12,649
Non-current assets held for sale	17	-	1,381	1,381	1,381	1,381
Total current assets		**81,836**	**140,796**	**99,982**	**130,894**	**91,123**
Non-current assets						
Property, plant and equipment	6	776,703	972,560	758,214	972,560	758,214
Intangible assets	7	31,932	42,116	34,782	42,116	34,782
Investment in joint venture accounted for using the equity method	11	429	673	429	-	-
Prepayments	15	11,989	15,027	12,872	15,027	12,872
Total non-current assets		821,053	1,030,376	806,297	1,029,703	805,868
Total assets		**902,889**	**1,171,172**	**906,279**	**1,160,597**	**896,991**
Liabilities						
Current liabilities						
Cash and cash equivalents	13	22,954	-	-	-	-
Borrowings	19	50	50	135	50	135
Employee entitlements	20/38	134,494	284,391	250,868	284,391	250,868
Trade and other payables under exchange transactions	21	63,811	95,641	64,635	95,623	64,618
Trade and other payables under non-exchange transactions	21	11,457	13,529	9,694	13,529	9,694
Provisions	22	1,036	1,065	1,044	1,065	1,044
Total current liabilities		**233,802**	**394,676**	**326,376**	**394,658**	**326,359**
Non-current liabilities						
Borrowings	19	-	-	50	-	50
Employee entitlements	20	8,587	7,991	9,786	7,991	9,786
Provisions	22	414	398	312	398	312
Restricted trust funds	23	8,691	9,314	8,300	-	-
Total non-current liabilities		17,692	17,703	18,448	8,389	10,148
Total liabilities		251,494	412,379	344,824	403,047	336,507
Net assets		**651,395**	**758,793**	**561,455**	**757,550**	**560,484**
Equity						
Crown equity (Contributed capital)	12	485,060	427,061	429,255	427,061	429,255
Revaluation reserve	12	351,488	591,806	351,488	591,806	351,488
Retained earnings (Accumulated deficit)		(185,791)	(260,645)	(219,831)	(261,317)	(220,259)
Trust funds	12	638	571	543	-	-
Total equity		**651,395**	**758,793**	**561,455**	**757,550**	**560,484**

Explanations of major variances to budget are provided in note 39. The accompanying notes form part of the financial statements.

Statement of cash flows for the year ended 30 June 2021

	Note	Group 2021 Budget $000	Group 2021 Actual $000	Group 2020 Actual $000	Parent 2021 Actual $000	Parent 2020 Actual $000
Cash flows from operating activities						
Operating receipts		1,726,152	1,759,629	1,618,790	1,758,736	1,618,933
Interest received		328	709	827	560	584
Payments to suppliers		(906,581)	(962,233)	(904,995)	(962,215)	(904,979)
Payments to employees		(807,276)	(727,497)	(692,427)	(727,497)	(692,427)
Interest paid		(1,029)	(81)	(796)	(81)	(796)
Payments for capital charge		(36,421)	(30,824)	(33,507)	(30,824)	(33,507)
Goods and services tax (net)		3,181	3,672	(1,573)	3,672	(1,573)
Net cash flows from operating activities	24	(21,646)	43,375	(13,681)	42,351	(13,765)
Cash flows from investing activities						
Purchase of property, plant and equipment		(52,076)	(26,162)	(36,632)	(26,162)	(36,632)
Purchase of intangible assets		(23,924)	(13,908)	(13,091)	(13,908)	(13,091)
Purchase of non current software licences		-	-	-	-	-
Receipts from sale of property, plant and equipment		1,381	-	19	-	19
Net cash flows from investing activities		(74,619)	(40,070)	(49,704)	(40,070)	(49,704)
Cash flows from financing activities						
Capital contribution from the Crown		58,000	-	120,000	-	120,000
Repayment of capital to the Crown		(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Proceeds from borrowings		-	-	-	-	-
Repayment of borrowings		(135)	(135)	(181)	(135)	(181)
Net cash flows from financing activities		55,671	(2,329)	117,625	(2,329)	117,625
Net increase/(decrease) in cash and equivalents		(40,595)	976	54,240	(48)	54,156
Cash and cash equivalents at beginning of year		27,057	27,058	(27,182)	18,218	(35,938)
Cash and cash equivalents at end of year	13	(13,538)	28,034	27,058	18,170	18,218

Explanations of major variances to budget are provided in note 39.

The accompanying notes form part of the financial statements.

For and on behalf of the governors

Dame Karen Poutasi
Commissioner
Waikato District Health Board
15 December 2021

Prof Margaret Wilson
Deputy Commissioner
Waikato District Health Board
15 December 2021

1. Statement of accounting policies

Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2021, and were authorised for issue by the commissioners on 15 December 2021.

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 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 disclosed in note 20 prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with the DHB to maintain its financial viability and acknowledges 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

The financial statements of the group have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practices in (NZ GAAP).

These financial statements have been prepared in accordance with, and comply with, Tier 1 PBE accounting standards.

Presentation currency and rounding

The financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000).

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:

1. Statement of accounting policies (continued)

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE IPSAS 41 Financial Instruments

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

PBR FRS 48 Service Performance Reporting

In November 2017, the XRB issued PBE FRS48, a new standard for Service Performance Reporting. PBE FRS48 is effective for periods beginning on or after 1 January 2021 with early adoption permitted.

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

The Waikato DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

Significant accounting policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Subsidiaries

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

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

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

Budget figures

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

Income tax

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

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.

1. Statement of accounting policies (continued)

Foreign currency transactions

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 6.

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

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires Waikato DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset. Waikato DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement gratuities and long service leave

Note 20 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

Holidays Act 2003

The significant assumptions applied in determining the accrual for Holidays Act 2003 are disclosed in note 20.

Critical judgements in applying accounting policies

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

2. Patient care revenue

Accounting policies

Revenue from exchange transactions is measured at the fair value of consideration received or receivable, taking into account the amount of any trade discounts and volume rebates allowed by the Waikato DHB. Revenue from non-exchange transactions is revenue other than revenue from exchange transactions, such as donations, grants and transfers. The specific accounting policies for significant revenue items are explained below:

Ministry of Health population-based revenue

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

Ministry of Health contract revenue

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

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

ACC contract revenue

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

Revenue from other district health boards

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

	Group		Parent	
Patient care revenue breakdown	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Non-exchange transactions				
Health and disability services (Crown appropriation revenue) [1]	1,457,231	1,333,397	1,457,231	1,333,397
Other Ministry of Health and government revenue	48,842	34,196	48,842	34,196
Patient co-payments	1,360	1,680	1,360	1,680
Inter district revenue from other district health boards [2]	-	48,439	-	48,439
Exchange transactions				
Health and disability services (Ministry of Health)	41,564	37,755	41,564	37,755
ACC contract revenue	20,452	16,649	20,452	16,649
Inter district revenue from other district health boards	159,213	99,563	159,213	99,563
Clinical Training Agency revenue	12,120	11,734	12,120	11,734
Other patient care related revenue	17,068	16,942	17,068	16,942
Total patient care revenue	1,757,850	1,600,355	1,757,850	1,600,355

1 - Performance against this appropriation is reported in the Statement of Performance on pages 53-109. The appropriation revenue received by Waikato DHB equals the Government's actual expenses incurred in relation to the appropriation, which is a required disclosure from the Public Finance Act. The budgeted appropriation amount from the Ministry of Health relating to personal and public health services and management outputs for the current year is $1,404,976,000 (2020 - $1,297,088,000).

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

3. Other revenue

Accounting policies

Rental revenue

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

Provision of services

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

Grants received

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

Donations and bequests

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

Vested or donated assets

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

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

	Group		Parent	
Other revenue breakdown	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Non-exchange transactions				
Donations and bequests received	4,907	1,605	3,199	137
Grants received	-	-	768	1,609
Exchange transactions				
Rental revenue	1,742	1,591	1,742	1,591
Gain on sale of property, plant and equipment	-	46	-	46
Other revenue	22,027	18,825	22,027	18,825
Total other revenue	28,676	22,067	27,736	22,208

Other revenue includes revenue from parking, cafeterias, drug trials, and tutoring.

4. Finance revenue

Accounting policy

Interest revenue

Interest revenue is recognised using the effective interest method.

	Group		Parent	
Finance revenue (exchange transactions) breakdown	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Interest revenue	680	521	560	288
Total finance revenue	680	521	560	288

5. Personnel costs

Accounting policy

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit plan contributors scheme

The group makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund (NPF). 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.

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve neither a surplus nor deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to so contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and the interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

		Group		Parent	
	Note	2021 Actual	2020 Restated Actual	2021 Actual	2020 Restated Actual
Personnel costs breakdown		$000	$000	$000	$000
Salaries and wages		704,734	671,033	704,734	671,033
Increase/(decrease) in liability for employee entitlements	38	31,728	80,387	31,728	80,387
Defined contribution plan employer contributions		22,763	21,393	22,763	21,393
Total personnel cost		759,225	772,813	759,225	772,813

6. Property, plant and equipment

Accounting policy

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

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

Land and buildings

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

Revaluations

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

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

6. Property, plant and equipment (continued)

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	2.5 - 58 years	1.7 - 40.0%
Clinical assets	2 - 20 years	5.0 - 50.0%
General assets	3 - 35 years	2.9 - 33.3%
Motor vehicles	5 - 11 years	9.1 - 20.0%

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.

6. Property, plant and equipment (continued)

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 revenue in the surplus or deficit.

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

Group Actual Cost	Freehold land $000	Freehold buildings $000	Leasehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Balance at 1 July 2019	50,039	632,886	-	226,881	31,067	940,873
Additions	-	-	-	-	36,632	36,632
Transfers	-	19,191	-	28,275	(47,466)	-
Disposals	-	(75)	-	(629)	-	(704)
Revaluation adjustment	-	37	-	-	-	37
Transfer to non current assets held for sale	(1,050)	(390)	-	-	-	(1,440)
Balance at 30 June 2020	**48,989**	**651,649**	**-**	**254,527**	**20,233**	**975,398**
Balance at 1 July 2020	48,989	651,649	-	254,527	20,233	975,398
Additions	-	-	-	-	26,541	26,541
Transfers	-	(1,709)	15,788	20,805	(34,884)	-
Reclassified to intangible assets	-	(822)	482	281	-	(59)
Disposals	-	-	-	(19,469)	-	(19,469)
Revaluation	44,637	129,554	-	-	-	174,191
Prior year adjustement	-	-	-	(42)	-	(42)
Balance at 30 June 2021	**93,626**	**778,672**	**16,270**	**256,102**	**11,890**	**1,156,560**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000	$000
Balance at 1 July 2019	-	-	-	166,933	-	166,933
Depreciation charge and impairment losses for the year	-	33,623	-	17,239	-	50,862
Disposals	-	96	-	(684)	-	(588)
Revaluation adjustment	-	36	-	-	-	36
Transfer to non current assets held for sale	-	(59)	-	-	-	(59)
Reclassification adjustment	-	(109)	-	109	-	-
Balance at 30 June 2020	**-**	**33,587**	**-**	**183,597**	**-**	**217,184**
Balance at 1 July 2020	-	33,587	-	183,597	-	217,184
Depreciation charge and impairment losses for the year	-	33,355	756	18,219	-	52,330
Disposals	-	-	-	(19,386)	-	(19,386)
Revaluation adjustment	-	(66,127)	-	-	-	(66,127)
Transfer to non current assets held for sale	-	-	-	-	-	-
Reclassification adjustment	-	335	(352)	16	-	(1)
Balance at 30 June 2021	**-**	**1,150**	**404**	**182,446**	**-**	**184,000**

6. Property, plant and equipment (continued)

Group Actual Carrying amounts	Freehold land $000	Freehold buildings $000	Leasehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
At 1 July 2019	50,039	632,886	-	59,948	31,067	773,940
At 30 June 2020	**48,989**	**618,062**	**-**	**70,930**	**20,233**	**758,214**
At 1 July 2020	48,989	618,062	-	70,930	20,233	758,214
At 30 June 2021	**93,626**	**777,522**	**15,866**	**73,656**	**11,890**	**972,560**

Parent Actual Cost	Freehold land $000	Freehold buildings $000	Leasehold buildings $000	Plant, equipment and vehicles $000	Work in progress $000	Total $000
Balance at 1 July 2019	50,039	632,886	-	226,881	31,067	940,873
Additions	-	-	-	-	36,632	36,632
Transfers	-	19,191	-	28,275	(47,466)	-
Disposals	-	(75)	-	(629)	-	(704)
Revaluation adjustment	-	37	-	-	-	37
Transfer to non current assets held for sale	(1,050)	(390)	-	-	-	(1,440)
Balance at 30 June 2020	**48,989**	**651,649**	**-**	**254,527**	**20,233**	**975,398**
Balance at 1 July 2020	48,989	651,649	-	254,527	20,233	975,398
Additions	-	-	-	-	26,541	26,541
Transfers	-	(1,709)	15,788	20,805	(34,884)	-
Transferred to intangible assets	-	(822)	482	281	-	(59)
Disposals	-	-	-	(19,469)	-	(19,469)
Revaluation	44,637	129,554	-	-	-	174,191
Prior year adjustement	-	-	-	(42)	-	(42)
Balance at 30 June 2021	**93,626**	**778,672**	**16,270**	**256,102**	**11,890**	**1,156,560**
Accumulated depreciation and impairment losses	$000	$000	$000	$000	$000	$000
Balance at 1 July 2019	-	-	-	166,933	-	166,933
Depreciation charge and impairment losses for the year	-	33,623	-	17,239	-	50,862
Disposals	-	96	-	(684)	-	(588)
Revaluation adjustment	-	36	-	-	-	36
Transfer to non current assets held for sale	-	(59)	-	-	-	(59)
Reclassification adjustment	-	(109)	-	109	-	-
Balance at 30 June 2020	**-**	**33,587**	**-**	**183,597**	**-**	**217,184**
Balance at 1 July 2020	-	33,587	-	183,597	-	217,184
Depreciation charge and impairment losses for the year	-	33,355	756	18,219	-	52,330
Disposals	-	-	-	(19,386)	-	(19,386)
Revaluation	-	(66,127)	-	-	-	(66,127)
Transfer to non current assets held for sale	-	-	-	-	-	-
Reclassification adjustment	-	335	(352)	16	-	(1)
Balance at 30 June 2021	**-**	**1,150**	**404**	**182,446**	**-**	**184,000**
Carrying amounts	$000	$000	$000	$000	$000	$000
At 1 July 2019	50,039	632,886	-	59,948	31,067	773,940
At 30 June 2020	**48,989**	**618,062**	**-**	**70,930**	**20,233**	**758,214**
At 1 July 2020	48,989	618,062	-	70,930	20,233	758,214
At 30 June 2021	**93,626**	**777,522**	**15,866**	**73,656**	**11,890**	**972,560**

6. Property, plant and equipment (continued)

Valuation

The most recent comprehensive valuation of land and buildings was carried out by P.D. Todd, an independent registered valuer and a member of the New Zealand Institute of Valuers. The valuation was carried out at 30 June 2021.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with 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. Land values were determined using a number of significant assumptions. Significant assumptions used in the 30 June 2021 valuation include:

- The land values that have been applied across the sites range from $10 to $1,060 (2019: $6 to $716) per square metre across all sites
- As there have been no direct sales of land comparable to the size of the main Hamilton hospital site which is over 180,000 square metres, land sales have been analysed taking size variation, zoning and related costs into account

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

All DHB building assets that have been valued are specialised hospital buildings (with the exception of $1.47 million in respect of assets valued at fair value using market based evidence).

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, these assumptions underpinning the valuation have been arrived at during uncertain times with labour and material cost and have been performed based on evidence currently available and include:

- 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. There have been no optimisation adjustments for the most recent valuation
- 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 DHB is not aware of any significant asbestos issues associated with the buildings and therefore no allowance has been made for deferred maintenance in this regard
- The remaining useful life of assets is estimated
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

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

The valuation is made up in part by the significant increase in value of the larger buildings in Hamilton, Waiora Waikato Centre and Meade Clinical Centre primarily driven by the large increases in buildings costs.

The Waiora Waikato Centre has been valued based on a range of costs per square metre ranging from $5,800 per square metre for offices facilities, physiotherapy blocks at $7,391 per square metre and laboratories at $9,804 per square metre.

6. Property, plant and equipment (continued)

The Meade Clinical Centre has been valued based on a range of costs per square metre ranging from $6,897 per square metre for clinics and offices with atriums, $8,750 for clinics and offices with atriums and part theatres and $9,500 per square metre for ICU and HDU wards.

The assumptions underpinning the valuation have been arrived at during uncertain times with labour and material cost and have been performed based on evidence currently available.

Restrictions

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

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

Finance leases

The net carrying amount of plant, equipment and vehicles held under finance lease is $0.06 million (2020: $0.19 million). Note 19 provides further information about finance leases.

Property, plant and equipment under construction

Buildings work in progress at 30 June 2021 is $3.0 million (2020: $10.7 million) and capital commitments is $3.2 million (2020: $1.3 million). Plant, equipment and vehicles work in progress at 30 June 2021 is $8.9 million (2020: $9.5million) and capital commitments is $11.1 million (2020: $4.2 million).

7. Intangible assets

Accounting policy

Software acquisition and development

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

Information technology shared services rights

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

Amortisation

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

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

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

Impairment of intangible assets

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

7. Intangible assets (continued)

Movements for intangible assets are as follows:

Group 2020 Actual	Internally generated	Software and development	Work in progress	Total
Cost	$000	$000	$000	$000
Balance at 1 July 2019	2,689	70,294	13,714	86,697
Additions	-	-	13,091	13,091
Disposals	-	(711)	-	(711)
Transfers	1,983	7,106	(9,089)	-
Balance at 30 June 2020	**4,672**	**76,689**	**17,716**	**99,077**
Balance at 1 July 2020	4,672	76,689	17,716	99,077
Additions	-	-	13,908	13,908
Disposals	-	(10)	-	(10)
Transfers	330	8,999	(9,329)	-
Transfer from Fixed Assets	-	59	-	59
Balance at 30 June 2021	**5,002**	**85,737**	**22,295**	**113,034**
Accumulated amortisation and impairment losses				
Balance at 1 July 2019	372	58,699	-	59,071
Amortisation and impairment charge for the year	648	5,287	-	5,935
Disposals	-	(711)	-	(711)
Balance at 30 June 2020	**1,020**	**63,275**	**-**	**64,295**
Balance at 1 July 2020	1,020	63,275	-	64,295
Amortisation and impairment charge for the year	33	6,600	-	6,632
Disposals	-	(10)	-	(10)
Reclassifications	-	1	-	1
Balance at 30 June 2021	1,053	69,866	-	70,918

7. Intangible assets (continued)

Group 2020 Actual Carrying amounts	Internally generated $000	Software and development $000	Work in progress $000	Total $000
At 1 July 2019	2,317	11,595	13,714	27,626
At 30 June 2020	**3,652**	**13,414**	**17,716**	**34,782**
At 1 July 2020	3,652	13,414	17,716	34,782
At 30 June 2021	**3,949**	**15,871**	**22,295**	**42,116**

Parent 2020 Actual Cost	Internally generated $000	Software and development $000	Work in progress $000	Total $000
Balance at 1 July 2019	2,689	70,294	13,714	86,697
Additions	-	-	13,091	13,091
Transfers	1,983	7,106	(9,089)	-
Disposals	-	(711)	-	(711)
Balance at 30 June 2020	**4,672**	**76,689**	**17,716**	**99,077**
Balance at 1 July 2020	4,672	76,689	17,716	99,077
Additions	-	-	13,908	13,908
Transfers	330	8,999	(9,329)	-
Transfer from Fixed Assets	-	59	-	59
Disposals	-	(10)	-	(10)
Balance at 30 June 2021	**5,002**	**85,737**	**22,295**	**113,034**
Accumulated amortisation and impairment losses				
Balance at 1 July 2019	372	58,699	-	59,071
Amortisation and impairment charge for the year	648	5,287	-	5,935
Disposals	-	(711)	-	(711)
Reclassifications	-	-	-	-
Balance at 30 June 2020	1,020	63,275	-	64,295
Balance at 1 July 2020	1,020	63,275	-	64,295
Amortisation and impairment charge for the year	33	6,600	-	6,632
Disposals	-	(10)	-	(10)
Reclassifications	-	1	-	1
Balance at 30 June 2021	1,053	69,866	-	70,918
Carrying amounts				
At 1 July 2019	2,317	11,595	13,714	27,626
At 30 June 2020	3,652	13,414	17,716	34,782
At 1 July 2020	3,652	13,414	17,716	34,782
At 30 June 2021	3,949	15,872	22,295	42,116

There are no restrictions over the title of Waikato DHB's intangible assets, nor are any intangible assets pledged as security for liabilities.

Impairments

The value of impairments in the current year is $nil (2020 $nil).

8. Other operating expenses

Accounting policy

Leases

Waikato DHB as lessee

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

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

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

Waikato DHB as lessor

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

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

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

	Group		Parent	
Breakdown of other expenses	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Allowance for credit losses on receivables	527	639	527	639
Audit fees for the audit of the financial statements – 2020/21	286	271	268	254
Audit related fees for assurance and internal audits	5	1	5	1
Board and committee members' remuneration and expenses	91	15	91	15
Koha and donations	212	138	212	138
Operating lease expenses	10,562	10,614	10,562	10,614
Loss on disposal of property, plant and equipment	82	92	82	92
Total other operating expenses	**11,765**	**11,770**	**11,747**	**11,753**

9. Finance costs

Accounting policy

Borrowing costs

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Interest and financing expenses	81	796	81	796
Total finance cost	**81**	**796**	**81**	**796**

10. Capital charge

Accounting policy

Capital charge

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Capital charge	30,824	33,507	30,824	33,507
Total capital charge	**30,824**	**33,507**	**30,824**	**33,507**

Waikato DHB pays a capital charge to the Crown every six months. This charge is based on actual closing equity as at 30 June and 31 December each year. The capital charge rate for the period ended 30 June 2021 was 5% (2020: 6%).

11. Investments in joint venture

Accounting policy

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

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

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

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

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

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

a) General information

Name of entity	Principal activities	Interest held at 30 June 2021	Balance date
HealthShare Limited	Provision of clinical regional services	20%	30 June

b) Carrying amount of investment

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Opening balance	429	443	-	443
Share of joint venture surplus/(deficit)	244	(14)	-	-
Correction – prior year equity accounting joint venture	-	-	-	(443)
Closing balance	**673**	**429**	**-**	**-**

11. Investments in joint venture (continued)

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Current assets	1,920	1,544	-	-
Non-current assets	5,535	5,977	-	-
Current liabilities	(828)	(1,851)	-	-
Non-current liabilities	(5,954)	(5,241)	-	-
Net assets	**673**	**429**	**-**	**-**
Revenue	4,270	3,726	-	-
Expenses	(4,026)	(3,740)	-	-
Share of surplus/(deficit) of joint venture	**244**	**(14)**	**-**	**-**

12. Equity

Accounting policy

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

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

Revaluation reserves

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

Trust funds

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

Group Reconciliation of movement in equity	Trust funds $000	Crown equity $000	Revaluation reserve $000	Retained earnings restated $000	Total equity $000
Balance at 1 July 2019	745	311,449	351,539	(84,329)	579,404
Total comprehensive revenue/(expense) restated	75	-	(51)	(135,501)	(135,477)
Contributed capital – deficit support funding	-	120,000	-	-	120,000
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(277)	-	-	-	(277)
Other movement		-	-	(1)	(1)
Balance at 30 June 2020	**543**	**429,255**	**351,488**	**(219,831)**	**561,455**
Balance at 1 July 2020	543	429,255	351,488	(219,831)	561,455
Total comprehensive revenue/(expense)	1,042	-	240,318	(40,814)	200,546
Repayment of capital to the Crown	-	(2,194)	-	-	(2,194)
Transfer to restricted trust fund	(1,014)	-	-	-	(1,014)
Other movement	-	-	-	-	-
Balance at 30 June 2021	**571**	**427,061**	**591,806**	(260,645)	**758,793**

12. Equity (continued)

Trust funds

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

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

Parent Reconciliation of movement in equity	Crown equity $000	Revaluation reserve $000	Retained earnings restated $000	Total equity $000
Balance at 1 July 2019	311,449	351,539	(84,329)	578,659
Total comprehensive revenue/(expense) restated	-	(51)	(135,487)	(135,538)
Contributed capital – deficit support funding	120,000	-	-	120,000
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Correction – prior year equity accounting joint venture			(443)	(443)
Balance at 30 June 2020	**429,255**	**351,488**	**(220,259)**	**560,484**
Balance at 1 July 2020	429,255	351,488	(220,259)	560,484
Total comprehensive revenue/(expense)	-	240,318	(41,058)	199,260
Repayment of capital to the Crown	(2,194)	-	-	(2,194)
Other movement	-	-	-	-
Balance at 30 June 2021	**427,061**	**591,806**	**(261,317)**	**757,550**

13. Cash and cash equivalents

Accounting policy

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

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions. Further information about trust funds is provided in note 23.

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Cash at bank/(overdraft) and cash on hand	48	49	48	49
Advance to/(from) New Zealand Health Partnerships Limited	18,122	18,169	18,122	18,169
Trust funds	9,864	8,840	-	-
Total cash and cash equivalents	**28,034**	**27,058**	**18,170**	**18,218**

14. Receivables

Accounting policy

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

In measuring expected credit losses, receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the shared credit risk characteristics and days past due. The expected loss rates are based on the payment profile of transaction over a period of 24 months before 30 June 2021 and the corresponding historical credit losses experienced within this period.

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Ministry of Health trade receivables	13,783	6,849	13,783	6,849
Other trade receivables	14,542	7,623	14,542	7,623
Less: Allowance for credit losses	(1,547)	(1,397)	(1,547)	(1,397)
Total trade receivables	**26,778**	**13,075**	**26,778**	**13,075**
Ministry of Health accrued revenue	32,342	19,081	32,342	19,081
Other accrued revenue	31,899	19,062	31,861	19,043
Total receivables	**91,019**	**51,218**	**90,981**	**51,199**
Total receivables comprises:				
Receivables from non-exchange transactions	13,491	2,913	13,491	2,913
Receivables from exchange transactions	77,528	48,305	77,490	48,286

The expected credit loss rates for receivables at 30 June 2021 are based on the payment profile of invoices issued over the past 2 years at the measurement date and the corresponding historical credit losses experienced for that period. The historical loss rates are adjusted for current and forward looking macroeconomic factors that might affect the recoverability of receivables.

The impact of the COVID-19 pandemic on credit loss history is minimal due to the customer type and nature of the receivable balances. Whilst the cyber-attack resulted in delayed billing of some revenue, there is no material impact on collectability.

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

The allowance for credit losses at 30 June 2021 was determined as follows:

Group	Receivables days past due				
	Current	More than 30 days	More than 60 days	More than 90 days	TOTAL
30 June 2021					
Expected credit loss rate	0.08%	4.07%	9.10%	17.32%	
Gross carrying amount ($000)	82,536	1,156	1,187	7,649	92,528
Lifetime expected credit loss ($000)	67	47	108	1,325	1,547
30 June 2020					
Expected credit loss rate	0.32%	13.16%	20.34%	44.05%	
Gross carrying amount ($000)	48,943	623	772	2,277	52,615
Lifetime expected credit loss ($000)	155	82	157	1,003	1,397

14. Receivables (continued)

Parent	Current	Receivables days past due: More than 30 days	More than 60 days	More than 90 days	TOTAL
30 June 2021					
Expected credit loss rate	0.08%	4.07%	9.10%	17.32%	
Gross carrying amount ($000)	82,574	1,156	1,187	7,649	92,566
Lifetime expected credit loss ($000)	67	47	108	1,325	1,547
30 June 2020					
Expected credit loss rate	0.32%	13.16%	20.34%	44.05%	
Gross carrying amount ($000)	48,924	623	772	2,277	52,596
Lifetime expected credit loss ($000)	155	82	157	1,003	1,397

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Opening allowance for credit losses at 1 July	1,397	1,234	1,397	1,234
Increase in loss allowance made during the year	364	467	364	467
Receivables written off during the year	(377)	(476)	(377)	(476)
Receivables recovered during the year	163	172	163	172
Balance at 30 June	**1,547**	**1,397**	**1,547**	**1,397**

15. Prepayments

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Current portion				
Prepayments	7,846	7,676	7,846	7,676
Total prepayments	**7,846**	**7,676**	**7,846**	**7,676**
Non-current portion				
Prepayments	15,027	12,872	15,027	12,872
Total prepayments	**15,027**	**12,872**	**15,027**	**12,872**

16. Inventories

Accounting policy

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Pharmaceuticals	1,426	1,167	1,426	1,167
Surgical and medical supplies	6,956	7,189	6,956	7,189
Other supplies	4,134	4,293	4,134	4,293
Total inventories	12,516	12,649	12,516	12,649

16. Inventories (continued)

The amount of inventories recognised as expense due to change in stock value during the year was $2,660 (2020:$35,334), which is included in the clinical supplies line item in the statement of comprehensive revenue and expense.

Write-down of inventories amounted to $2,552 for 2021 (2020: $18,192). There have been no reversals of write-downs. The provision for obsolete inventories adjustment recognised in the statement of comprehensive revenue and expense for the year ended 30 June 2021 was $Nil (2020: $Nil). No inventories are pledged as security for liabilities.

No inventories are pledged as security for liabilities (2020: $Nil). However, some inventories are subject to retention of title clauses.

17. Non-current assets held for sale

Accounting policy

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

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

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

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

	Group		Parent	
Breakdown of non-current assets held for sale	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Non-current assets held for resale include:				
Land	1,050	1,050	1,050	1,050
Buildings	331	331	331	331
Total non-current assets held for sale	1,381	1,381	1,381	1,381

The group owns land and buildings which have been classified as held for sale following the commissioner and Ministry of Health approval to sell the properties as they will provide no future use to the group. The sale is expected to be completed in the 2021/22 financial year.

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

18. Derivative financial instruments

Accounting policy

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

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

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

The notional principal amount of outstanding forward foreign exchange contracts in NZ$ was $Nil (2020: $Nil). The foreign currency principal amounts were $ Nil (2020: USD Nil).

19. Borrowings

Accounting policy

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

Borrowings are classified as current liabilities unless Waikato DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Finance Leases

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

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

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

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Current portion				
Loan from Energy Efficiency and Conservation Authority	-	15	-	15
Finance leases	50	120	50	120
	50	**135**	**50**	**135**
Non-current portion				
Loan from Energy Efficiency and Conservation Authority	-	-	-	-
Finance leases	-	50	-	50
	-	**50**	**-**	**50**
Analysis of finance leases				
Minimum lease payments payable:				
No later than one year	50	120	50	120
Later than one year and not later than five years	-	50	-	50
Later than five years	-	-	-	-
Total minimum lease payments	**50**	**170**	**50**	**170**
Future finance charges	-	(1)	-	(1)
Present value of minimum lease payments	**50**	**169**	**50**	**169**
Present value of minimum lease payments payable:				
No later than one year	50	119	50	119
Later than one year and not later than five years	-	50	-	50
Later than five years	-	-	-	-
Total present value of minimum lease payments	**50**	**169**	**50**	**169**

Finance Leases

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

The fair value of finance leases is $50,000 (2020: $169,000). Fair value has been determined by using a discount rate of 0.38% (2020:0.24%).

Description of finance leases

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

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

20. Employee entitlements

Accounting policy

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

	Note	Group 2021 Actual	Group 2020 Restated Actual	Parent 2021 Actual	Parent 2020 Restated Actual
Current portion		$000	$000	$000	$000
Liability for long service leave		3,665	3,542	3,665	3,542
Liability for retirement gratuities		3,809	3,450	3,809	3,450
Liability for annual leave		210,648	129,851	210,648	129,851
Holidays Act Remediation adjustment to prior year	38	-	63,037	-	63,037
Liability for sick and sabbatical leave		2,184	2,547	2,184	2,547
Liability for continuing medical education leave and expenses		19,962	13,498	19,962	13,498
PAYE payable		19,047	11,377	19,047	11,377
Overpayment recovery		(4,955)	-	(4,955)	-
Salary and wages accrual		30,031	23,566	30,031	23,566
		284,391	**250,868**	**284,391**	**250,868**
Non-current portion					
Liability for long service leave		1,963	1,704	1,963	1,704
Liability for retirement gratuities		6,028	8,082	6,028	8,082
		7,991	**9,786**	**7,991**	**9,786**

20. Employee entitlements (continued)

Key assumptions in measuring retirement and long service leave obligations

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

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advise from an independent actuary. Two discount rates for retirement and long service leave are used, 1.31% and 0.59%, respectively. (2020: 0.4% and 0.1% respectively) and a salary inflation factor of 3.0% (2020: 3.0%) was used.

If the discount rate were to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.4 million higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all the other factors held constant, the carrying amount of the retirement and long service leave obligations would be an estimated $0.4 million higher/lower.

Holidays Act 2003

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2021/22 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2021, in preparing these financial statements, Waikato DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

The current estimate of the liability is $112.67 million. However, until the project has progressed further, there remain uncertainties.

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

21. Trade and other payables

Accounting policy

Short-term payables are recorded at their face value.

	Group		Parent	
	2021 Actual	2020 Actual	2021 Actual	2020 Actual
Payables under exchange transactions	$000	$000	$000	$000
Creditors	87,605	63,938	87,587	63,921
Revenue received in advance	8,036	697	8,036	697
Total payables under exchange transactions	**95,641**	**64,635**	**95,623**	**64,618**
Payables under non-exchange transactions				
ACC levy payable	1,091	851	1,091	851
GST payable	11,227	7,555	11,227	7,555
Accrual – non-exchange expenses	1,211	1,288	1,211	1,288
Total payables under non-exchange transactions	**13,529**	**9,694**	**13,529**	**9,694**
Total payables	**109,170**	**74,329**	**109,152**	**74,312**

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

22. Provisions

Accounting policy

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

ACC Partnership Programme

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

Repairs to motor vehicles provision

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

Restructuring

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

	Group		Parent	
	2021 Actual	2020 Actual	2021 Actual	2020 Actual
Current liabilities	$000	$000	$000	$000
ACC Partnership Programme	1,042	957	1,042	957
Motor vehicle repairs on disposal	23	87	23	87
	1,065	**1,044**	**1,065**	**1,044**
Non-current liabilities				
Motor vehicle repairs on disposal	398	312	398	312
	398	**312**	**398**	**312**

22. Provisions (continued)

Movements for each class of provision are as follows:

	ACC Partnership Programme $000	Motor vehicle repairs on disposal $000	Total $000
Balance at 1 July 2019	933	545	1,478
Additional provisions made/released	1,354	53	1,407
Amounts used	(1,330)	(199)	(1,529)
Balance at 30 June 2020	**957**	**399**	**1,356**
Balance at 1 July 2020	957	399	1,356
Additional provisions made/released	1,475	122	1,597
Amounts used	(1,390)	(100)	(1,490)
Balance at 30 June 2021	**1,042**	**421**	**1,463**

ACC Partnership Programme

Waikato DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all claims costs for a period of four years and up to a specified maximum amount. At the end of the four year period, Waikato DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

Exposures arising from the programme are managed by promoting a safe and healthy working environment by:

- implementing and monitoring health and safety policies
- induction training on health and safety
- actively managing workplace injuries to ensure that employees return to work as soon as practical
- recording and monitoring workplace injuries and near misses to identify risk areas and implementing mitigating actions; and
- identifying workplace hazards and implementation of appropriate safety procedures.

Waikato DHB is not exposed to any significant concentrations of insurance risk, as work-related injuries are generally the result of an isolated event involving an individual employee.

An external independent actuarial valuer, Simon Ferry from Aon New Zealand, provided the ACC actuarials valuation to 30 June 2021. The valuer has attested that they are satisfied as to the nature, sufficiency, and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the valuer's report.

A prudent margin of 11.6% (2020: 11.6%) has been assessed to allow for the inherent uncertainty in the central estimate of the claims liability. This is the rate used by ACC. The key assumptions used in determining the outstanding claims liability are:

- pre valuation date claim inflation of 50% of movements in the Consumer Price Index and 50% of the movements in the Average Weekly Earnings index
- post valuation date claim inflation of 1.85% per annum (2020: 1.70%); and
- a discount factor of 0.50% for 30 June 2021 (2020: 1.08%).

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

Motor vehicle repairs on disposal

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

23. Restricted trust funds

Movements are as follows:	Group 2021 Actual $000 Waikato Health Trust	Group 2020 Actual $000 Waikato Health Trust
Balance at 1 July	8,300	8,023
Transfer from accumulated funds	1,014	277
Balance at 30 June	**9,314**	**8,300**

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

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

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

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

	Note	Group 2021 Actual $000	Group 2020 Restated Actual $000	Parent 2021 Actual $000	Parent 2020 Restated Actual $000
Net surplus/(deficit)		(39,772)	(135,426)	(41,058)	(135,487)
Add/(less) non-cash items:					
Depreciation	6	52,330	50,862	52,330	50,862
Amortisation	7	6,632	5,935	6,632	5,935
Bad and doubtful debts	14	364	467	364	467
Share of joint venture (surplus)/deficit	11	(244)	14	-	-
Add/(less) items classified as investing activity:					
Net loss/(gain) on disposal of property, plant and equipment	8	82	46	82	46
Add/(less) movements is statement of financial position items:					
(Increase)/decrease in inventories	16	133	(431)	133	(431)
(Increase)/decrease in gross receivables	14	(40,165)	(3,328)	(40,146)	(3,336)
(Increase)/decrease in prepayments	15	(2,325)	(8,073)	(2,325)	(8,073)
Increase/(decrease) in employee entitlements	20	31,728	80,387	31,728	80,387
Increase/(decrease) in trade and other payables	21	34,505	(4,012)	34,504	(4,013)
Increase/(decrease) in other provisions	22	107	(122)	107	(122)
Net cash flows from operating activities		**43,375**	**(13,681)**	**42,351**	**(13,765)**

25. Capital commitments and operating leases

Capital commitments	Group 2021 Actual $000	Group 2020 Actual $000	Parent 2021 Actual $000	Parent 2020 Actual $000
Buildings	3,194	1,326	3,194	1,326
Plant, equipment and vehicles	11,174	4,235	11,174	4,235
Intangible assets	1,795	4,187	1,795	4,187
Total capital commitments	**16,163**	**9,748**	**16,163**	**9,748**

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

25. Capital commitments and operating leases (continued)

Non-cancellable operating lease commitments

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

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Not later than one year	8,096	7,804	8,096	7,804
Later than one year and not later than five years	27,691	26,495	27,691	26,495
Later than five years	13,904	16,599	13,904	16,599
	49,691	**50,898**	**49,691**	**50,898**

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

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

26. Contingencies

	Group		Parent	
Contingent liabilities	$000	$000	$000	$000
Personal grievances	330	465	330	465
Legal proceedings and disputes by third parties	75	40	75	40
	405	**505**	**405**	**505**

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

Compliance with Holidays Act 2003

Many public and private sector entities, including the DHB, have considered and continue to investigate historic underpayment of holiday entitlements.

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

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

Contingent assets

Waikato DHB has no contingent assets at 30 June 2021 (2020:$Nil).

27. Client funds

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

	2021 Actual $000	2020 Actual $000
Balance at 1 July	57	45
Receipts	80	109
Payments	(93)	(97)
Balance at 30 June	**44**	**57**

28. Financial instruments

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

	Group		Parent	
Financial instrument categories	2021 Actual	2020 Actual	2021 Actual	2020 Actual
Financial assets measured at amortised cost	$000	$000	$000	$000
Cash and cash equivalents	28,034	27,058	18,170	18,218
Receivables – credit impaired	91,019	51,218	90,981	51,199
Total financial assets measured at amortised cost	**119,053**	**78,276**	**109,151**	**69,417**
Fair value through surplus or deficit				
Derivative financial instrument	-	-	-	-
Total derivative financial instrument	**-**	**-**	**-**	**-**
Financial liabilities measured at amortised cost				
Cash and cash equivalents	-	-	-	-
Trade and other payables (excluding income in advance)	101,134	73,632	101,116	73,615
Borrowings – loans	50	185	50	185
Total other financial liabilities	101,184	**73,817**	101,166	**73,800**

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

Financial instrument risks

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

Credit risk

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

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

Concentrations of credit risk from trade receivables are limited due to ACC and Ministry of Health being the largest single debtors (13% and 53% respectively, at 30 June 2021). They are assessed to be a low risk and high-quality entity due to their nature as the government funded purchaser of health and disability support services.

The impact of the COVID-19 pandemic on the collectability of trade receivables was considered, and as a high proportion of receivables are Crown entities (85% as at June 2021), the risk of higher expected credit loss rate is considered low.

No collateral or other credit enhancements are held for financial assets that give rise to credit risk.

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

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

28. Financial instruments (continued)

Credit quality of financial assets

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

	Group		Parent	
Counterparties with credit ratings	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Cash and cash equivalents				
AA	48	49	48	49
AA-	9,864	8,840	-	-
Total cash and cash equivalents	9,912	8,889	48	49
Counterparties without credit ratings				
New Zealand Health Partnership Limited	18,122	18,169	18,122	18,169
Receivables				
Counterparty with no defaults in the past	90,749	50,753	90,711	50,734
Counterparty with defaults in the past	270	465	270	465
Total receivables – credit impaired	91,019	51,218	90,981	51,199

Liquidity risk

Liquidity risk represents the ability for Waikato DHB to meet its contractual obligations and its liquidity requirements on an ongoing basis. Waikato DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the management of loan facilities.

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are contractual undiscounted cash flows.

	Group 2021 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Loans from Energy Efficiency and Conservation Authority	-	-	-	-	-	-	-
Finance leases	50	50	25	25	-	-	-
Trade and other payables	101,134	101,134	101,134	-	-	-	-
	101,184	**101,184**	**101,159**	**25**	**-**	**-**	**-**

	Parent 2021 Actual $000's						
	Balance sheet	Contractual cash flow	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
Loans from Energy Efficiency and Conservation Authority	-	-	-	-	-	-	-
Finance leases	50	50	25	25	-	-	-
Trade and other payables	101,116	101,116	101,116	-	-	-	-
	101,166	**101,166**	**101,141**	**25**	**-**	**-**	**-**

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

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

28. Financial instruments (continued)

Market price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Waikato DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market interest rates. Waikato DHB's exposure to fair value interest rate risk is limited to its cash balance held under a contract with New Zealand Health Partnership Limited (NZHPL) through a national DHB shared banking arrangement. NZHPL actively manages this risk. The exposure to fair value interest rate risk for long term borrowings is low due to long term borrowings generally being held to maturity.

Fair value interest rate sensitivity analysis

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

In managing fair value interest rate risks Waikato DHB aims to reduce the impact of short-term fluctuations on revenue and expenses. Over the longer-term, however, permanent changes in interest rates would have an impact on revenue and expenses.

Sensitivity analysis

For the year ended 30 June 2021, if floating interest rates had been 1% higher/lower, with all other variables held constant, the result for the year would have been approximately $868,000 higher/lower (2020: $157,000 lower/higher).

Currency risk

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

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

The group has no unhedged foreign-denominated payables at balance date (2020: $ Nil).

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

29. Capital management

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

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

30. Related parties

Ownership

Waikato DHB is a crown entity in terms of the Crown Entities Act 2004, and is a wholly owned entity of the Crown. The Crown significantly influences the role of Waikato DHB as well as being its major source of revenue. During the year Waikato DHB received $1.55 billion (2020:$1.42 billion) from the Ministry of Health to provide health and disability services. The amount owed by the Ministry of Health at 30 June 2021 was $46.13 million (2020:$25.9 million). Waikato DHB incurred a capital charge of $30.8 million (2020:$33.5 million) to the Government during the year.

30. Related parties (continued)

Identity of related parties

Waikato DHB has a related party relationship with the Waikato Health Trust, HealthShare Limited, New Zealand Health Partnership Limited and with its commissioners.

Transactions with the Waikato Health Trust, HealthShare Limited and New Zealand Health Partnership Limited are priced on an arm's length basis.

Significant transactions with government-related entities

Waikato DHB has received funding from ACC for the year ended 30 June 2021 of $20.5 million (2020:$16.6 million) to provide health services.

Revenue earned from other DHBs for the care of patients outside of the Waikato DHB district for the year ended 30 June 2021 was $159.2 million (2020:$148.0 million). Expenditure to other DHBs for their care of patients from Waikato DHB's district for the year ended 30 June 2021 was $68.3 million (2020:$65.3 million).

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

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

Waikato DHB also purchased goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended the 30 June 2021 totalled $30.0 million (2020 $26.2 million). These purchases included the purchase of electricity from Genesis and Merdian Power NZ, air travel from Air New Zealand, postal services from New Zealand Post and blood products from NZ Blood Service.

HealthShare Limited

HealthShare Limited is a company, established in February 2001 by the five DHBs in the Midland Region under a joint venture agreement, which provides regional services for these DHBs. No dividends have been received from HealthShare Limited.

As at 30 June 2021, HealthShare Limited had total assets of $37.274 million (2020:$37.605 million) and total liabilities of $33.908 million (2020:$35.460 million).

During the year Waikato DHB received $1,583,252 (2020: $1,511,000) from HealthShare Limited for services provided. Waikato DHB incurred expenses from HealthShare Limited of $10,765,597 (2020:$11,494,000) for services provided.

As at 30 June 2021 Waikato DHB owed Healthshare Limited $644,586 (2020: $1,099,000) and HealthShare Limited owed Waikato DHB $69,586 (2020: $973,000).

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

Waikato Health Trust

Waikato Health Trust (formerly the Health Waikato Charitable Trust) was incorporated in 1993 as a charitable trust in accordance with the provisions of the Charitable Trust Act 1957. Under the Trust Deed the trustees are appointed by the Waikato DHB, these trustees acting independently in accordance with their fiduciary responsibilities under trust law. The trustees at 30 June 2021 are Mark Cawthorne and Margaret Wilson. The purpose of the Trust is to fund health or disability services, related services or projects, health research or education and other appropriate health related purposes within the communities served by Waikato DHB.

Administration costs of the trust are borne by Waikato DHB. Revenue received from the Trust during the period was $0.768 million (2020:$1.609 million). There was $Nil owing to Waikato DHB at 30 June 2021 (2020:$Nil).

New Zealand Health Partnerships Limited

New Zealand Health Partnerships Limited was incorporated on 16 June 2015. Waikato DHB owns 6,948,005 (2020:6,948,005) shares being 10.17% (2020:10.17%). Waikato DHB does not have a controlling interest in New Zealand Health Partnership Limited.

31. Key management personnel remuneration

Key management personnel

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

Compensations

There were no loans to commissioners during the year ended 30 June 2021 (2020:$Nil).

The Waikato DHB has a standard Directors and Officers Insurance Policy. No claims were made under this policy during the year ended 30 June 2021 (2020:$Nil).

Remuneration

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

Commissioner and deputy commissioners	2021 Actual	2020 Actual
Commissioner	$	$
Dame Karen Poutasi	224,692	221,092
Deputy commissioners		
Andrew Connolly	9,500	14,300
Chad Paraone	40,400	60,000
Prof Margaret Wilson	81,500	80,205
	356,092	**375,597**

Executive management team	2021 Actual	2020 Actual
	$000	$000
Salaries and other short-term benefits	3,586	3,947
Contributions to superannuation schemes	145	162
Full-time equivalent members	10	11

Total remuneration and compensation to close members of the family of key management personnel occurred within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the Waikato DHB would have adopted if dealing with that individual at arm's length in the same circumstances.

Non-Board members who attended committee meetings	No. of meetings eligible to attend 2021	No. of meetings actually attended* 2021	Remuneration 2021 Actual	2020 Actual
			$	$
Judy Small	10	6	1,500	1,500
Rachel Karalus	10	5	1,125	1,500
David Slone	10	8	2,000	1,500
John McIntosh	10	6	1,500	1,500
Gerri Pomeroy	10	6	1,500	1,500
Te Pora Thompson-Evans	21	21	5,250	3,750
Glen Tupuhi	10	4	1,000	1,500
Paul Malpass	10	10	2,500	1,500
Fungai Mhlanga	10	8	2,000	1,250
			18,375	**15,500**

32. Termination payments to employees

During the year payments were made to 17 employees (2020:33) in respect of the termination of employment with Waikato DHB.

	2021 Actual $000	2020 Actual $000
Amount paid	596	1,505

33. Waikids early childhood centre – Waikato Hospital

	Group		Parent	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Summary of transactions relating to Waikids:				
Subsidy funding – Ministry of Education	197	214	197	214
Equity funding – Ministry of Education	41	34	41	34
Other funding – Ministry of Education	11	-	11	-
Other income	1	11	1	11
Personnel costs	(341)	(262)	(341)	(262)
Minor equipment purchases	(12)	(5)	(12)	(5)
Administration costs	(17)	(30)	(17)	(30)
Surplus/(Deficit) for the year	(120)	(38)	(120)	(38)
Accumulated surplus attributed to Waikato early childhood centre				
Balance at 1 July	162	200	162	200
Surplus/(Deficit) for the year	(120)	(38)	(120)	(38)
Accumulated surplus attributed to Waikato early childhood centre	42	162	42	162

Waikids early childhood centre is a hospital based play specialist service operated by the Waikato DHB within the Waikato Hospital, funded primarily by the Ministry of Education.

Waikato DHB supports the centre through provision of building, facilities and general administration.

Waikato DHB contributed to personnel costs to the extent of the work done in relation to inpatient care.

$389,248 of the personnel costs are offset from the total of $729,972.

Approved project costs of $120,092 for personnel expenses have been funded from retained earnings/ accumulated surplus attributed to Waikids early childhood centre.

34. Impact of COVID-19 on Waikato DHB

On 11 March 2020, the World Health Organization declared the outbreak of COVID-19 a pandemic. During the 2019/20 year, the country was in lockdown for a number of weeks, impacting service delivery. In the current financial year, as well as rescheduled recovery activity, the DHB has participated in Managed Isolation and Quarantine facilities and COVID-19 vaccination programmes.

An assessment of the impact of COVID-19 on the results of Waikato DHB at 30 June 2021 and its future viability has been performed and the effect on our operations is reflected in these financial statements, based on the information available to the date these financial statements are signed.

- Revenue: The bulk of Patient Care revenue is secured from funding from the Ministry of Health. Additional funding to assist with the COVID-19 response was approved.
- Expenses: Additional direct costs incurred associated with supporting the response to the pandemic include payroll, community health providers and other clinical expenses and have largely been funded by the Ministry of Health.

35. Impact of criminal cyber-attack on Waikato DHB

On 18 May 2021, Waikato DHB was subject to a criminal cyber-attack which disrupted the computer network and systems. No ransom was paid.

Working with the National Cyber Security Centre and NZ Police, a Coordinated Incident Management System team was set up to identify, manage and direct investigation and remediation of the impacts of the complex and challenging event.

All campuses were impacted with some outpatient activity and elective surgeries deferred at both Waiora and rural hospitals.

The immediate focus was on minimising the disruption to patients, with business continuity plans to keep patient care and clinical support services running. Urgent work was commenced on the secure restoration of digital systems followed by a recovery phase. At the date of signing of the Annual Report, most systems have been restored.

Waikato DHB has increased its resilience to cyber security threats following the cyber attack.

The financial accounting system was brought back on line prior to the year end. Material accounting estimates arising as a result of the cyber-attack were not required.

There were no material financial impacts on Waikato DHB due to the cyber attack. While the cyber attack caused considerable temporary disruption to the organisation, the costs of systems recovery and return to full service are the subject of a claim under our and broader government insurance policies. As at 30 June 2021, net cyber attack costs amount to $4.6 million.

36. Subsequent event

COVID-19 Delta community emergence – on 17 August 2021 New Zealand entered an alert level 4 lockdown following the identification of community cases within Auckland. This has impacted the DHB's operations through additional unbudgeted expenditure being incurred which the DHB expects will be funded by Ministry of Health. Some services have also been disrupted as a result of the level 4 restrictions which may have a flow on impact on revenue and expenses with impacts on Planned care and IDF revenue that is subject to wash-ups. Depending on the duration of this outbreak or any future outbreaks, it is highly likely that the DHB may not be able to achieve some financial and non-financial performance measures in the subsequent financial year. COVID impacts are reported to the Ministry of Health each month and historically, a significant portion of COVID impacts have been funded by the Ministry of Health.

37. Comparative information

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

38. Restatement of comparative figures

At 30 June 2020 the Waikato DHB recognised a liability in respect of Holidays Act remediation of $38.463 million. This liability was uncertain as it was based on a small sample with a high degree of assumptions applied. As at 30 June 2020 Waikato DHB Group already embarked on a process to enhance the reliability of this estimate, however work was not complete at the time the annual report was due for issue. This work was subsequently completed in February 2021 and a more reliable estimate of the liability at that date equalled $101.5 million. As this is a material change to the initial recognised liability of $38.463 million, balances as at 30 June 2020 were restated as follows:

- an increase to employee entitlement liability of $63.037 million
- an increase to personnel costs of $63.037 million

The following table summarises the impact on the Waikato DHB Group consolidated and parent financial statements:

38. Restatement of comparative figures (continued)

	Group			Parent		
	As previously reported $000	Adjustment $000	As restated $000	As previously reported $000	Adjustment	As restated
Statement of comprehensive revenue and expense for the year ended 30 June 2020						
Personnel costs	(709,776)	(63,037)	(772,813)	(709,776)	(63,037)	(772,813)
Line items not impacted by restatement	637,336	-	637,336	637,275	-	637,275
Total comprehensive revenue for the year	**(72,440)**	**(63,037)**	**(135,477)**	**(72,501)**	**(63,037)**	**(135,538)**
Statement of Financial Position as at 30 June 2020						
Total assets	**906,279**	**-**	**906,279**	**896,991**	**-**	**896,991**
Employee entitlements – current	187,831	63,037	250,868	187,831	63,037	250,868
Total liabilities	281,787	**63,037**	344,824	**273,470**	**63,037**	**336,507**
Retained earnings	(156,794)	(63,037)	(219,831)	(157,222)	(63,037)	(220,259)
Total equity	624,492	**(63,037)**	561,455	**623,521**	**(63,037)**	**560,484**

There is no impact on the Waikato DHB group and parent total operating, investing or financing cash flows for the year ending 30 June 2020.

39. Explanation of financial variances from budget

Waikato DHB recorded a net group deficit of $39.8 million against a budgeted deficit of $29.0 million with an unfavourable variance against budget of $10.8 million.

An unbudgeted increase in revaluation reserve resulted in an favourable variance of $240.3 million against budgeted comprehensive revenue.

Variances in group deficit

The unfavourable group deficit against budget of $39.8 million includes:

- revenue is $58.1 million favourable which includes additional funding for extra health services delivered together with reimbursement of specific costs incurred (materially offset in expenses). This includes $25.2 million in respect of funding to cover COVID-19 costs.
- personnel costs are $6.6 million unfavourable to budget which includes the recognition of estimated potential liability relating to Holidays Act 2003 remediation of $10.0 million. The unfavourable variance also includes COVID-19 related costs of $4.6 million. Higher costs were part offset by favourable vacancy variances.
- outsourced services and personnel are $24.9 million unfavourable. Variances include higher than planned use of outsource personnel to cover for vacancies, and higher outsource costs of PCI and covid recovery.
- clinical supplies expense is $17.4 million unfavourable mainly due to higher cost of treatment disposables and pharmaceuticals as a result of pricing and volume mix, as well as COVID-19 lab testing costs.
- infrastructure costs $17.1 million unfavourable due to savings that were budgeted to be acheived as infrastructure costs, but were instead achieved across other cost categories.
- non-health board provider expenses are $10.2 million unfavourable mainly due to costs incurred for which additional funding was received (offset in revenue).
- capital charge expense is $5.6 million favourable largely due to a reduction in rate from 6% to 5%. This offset by a reduction in revenue.

39. Explanation of financial variances from budget (continued)

Variances in statement of changes in equity

Total equity is $107.4 million favourable to budget. This includes:

- Revaluation Reserve $240.3 million higher than budget as a result of a revaluation of land and buildings at 30 June 2021.
- Unfavourable group deficit variance $10.8 million.
- Crown Equity is $58 million lower than budget due to lower than budgeted capital and equity contribution received. Budget includes an equity contribution towards the budgeted settlement of the Holidays Act remediation liability which did not eventuate.

Variances in financial position

Current assets are $59.0million higher than budget due to higher receivables balances $36.8 million arising from the unbudgeted accrual of COVID-19 revenue and as a result of the impact of the cyber-attack which delayed some invoicing and the accrual of the insurance refund. In addition, the bank balance was higher than budget as a result of the underspend on fixed assets together with receipt and payment timing differences.

Non current assets are $209.3 million higher than budget. This due to the impact of the revaluation of land and buildings $240.3 million offset by lower than planned capital spend $35.7 million. The revaluation is based on a number of assumptions as described in note 6. The significant increase is in part attributed to large increases in building costs which have been impacted by the disruptions and restitutions over supply chains resulting in greater demands and limited capacity as it related to building materials.

Current liabilities are $160.9 million higher than budget. This includes:

- Employee entitlements are $149.1 million higher than budget mainly due to the recognition of an additional Holidays Act remediation liability. Furthermore, budget includes settlement of the full Holidays Act remediation liability in the current year which did not eventuate.
- Trade and other payables are $33.9 million higher than budgeted which includes the impact of the cyber-attack as processing of supplier invoices was delayed.

Non current liabilities are close to budget.

Variances in cash flows

- Net cash outflows from operating activities are $65.0 million lower than budget due mainly to the postponement of budgeted payment of Holidays Act remediation $41.6 million. In addition, the cyber attack impacted timing of certain receipts and payments.
- Net cash outflows from investing activities are $34.5 million lower than budget due to lower than planned capital spend.
- Net cash inflows from financing activities are $58.0 million lower than budget due to planned capital and equity funding not eventuating.

40. Statement of Performance Expectations for the 2020/21 year – Breach of Section 149C of the Crown Entities Act 2004

In terms of Section 149C of the Crown Entities Act 2004, a Crown entity must prepare a statement of performance expectations (SPE) before the start of each financial year. At 30 June 2021 the 2021/22 SPE was in draft format as a result of the impact of the cyber-attack. The SPE has been approved by the commissioners in July 2021.

> Surgery went fantastic – what a great team, they were informative, professional and we were thrilled with the whole process. You made a worrying time much better.

General Surgery

Part six:
Audit report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Waikato District Health Board and Group's financial statements and performance information for the year ended 30 June 2021

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

We have audited:

- the financial statements of the Health Board and Group on pages 116 to 155, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board and Group on pages 54 to 109.

Opinion

In our opinion:

- the financial statements of the Health Board and Group on pages 116 to 155, which have been prepared on a disestablishment basis:
  - present fairly, in all material respects:
- its financial position as at 30 June 2021; and
- its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board and Group on pages 54 to 109:
  - presents fairly, in all material respects, the Health Board and Group's performance for the year ended 30 June 2021, including:
- for each class of reportable outputs:

- its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
  - complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 15 December 2021. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Commissioners and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 120 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health Board and Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 20 on page 142 outlines that the Health Board and Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board and Group has estimated a provision of $112.7 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Health Board and Group is reliant on financial support from the Crown

Note 1 on page 120 outlines that Crown support would be required if the Health Board and Group was required to settle the estimated historical Holidays Act 2003 liability prior to its disestablishment. The Health Board and Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board and Group with financial support, where necessary.

Health Service User population information was used in reporting Covid-19 vaccine strategy performance results

Note 2 on pages 108 and 109 outline the information used by the Health Board and Group to report on its Covid-19 vaccine coverage. The Health Board and Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on pages 108 to 109. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board and Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 34 on page 152 of the financial statements and pages 54 to 109 of the performance information outline the impact of Covid-19 on the Health Board and Group.

Basis for our opinion

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

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

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

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

The Commissioners are responsible on behalf of the Health Board and Group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

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

In preparing the financial statements and the performance information, the Commissioners are responsible on behalf of the Health Board and Group for assessing the Health Board and Group's ability to continue as a going concern. If the Commissioners conclude that the going concern basis of accounting is inappropriate, the Commissioners are responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

The Commissioners's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board and Group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and Group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioners.

- We evaluate the appropriateness of the reported performance information within the Health Board and Group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Commissioners.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Group audit. We remain solely responsible for our audit opinion.

We communicate with the Commissioners regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Commissioners are responsible for the other information. The other information comprises the information included on pages 1 to 53; 110 to 115; 156 to 157; and 164 to 168, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board and Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than the audit, we have no relationship with, or interests in, the Health Board and Group.

Wikus Jansen van Rensburg
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

I enjoyed the mix of staff. It was a joy seeing them all working so cooperatively together and getting on so well. It was a scary experience but everyone from the Emergency Department to the ward was very caring and supportive. I could see how they all played their part to help me get better.

Thankfully, it had been a very long time since I was an inpatient at any hospital, but I am so grateful that it was there when I needed it.Overall it was an amazing experience and I want to thank everyone who helped me to get better and back to enjoying life!

Jo

Part seven:
Glossary of acronyms

Glossary of acronyms

At Waikato DHB and across the health system we often use acronyms to refer to common terms or services. Some of the more commonly used are listed below.

Acronym	Meaning
ACC	Accident Compensation Corporation
ACP	Advance Care Plan
AODTC	Alcohol and Other Drug Treatment Court,
API	Asset Performance Indicators
ASH	Ambulatory Sensitive Hospital Admissions • Hospital admissions that are considered as avoidable
CE	Chief Executive
CHF	Community Health Forum
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CT	Computed Tomography
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
DMFT	Decayed, Missing, and Filled Teeth
DNA	Did Not Attend • When a patient does not attend their scheduled appointment without notification
ED	Emergency Department
EEO	Equal employment opportunities
FCT	Faster Cancer Treatment • A healthcare pathway
FTE	Full Time Equivalent • Refers to staffing levels
GP	General Practice
HDU	High Dependency Unit
HPV	Human Papilloma Virus
HR	Human Resources
HRT	Hormone Replacement Therapy
HSU	Health service user
HUD	Ministry of Housing and Urban Development
ihub	Hauora ihub • A welcoming place for health and wellbeing information, advice, and some opportunistic health services. Located on level one of the Meade Clinical Centre, Waikato Hospital
ICT	Information communication and technology
ICU	Intensive Care Unit
InterRAI	International Resident Assessment Instrument • The primary assessment instrument in aged residential care and home and community services for older people living in the community

Acronym	Meaning
IT	Information Technology
KPI	Key Performance Indicators
LMC	Lead Maternity Carer
LOS	Length of Stay
MDS-HC	Minimum Dataset Homecare Assessment Tool
MSD	Ministry of Social Development
MOU	Memorandum of Understanding
MP	Member of Parliament
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment and Service Coordination
NGO	Non-Government Organisation
NHI	National Health Index number • A unique identifier that is assigned to every person who uses health and disability services in New Zealand
NICU	Newborn Intensive Care Unit
NIR	National Immunisation Register
NRT	Nicotine Replacement Therapy
NZ	New Zealand
NZBN	New Zealand Business Number
NZPHD	New Zealand Public Health and Disability Act 2000
OARS	Outpatients Automated Reminder System
OPR	Older Persons and Rehabilitation
PCI	Planned Care Initiatives
PHN	Public Health Nurse
PHO	Primary Health Organisation
POAC	Primary Options for Acute Care
PPE	Personal Protective Equipment
PSC	Public Service Commission
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SMO	Senior Medical Officer
SPE	Statement of Performance Expectations
TAVI	Transcatheter Aortic Valve Implantation
VTE	Venous Thromboembolism
WKTO	Whaanau Kori Tamariki Ora – Active Families, Healthy Kids



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