Waikato District Health Board

2020-21 ANNUAL PLAN

INCORPORATING THE
2020/21 STATEMENT OF PERFORMANCE EXPECTATIONS

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

Contents

Published by Waikato District Health Board
Private Bag 3200, HAMILTON 3240

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

Mihi

He honore, he kororia ki te Atua	All honour and glory to God
He maungarongo ki te whenua	Peace on earth
He whakaaro pai ki nga tāngata katoa	And good will to all mankind
Ka tau te kei o te waka ki te Kiingi Tuheitia me te whare o te Kahui ariki whānau whanui tonu	Including Kiingi Tuheitia his family and the royal household
Paimarire.	Paimarire.
Kahuri ki te korowai aitua	We turn to acknowledge those
O ratou ko wehi ki te po	Who have passed beyond the veil
Takoto mai, moe mai koutou	Rest in peaceful slumber.
Haere, haere, haere atu raa.	Haere, haere, haere atu raa
Noreira, ka puari te kuaha pounamu	Therefore the green stone door
Mahana kia taatou katoa.	Opens wide with a very warm greeting to us all
“Mehemea ka moemoeā ahau	“If I am to dream
Ko au anake	I dream alone
Mehemeā ka moemoeā e tātou,	If we all dream together
ka taea e tātou”	Then we will achieve”

Minister's letter of expectations to Waikato DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Tēnā koe

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

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

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

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

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

Minister's 2020/21 letter to Waikato DHB

Hon Andrew Little

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

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

Dear Dame Karen

Waikato District Health Board 2020/21 Annual Plan

This letter is to advise you that we have approved and signed Waikato District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

We are pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

We are disappointed with your significant planned deficit position and agree to approve your DHB's Plan on the basis that it is a maximum anticipated deficit.

We ask that you provide an assurance letter to the Minister of Health confirming your focus on improving the DHB's planned financial position over the remainder of 2020/21.

We expect that the DHB will:

- provide a verbal update to the Ministry of Health on the local governance and operational arrangements in place to ensure better financial performance management including financial controls, probity, compliance, reporting and scrutiny processes, at your next performance meeting
- provide a written report confirming these local assurance arrangements as part of quarter two reports due with the Ministry in January 2021.

Please ensure both your assurance letter and this approval letter are attached to any copies of your signed Plan that are made available to the public

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your performance is consistent with the agreed plan.

We particularly encourage you to ensure that your senior executives maintain the tight fiscal controls and implement planned service improvements that will be necessary to sustain financial performance in the out years. Good financial performance allows us to invest more in new models of care, both in hospitals and the community, improve population prevention, and to invest in better health assets.

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The Ministry will have engaged with the DHB on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. If your DHB has not done so already, we encourage you to accept offers from the Ministry to utilise this funding.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

We look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dr Kevin Snee
Chief Executive

Strategic intentions, priorities and outcomes

Introduction

The 2020/21 Waikato District Health Board (DHB) Annual Plan (the plan) meets the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health. It is prepared in accordance with sections 100 and 141 of the Crown Entities Act 2004.

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

The plan sets out the DHB's goals and objectives and what it intends to achieve, in terms of improving the health of the population it serves, and ensuring the sustainability of the health system over the coming year (see pages 23-24 for sustainability actions). It outlines our strong focus on health equity and access, financial viability, and improved service performance to meet legislative requirements.

Key assumptions	2020/21	2021/22	2022/23	2023/24
Employee agreement assumptions: MECA and Step increases	1% - 5%	1% - 5%	1% - 5%	1% - 5%
Payments to NGOs (cost pressure)	2% - 4.6%	2% - 4.6%	2% - 4.6%	2% - 4.6%
Payments to suppliers	2.43%	2.43%	2.43%	2.43%
Capital charge – fixed rate	6.00%	6.00%	6.00%	6.00%

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

National

The Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of the Treaty.

Central to the implementation of the Treaty principles is a shared understanding that health is a 'taonga' (treasure). The principles within the Treaty and recognised by the WAI2575 inquiry of partnership, tino rangatiratanga, active protection, equity and options implicitly recognise the important role the health sector plays in the indigenous rights of Māori to achieve radical improvements in health and eliminate health inequities.

New Zealand Health Strategy

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

He Korowai Oranga

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

Whakamaua: Māori Health Action Plan 2020-2025

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

The Healthy Ageing Strategy

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

The UN Convention on the Rights of Persons with Disabilities

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

New Zealand Disability Strategy 2016-2026

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

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

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

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

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

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

Regional

The 2020/21 regional planning priorities identified by Government are:

- data and digital
- workforce
- hepatitis C
- cardiac and stroke services; and
- implementation of the New Zealand Framework for Dementia Care

Legislation requires the DHBs to collaborate regionally and for each of the four regions of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB annual plans.

HealthShare Ltd, Te Manawa Taki DHBs (formally referred to as the Midland DHBs) shared services agency, is tasked with developing the Midland RSP, which is now known as the Te Manawa Taki Regional Equity Plan, on our behalf. This work is carried out in consultation with the Te Manawa Taki DHBs annual plan writers group and DHB executive groups to ensure collaboration and alignment between the region and DHB planning.

About **Te Manawa Taki**

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

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

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

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

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

Transition from RSP to Te Manawa Taki Regional Equity Plan

For the first time, in 2020/21 the Midland RSP transitioned to Te Manawa Taki, Regional Equity Plan. The equity priorities of previous RSPs and the 2019 Memorandum of Understanding between the Te Manawa Taki DHBs Region Governance Group and Te Manawa Taki Iwi Relationship Board are the foundations of this plan. The vision of Te Manawa Taki is *He kappa kī tahi – a singular pursuit of Māori health equity*.

This Regional Equity Plan is a significant milestone. It is the direct result of an enhanced, Te Tiriti o Waitangi based partnership between Iwi and five DHBs. It epitomises the value of DHBs and Iwi engaging in respectful ways; not only to embed Te Tiriti in our health and disability system but also to do what is tika/right with regard to tackling one of New Zealand's most persistent problems: Māori health inequity. Improving equity for Māori is an imperative of Article III and the Equity Principle of Te Tiriti o Waitangi.

The Regional Equity Plan also acknowledges that Iwi have their own aspirations over and above this regional plan and that DHBs have numerous accountabilities they need to meet. Within this reality, DHBs and iwi will seek mutual ways to support each other's aspirations and accountabilities.

Working in partnership

"As a collaborative of Māori and Iwi leaders working in unison with DHBs, we are committed to building a credible, culturally safe, and competent Te Manawa Taki system. We will build upon our current strengths, prioritise kaupapa Māori and mātauranga Māori solutions and models of care, continue to build a committed workforce, challenge ourselves in terms of what we can do better and solve issues that we all know we need to work on including; continuous quality improvement, prioritising consumer/whānau voice, continuing to invest in workforce wellbeing and building a system infrastructure that is fit for purpose and agile.

We will prioritise our collective effort towards enabling people who need our support the most, to flourish, to meet their self-determined aspirations and to achieve equitable health status (as a minimum). We are clear that Māori are our priority population for this plan as they are affected by inequities the most in our region. However, we also know that we have other populations or cohorts with high needs, such as people with low socio-economic status, Pacific peoples, some rural populations, people with disabilities, and others. We will continue to support all people with high needs however, we are determined to 'shift the dial' for our valued Māori population and believe that if we can make traction for Māori, we will learn valuable lessons along the way that will support equity for all populations."

Te Manawa Taki Governance Group have identified three priority service areas for achieving equitable health outcomes for Māori:

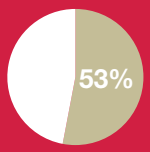
1. Mental health
2. Child health
3. Cancer

Te Manawa Taki iwi

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

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

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



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

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

Te Manawa Taki's definition of Equity

Te Manawa Taki's definition of equity is focused on ensuring all people have a fair opportunity to attain their full health potential. In Te Manawa Taki, this means prioritising service delivery to achieve equity of access, equity of quality and equity of outcomes for Māori that reflects their own aspirations and needs in the context of advancing overall health outcomes. This is an urgent priority if we are to demonstrate good faith in our Te Tiriti o Waitangi-based partnership, given the status of Māori health compared with other populations:

"Equity is purposeful investment of resources that transforms pathways of disadvantage to advantage:

1. **Supports rectifying differences that are avoidable, unfair and unjust:**
   It recognises that avoidable, unfair, and unjust differences in health are unacceptable.
2. **Proportionate investment of resources based on rights and needs:**
   It requires that people with different levels of advantage receive proportionate investment of resources and approaches based on rights and need.
3. **Implements Te Tiriti o Waitangi in contemporary ways at system and service levels:**
   It demands a health and disability system that is committed to implementing Te Tiriti o Waitangi in contemporary ways as a catalyst for success; that our system is culturally safe, competent and enabling of wellbeing.
4. **Success is measured by equity of access, quality and/or outcomes:**
   We will know we have achieved Equity when we see equity of access, quality and outcomes in the region, particularly for Māori, and then for all others who are affected unnecessarily by disadvantage."

Clinical leadership

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

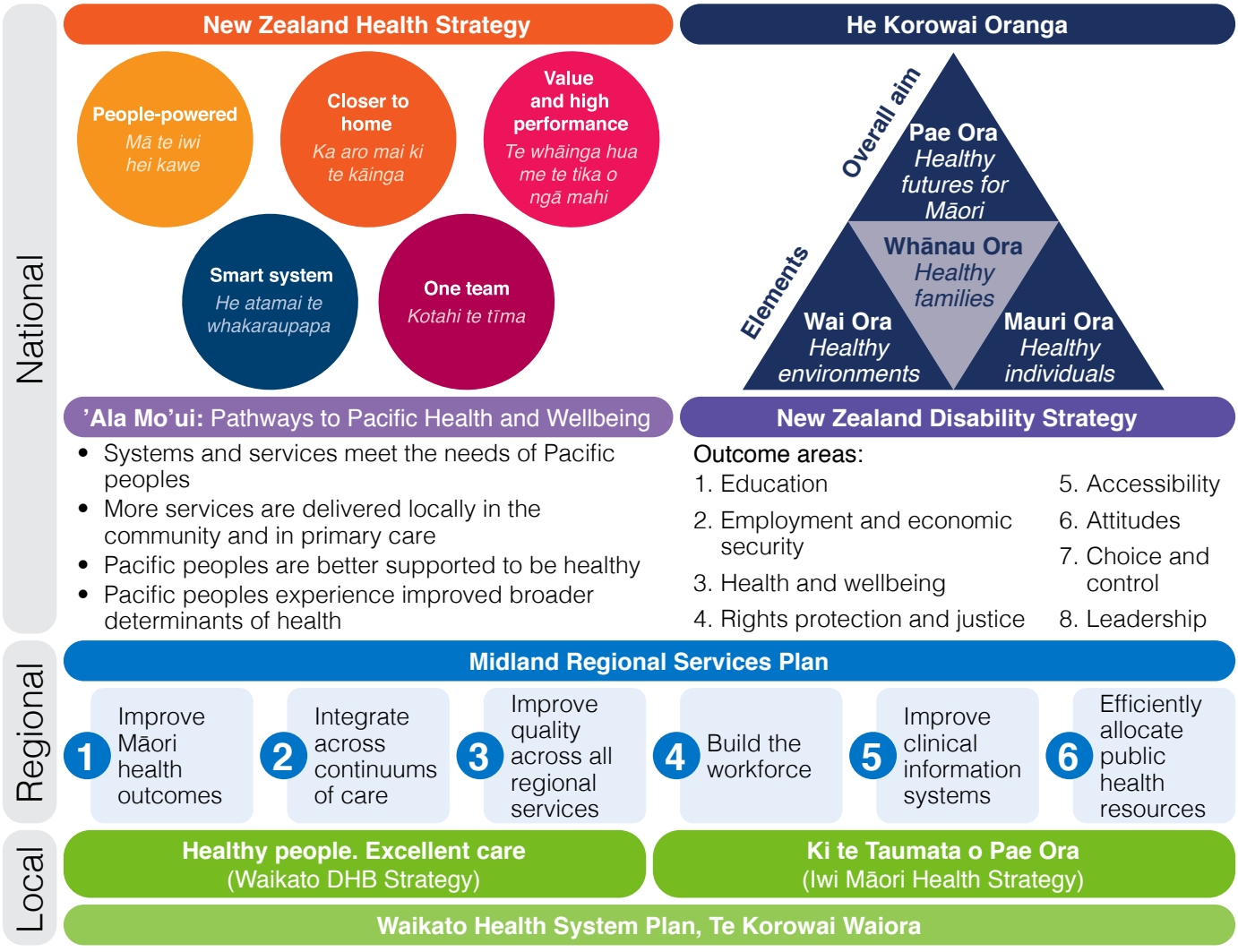


Figure 1: National, regional and local strategic intent

Figure 2: Waikato DHB strategy wheel incorporating our vision, mission and strategic imperatives

Local strategic intentions

This plan articulates Waikato DHB's commitment to meeting the Minister's expectations, and our vision of "Healthy people. Excellent care." It makes clear links to national, regional and local agreed strategic priorities including the Waikato DHB Strategy (2016) and Waikato Health System Plan, Te Korowai Waiora (2019) (see figure 1). Waikato Health System Plan, Te Korowai Waiora will focus the DHB's work on what is needed to support our population to improve their health, make services easier to access and improve the way services are delivered over the next 10 years. Waikato DHB is committed to working in partnership with local iwi, community service providers and consumers, as well as with the other Te Manawa Taki DHBs to achieve this.

Waikato DHB Strategy

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

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

The strategy describes the organisation as part of a wider health and social system, outlining six key strategic imperatives. Under each strategic imperative are four priorities which connect the strategy with the day-to-day activities of the Waikato DHB. These priorities are areas of work that will be our focus (see figure 3).

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

Figure 3: Waikato DHB strategic imperatives and priorities

Ki te Taumata o Pae Ora (Iwi Māori Health Strategy)

Ki te Taumata o Pae Ora – Iwi Māori Health Strategy is in final draft and is the response to the implementation of He Korowai Oranga, New Zealand's Māori Health Strategy, and the organisation's driver for achieving our strategic priority of radical improvement in Māori health outcomes by eliminating health inequities for Māori.

Ki te Taumata o Pae Ora is based on the WAI2575[1] findings. By applying a continuous quality improvement lens, this plan will strengthen DHB alignment to national thinking around Te Tiriti and ensure we fulfil our responsibilities as a Crown partner.

Six key priorities have been identified as essential to operating in a different and transformative way to address the health of Māori. The six priorities are interlinked and are areas we will monitor performance against, and be held accountable for achieving.

Priority	What will this look like?
1. Iwi partnership with DHB Governance	Te Tiriti is honoured and a respectful relationship exists at governance level A Māori lens will be put over the strategic priorities of Waikato DHB and this will be highly visible in the wider community
2. Internal operations	All parts of the DHB (Hospital and Community Services, Strategy and Funding, Corporate functions) will have an equity and Māori health perspective Māori input and influence in service design, delivery, monitoring Equity in policies, processes, decision-making (executive, operational, Planning and Funding) Workforce development Tackling overt and unconscious racism, bias, discrimination Commitment to proportionate investment Greater recognition of whānau component to care (beyond individuals)
3. Iwi hauora priorities	Alignment of iwi Hauora priorities within the existing Waikato DHB planning framework The Māori world view will be incorporated
4. Radical improvement in Māori health outcomes for agreed priorities (e.g. Diabetes, Mental Health, Renal Disease)	Increased or improved: a. Māori voice/input b. access (including kaupapa Māori involvement) c. service quality (including cultural safety) d. direct outcomes from service interventions e. patient experience ratings
5. Investment, performance and growth in kaupapa Māori services	Locality development approach will enable a more nuanced approach to addressing community needs
6. Cross-sector collaboration	Working with the wider public sector to address the determinants of health that are the underlying causes of inequity of health outcome Working in partnership with iwi to achieve significant long term gains

[1] The Health Services and Outcomes Inquiry. Full report and information can be found here: waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry

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

During 2019 the Te Korowai Waiora, Waikato HSP development process began by engaging with the community about how care could be better provided in community settings. As part of the engagement process wānanga were held in seven Māori communities, attracting 213 participants which provided significant insights into Māori perspectives. The rangatahi voice was captured through seven separate hui where 119 attended. The feedback from these wānanga was analysed and incorporated into what became the seven goals of Te Korowai Waiora, Waikato HSP which will guide the Waikato DHB for the next 10 years and put into action our strategy "Healthy people. Excellent care" and Ki te Taumata o Pae Ora.

Te Korowai Waiora, Waikato HSP seven goals:

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

Te Korowai Waiora, Waikato HSP has been formally adopted and 2020/21 will be focussed on the first stage of implementation. To successfully achieve this new direction over the short to medium term, the organisation and other health system partners will need to consider changes to how it funds services, review the scope and nature of services provided and transform the DHB's culture.

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

COVID-19 recovery and reset

COVID-19 has caused unprecedented challenges and the health system will need to work with a number of other agencies during the response and recovery phases to ensure the needs of our communities are met. Recovery will require assessing the impact of COVID-19 on services (primary and secondary), determining and prioritising areas of recovery, implementation of recovery activities and the continued monitoring and reporting on recovery activities.

COVID-19 has allowed for new innovative ways of delivering services. During the response the DHB worked in partnership with iwi to coordinate communities and deliver mobile community testing and flu vaccination to high need populations which had positive results increasing vaccination uptake. A joint approach with iwi was also taken to ensure children received their measles vaccination.

While we are still learning lessons some benefits that have evolved during this pandemic will be utilised to inform and drive future change. Implementing recovery by locality will be necessary, partly because of the geographical spread of the Waikato District, and partly because of the disparate nature of the communities likely to be affected.

2020/21 will be largely focussed on coordinating the strengths and resources of the DHB in order to better recover from the impacts of COVID-19. Opportunities to implement the Te Korowai Waiora, Waikato HSP and the Resource Review which identified 86 recommendations to improve organisational performance will play a key role in any recovery planning. The recovery phase offers a unique opportunity to accelerate the DHB in a new direction and ensure alignment of improvement and innovation activity while also measuring and monitoring the impact of changes.

The four key recovery actions will be:

- capturing lessons learnt
- catch up on planned care or services delayed due to COVID-19
- implement agreed changes and innovations
- manage the ongoing risk of future COVID-19 outbreaks.

In addition to the recovery activities included throughout the table below, some of the key areas of work that will support recovery include:

What are we doing	What will this look like?
Localities development and new models of care Enhanced primary and community care ensuring people can access services closer to home, improving access, equity and health outcomes	Partnerships formalised with iwi that advance iwi hauora aspirations and improve health service design, delivery and monitoring Greater investment in primary and community care services Planned care New integrated models of care for: • mental health and wellbeing • diabetes • renal • cardio-vascular disease • first 1000 days Complete the business proposal for health hubs in South Waikato and North Ruapehu, Thames, Waitomo and North Waikato Deliberate focus on leveraging digital and tele/virtual health technologies to improve the reach and experience of health care
Whānau-centred care Service and programme development that centres around whānau, strengthening Kaupapa Māori and Whānau ora approaches	Growth in funded kaupapa Māori services Deliberate service design focus on empowering and building whānau capability to better manage their health matters Enhanced hapū wānanga services Rangatahi leadership programme Continued implementation of primary mental health and addictions services Tobacco control with a focus on Māori and Pacific initiatives (Whānau Ora approach) Updated approach to the healthy weight programme
Operational and quality improvement Process improvement across the DHB provider services, increasing efficiency and sustainability	Improved theatre productivity Outsourced procedures will be repatriated to the Waikato Hospital Technical design and delivery of workforce management Enhanced service delivery model for supply chain and procurement Reconfigured patient flow management
Governance and finance Governance and Process Improvement to ensure the organisation operates efficiently within clearly agreed parameters	New financial management processes Increased financial competency across the organisation Embedding of a Corporate Risk Management Framework

Message from the Commissioner

DAME KAREN POUTASI

Tēnā koutou katoa,

The past year has confirmed the immense quality of the people working in all areas of healthcare delivery throughout our region. Through the major events of Whakaari/White Island and the COVID-19 pandemic we saw the individual commitment and ability of so many healthcare workers backed by the support of our iwi and community.

The pandemic will have short and long-term effects which must be considered in our future planning. The DHB has made strong progress in recent months and has the capacity to continue this trajectory while adapting to new challenges. COVID-19 confirmed for us the importance of a focus on our localities and access.

The commissioners support Te Korowai Waiora, Waikato HSP, which is now being implemented alongside a host of new initiatives to build person and whānau-centric healthcare models, well prepared to support a rapidly growing population.

At the heart of this person-centric model is the need to drive actions which improve health equity across our region and uphold the DHB's responsibilities to Te Tiriti o Waitangi. The DHB has committed to improving health outcomes for Māori with a requirement for equity impacts to be considered across all plans and actions.

The commissioners have been pleased with the progress made by the DHB in setting and achieving its financial targets during the past year. This result is worthy of recognition and celebration. It is our intention that the year should mark a turning point for the organisation, reversing the trend of increasing deficits and beginning on a new path towards surplus, investment and sustainability. A strengthened financial position underpins all DHB activity and has a positive impact on our daily operations as well as our ability to plan and prepare for the future.

Following the publication of the Health and Disability Review in June, the commissioners share the view of the chief executive – we anticipate change for the sector and are clear that our immediate focus must remain on building an organisation which is sustainable, provides the best possible care for our community and values all those who work with us.

The commissioners and chief executive will assist in providing stability and support as the organisation implements the initiatives described in the following pages. The past 12 months have been highly rewarding as the DHB continues to make great strides as an organisation and we are committed to providing opportunities for health improvement and enhanced access.

Dame Karen Poutasi

TE PORA
THOMPSON-EVANS

Message from the Chair, Iwi Māori Council

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

The focus on equity within this Annual Plan reflects the growing urgency for change in how healthcare is delivered for Māori across our rohe and throughout New Zealand.

This is heightened with the impact of the COVID-19 pandemic. Now more than ever, the increased social and economic hardship as contributors to health inequities will impact significantly and disproportionately on Māori. To counter this will require authentic partnership with Māori.

As we together developed the Te Korowai Waiora, Waikato HSP and the Māori Health Strategy – Ki te taumata o Pae Ora – so too must we be together in its implementation and delivery to be successful in achieving equity for Māori. The appointment of the Executive Director Māori Equity and Health Improvement is a crucial step, as is the commitment to increase the DHB's Māori workforce under the He Korowai Oranga - Māori Health Action Plan.

The partnership approach was evident in the COVID-19 pandemic response as the DHB worked with iwi and Māori organisations to deliver mobile assessment and testing services coupled with health and welfare checks and vaccine services. That this approach allowed us to achieve testing equity across the majority of districts and significantly higher immunisation rates for kaumātua and tamariki than ever before is a testament to the value of partnership.

Lessons must be taken from this experience and applied across DHB services. Te Korowai Waiora outlines a rebalancing of the healthcare model to bolster primary and community care which enables greater whānau involvement in planning their own care on their own terms. A strengthened primary care system in which whānau are engaged, empowered and supported moves us toward sustainable health outcomes, community-based care which is closer to home, and away from acute and hospital facilities.

The Health and Disability Services Review, released in June, sets a clear direction for fundamental change in the healthcare sector, with a focus on improving Māori outcomes. The move to recommend adoption of Hauora Report (Wai2575) te Tiriti principles is a critical indicator of our pathway forward. The required change will not happen overnight but this allows time enough to solidify our relationship as partners, build trust and walk through the coming change together. All of us will need to work together, uphold the principles of te Tiriti, respectfully apply Te Ao Māori knowledge and leadership, and maintain our commitment to achieving Māori wellbeing.

Heoi anō

Te Pora Thompson-Evans

Message from the Chief Executive

DR KEVIN SNEE

At Waikato DHB our people have shown their dedication, expertise, compassion, and willingness to respond when needed many times during the past year. While it has been a year of unprecedented events and they have been called on to go above and beyond more often than we would hope, it has demonstrated a high level of capability within the organisation which puts us in good standing to achieve our goals in the year ahead.

The full executive leadership team has now been confirmed and will be responsible for leading the implementation of this annual plan.

To support a growing population the DHB created Te Korowai Waiora, Waikato HSP. With this document formally adopted, 2020/21 will deliver the first stages of implementation. Te Korowai Waiora, Waikato HSP puts people at the centre of healthcare with a focus on delivering services in the community in a way which is culturally appropriate and highly accessible.

Healthcare equity remains a priority for all DHBs and with a population which is geographically and culturally diverse, Waikato DHB is committed to improving access and delivery of healthcare services for each member of our community. Partnership is key to improving outcomes for our Māori and Pacific population and to the DHB's responsibility to uphold and protect Te Tiriti o Waitangi.

The COVID-19 pandemic was an unprecedented event which required a national response. It will almost certainly remain a dynamic situation in the future, with our response requiring regular review and flexibility. Lockdown requirements led to many elective procedures being deferred and ensuring all those affected can receive timely treatment is a vital piece of work. The response also brought positive developments in how we work with our community and partners to ensure a unified and inclusive approach.

Through the pandemic we have seen some initiatives to improve equity of access accelerated such as telehealth and mobile services to provide testing and vaccinations to rural areas. Our challenge now is to retain and build on this progress.

Over the past year the DHB has demonstrated its ability to reduce spending while maintaining and improving services and we are on track to achieve our targeted budget outcome. This has not been a simple exercise but a strengthened financial position and deeper understanding of the organisation is the reward for this hard work.

The DHB will receive a significant funding boost for the 2020/21 year. This news was well received however, any uplift in revenue must be offset against the increased demand for services, the need to address equity, a rapidly growing population, and the ongoing work to reduce our deficit and return to surplus.

Following the Health and Disability System review, it is anticipated that the healthcare sector is entering a period of change. At the same time Waikato DHB must maintain focus on delivering our vision of Healthy people. Excellent care, improving health outcomes and supporting our community, while building a financially sustainable organisation.

Dr. Kevin Snee

Signatories

Agreement for the Waikato DHB 2020/21 Annual Plan

between

Hon Andrew Little
Minister of Health

Date:

Hon Grant Robertson
Minister of Finance

Date:

Dame Karen Poutasi
Commissioner
Waikato DHB

Date: 28 July 2020

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

Date: 28 July 2020

Dr Kevin Snee
Chief Executive
Waikato DHB

Date: 28 July 2020

Waikato DHB is committed to delivering on the Minister's Letter of Expectations and to the agreed planning priorities in its 2020/21 Plan. These planning priorities include a particular focus on improving Māori health and health equity.

The DHB will have a significant savings plan for 2020/21 that may restrict new activity and may impact on the achievements in the 2020/21 financial year. As part of this savings plan, the DHB will implement recommendations from the 'Resource Review' completed in June 2019.

Minister of Health's planning priorities

Government priorities and desired outcomes for New Zealand include planning priorities for health, wellbeing and equity. The 2020/21 annual planning priorities for all DHBs are:

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

These priorities form the foundation of this annual plan and support the Government's overall priority of "improving the well-being of New Zealanders and their families" through:

- supporting healthier, safer and more connected communities
- making New Zealand the best place in the world to be a child
- ensuring everyone who is able to, is earning, learning, caring or volunteering

Health and disability system outcomes framework

The health and disability system outcomes framework supports a stable system by articulating what outcomes the system intends to achieve for New Zealanders, and the areas of focus through which to obtain those outcomes. Figure 4 shows the elements of the health and disability system outcomes framework.

Figure 4: The health and disability system framework elements (Ministry of Health, 2019)

Māori health improvement in DHB annual plans

Māori health improvement is a priority for Waikato DHB and a key focus for this plan. To ensure this focus remains at the forefront Te Puna Oranga (Waikato DHB Māori Health), Iwi Māori Council and Waikato Public Health have been active contributors to the development of the plan. From 2020/21 the Public Health Annual Plan has been integrated into the DHB Annual Plan to achieve more integrated sector planning.

Recently Waikato Public Health and Te Puna Oranga were brought together under one executive. Combining the efforts of these two teams that already have strongly aligned programmes of work, but have traditionally operated separately, will strengthen and drive health improvement and the elimination of health inequities for Māori.

While the whole plan has a focus on equity, a snapshot of Māori health equity initiatives being implementing in 2020/21 can be seen on pages 30-33 in the section 'Giving practical effect to He Korowai Oranga.' Strengthened partnership has been demonstrated through the joint approach taken between iwi and Waikato DHB in the development of the business case for the new mental health build. Other examples of recent partnership are included above in the COVID-19 recovery and reset (pages 23-24)

Waikato DHB will continue to uphold its obligations as a Treaty of Waitangi partner as specified in the New Zealand Public Health and Disability Act 2000. To ensure the organisation is responding to these obligations, a progress report will be completed on how we are meeting these obligations through our quarterly reporting process and in the Waikato DHB Annual Report.

Achieving health equity in DHB annual plans

There is a Ministry requirement that all priority areas are to include evidence based equity actions that specifically target the Māori and Pacific population. Applying an equity lens across the annual plan will ensure active prioritisation of resources to achieve equitable health outcomes. These actions are marked as "Equity Outcome Action (EOA)" throughout the following activity table. To assess if an activity is in fact "EOA" Waikato DHB is using a tool that will help prioritise investment based on whether it will drive radical improvements to Māori health.

The partnership approach in Ki te Taumata o Pae Ora will guide the DHB in (governance and decision-making), participation (iwi, kaupapa Māori service providers, workforce and whānau), protection (targeted approaches and services), and pono (tikanga). It will support DHB planning and funding decisions that will enable the achievement of a key Waikato DHB strategic objective: Radical improvement in Māori health outcomes by eliminating health inequities for Māori.

Responding to the guidance

The 2020/21 Annual Plan is a further refinement of the 2019/20 Annual Plan. The priorities have been updated to reflect the Minister's direction. In responding to this guidance, engagement with relevant stakeholders has been undertaken to support development of this document.

Giving practical effect to He Korowai Oranga – the Māori Health Strategy

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Giving practical effect to He Korowai Oranga – the Māori Health Strategy	Oranga – Health equity for high need populations	Goal 1: Partner with Māori in the planning and delivery of health services	**Engagement and obligations as a Treaty partner** The Waikato DHB displays partnership through ongoing relationships with the Iwi Māori Council, individual iwi, and through relationships with Māori providers throughout the rohe. The following actions support our commitment to a Te Tiriti-based approach to all of our service planning and delivery:	
			A memorandum of understanding (MoU) exists that formalises the partnership between the Iwi Māori Council (IMC) and the DHB which includes six iwi plus maata waka of the DHB district. Commissioners attend IMC meetings on a monthly basis. The Chair of IMC works alongside the commissioners to implement the actions in the MoU. (EOA)	Reporting completed Q2 and Q4
			Iwi partnerships will be built or enhanced to provide a foundation for each locality plan. At least two locality partnerships will be formalised in 2020/21.	Q4
			Complete an update of Ki Te Taumata o Pae Ora, the DHB's iwi Māori Health Strategy. This will drive decision making around improving Māori health outcomes. (EOA)	Q2 and Q4
			The investment approval pathway used to inform investment decision making, has equity throughout its components, including valuing Māori in governance. (EOA)	Q1
			Te Korowai Waiora, Waikato HSP underpins partnership with Māori, community engagement and co-designed models of care with Māori. This will be implemented by locality. (EOA)	Q4

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Giving practical effect to He Korowai Oranga – the Māori Health Strategy	Oranga – Health equity for high need populations	Goal 1: Partner with Māori in the planning and delivery of health services	**Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services**	
			Waikato DHB is committed to ensuring Māori have options when choosing care providers and pathways and will:	
			Agree on partnership approach with Raukawa; and Maniapoto, Tūwharetoa and Whanganui to support implementation of Te Korowai Waiora, Waikato HSP by locality.	Q1-Q4
			Work 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.	Q2
			Develop and implement new service models with funding radically prioritised for Māori. (EOA)	Q1 and ongoing
			Provide alternative acute community service options that better meet the needs of whānau opposed to admission to the Henry Rongomau Bennett Centre.	Q1
			Complete a proposal for the development of a South Waikato health hub. Work with current local providers to identify unmet need and enhance services where required.	Q4
			The Waikato DHB Mental Health and Addictions service will establish, in partnership with Māori service providers, a local point of access service in rural communities.	Q2
			Support and monitor the implementation of the Whānau Pai Collaborative, a new mental health 'Māori for All' initiative to better meet the needs of Māori. Whānau are linked into holistic and culturally responsive primary mental health and addictions services integrated with their local general practice.	Q1 and ongoing
			Support the delivery of Kaumātua Day Programmes. This is a Māori cultural response to the Healthy Ageing Strategy framework. They vary from Community Day programmes as they are based on Māori principles of manākitanga (looking after each other), wairuatangata (spiritual growth), and whānautanga (importance of whānau).	Q1-Q4
			Commence implementation of the Hapū Māmā, Pēpē Ora service delivery for Māori.	Q4
			Māori Health Action Plan – Shifting cultural and social norms	
			Waikato DHB is committed to eliminating racism and discrimination within the health and disability system and will:	
			Provide training for commissioners and the executive leadership team regarding bias and institutional racism (with inclusion of Māori health and equity within the framing). (EOA)	Q1
			Set aside space and time for all staff to attend Te Tiriti Based Futures 2020, a lecture series online about combatting institutional racism. This will be the first in a series of activities and events aimed at combatting institutional racism. (EOA)	Q1
			Implement Te Hono Whakataki, the DHB orientation and induction, which has been designed to adhere to tikanga (i.e. starting with a pōwhiri) and focuses on whakawhānaungatanga (building connections between new staff members). (EOA)	Q4
			Deliver equity training to multiple staff groups, including booking clerks, Allied Health managers and staff, OPAL, and RMOs. This will challenge unconscious bias and the role staff play in institutionalised racism. (EOA)	Grow the participation to include all staff by 2021
			Te Whare Wānanga o Awanuiārangi are providing on site level three Te Reo Māori courses for an initial cohort of 60 staff. (EOA)	Q1
			Inform staff of Te Tiriti o Waitangi obligations and commit to supporting te reo me ōna tikanga throughout the Waikato DHB. (500 staff annually) (EOA)	Q2
			Implement the new mental health orientation programme with support by pou herenga that will provide all new mental health staff training on tikanga and local Māori history to enable staff to provide culturally safe care. (EOA)	Q1
			Build equity into the Choosing Wisely Initiative[2] being rolled out across the DHB. (EOA)	Q1
			Develop dual signage in Te Reo Māori and promote Māori imagery in Waikato Hospital.	Q1
			The DHB will continue to contractually require Mental Health and Addictions service providers to utilise the Let's Get Real framework and all appropriate providers to undertake He Ritenga audits as part of quality improvement and workforce planning. This will be assessed as part of routine audit processes. (EOA)	Q2
			Matauranga Māori is protected within the DHB Intellectual Property policy that ensures that all resources created with Māori staff and communities maintain kaitiakitanga).	Q1

[2] The Choosing Wisely Campaign is to improve the safety and quality of healthcare delivered by ensuring that consumers receive the right test for the right reason at the right time. The aim is to implement across all Waikato hospitals and then primary care.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Giving practical effect to He Korowai Oranga – the Māori Health Strategy	Oranga – Health equity for high need populations	Goal 1: Partner with Māori in the planning and delivery of health services	**Māori Health Action Plan – Reducing health inequities** Ki Te Taumata o Pae Ora applies Te Tiriti to drive equity throughout the Waikato DHB. The following actions will drive equity within this framework:	
			The DHB will create an equity report, supported by the reporting of all data by Māori and non-Māori, to quantify the equity gaps for Māori. The equity report will provide baseline and regular data updates to inform and track Waikato DHB performance for Māori, including the agreed Māori priority areas. (EOA)	Q1
			The Maternity Quality Safety Programme governance board will monitor access to services by ethnicity and locality to ensure equity. (EOA)	Q1
			Through locality development iwi will deliver kaitiaki services in their community. (EOA)	Q2
			Develop Māori peer support and whānau ora approaches to enable wrap-around mental health supports in rural localities.	Q2
			Reconfigure the REACH programme to include more responsive services to Māori whānau that will help to provide access to employment and training after chronic illness and rehabilitation (expanding the whānau ora approach). (EOA)	Q4
			Partner with Raukawa (South Waikato), Maniapoto, Tūwharetoa and Whanganui (North Ruapehu) to agree on a partnership approach to support implementation of Te Korowai Waiora, Waikato HSP by locality. (EOA)	Q1
			Work in partnership with "Support to Screening Services" and GP practices to increase enrolment and screening rates for Māori. (EOA)	Q1
			Whare Ora (Waikato's cross sector healthy housing programme) will provide more heating and healthy home products (e.g. curtains and bedding) to Māori whānau and other priority populations. (EOA)	Q1
			Implement 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. This will include co-development of solutions that empower Māori ownership, self-management and care coordination to ensure individual and whānau centred care. (EOA)	Q1-Q4
			Develop and test a prototype programme to improve access to cervical screening. (A mobile Hauora iHub model, supported by Māori workforce). (EOA)	Q1
			Māori Health Action Plan – Strengthening system settings Ki Te Taumata o Pae Ora uses a Te Tiriti approach to creating a system-wide change to improve Māori health and equity, with a clear focus on partnering with Māori organisations and providers to transform health and wellness. The following actions will drive Māori equity from a system level:	
			Waikato DHB will be focussed on delivering a model of care approach for diabetes, CVD, renal, cancer, first 1000 days. (EOA)	Q2
			The Waikato DHB commissioning approach will drive Māori health improvement and ensure equity is a key requirement across all providers of health services, including those services provided by Waikato DHB. (EOA)	Q1
			Working with Whānau Ora Initiatives and it's commissioning agencies and partners to contribute to Māori health advancement and to achieve equity, including (EOA): • Prioritising future investment and disinvestment to support whānau ora centred services and whānau ora approaches • Clear understanding of the strengths, weaknesses, opportunities and challenges facing parties • Exploration of opportunities for alignment	Q1 and ongoing
			Establish local leadership groups in each locality to inform ongoing locality planning and health service enhancement. (EOA)	Q3
			Facilitate training opportunities to improve staff knowledge of Māori data sovereignty and cultural competency and safety when working with Māori data.[3] (EOA)	Q4

[3] Action and reporting will be completed by Public Health

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Giving practical effect to He Korowai Oranga – the Māori Health Strategy	Oranga – Health equity for high need populations	Goal 1: Partner with Māori in the planning and delivery of health services	**Māori Health Action Plan – Strengthening system settings** – continued	
			Increase the DHB's Māori workforce to better reflect our population. (EOA)	Q1 and ongoing
			The DHB commits to supporting te reo me ōna tikanga throughout the Waikato DHB (500). (EOA)	Q1 and ongoing
			The DHB will continue to support the Consumer Council to provide valuable lived experience to our strategic planning mechanisms. (EOA)	Q1
			Build stronger collaborative relationships with Ministry of Social Development and Kainga Ora to help address social determinants of health. (EOA)	Q1 and ongoing
			In early 2020 the Government announced the establishment of an Alcohol and Other Drug Treatment Court (AODTC) in the Waikato. The Mental Health and Addictions Service will work with wider sector partners to support the development and implementation of a coherent service for AODTC participants. (EOA)	Q1 and ongoing
			Work with Māori providers in each locality to tailor and enhance whānau ora approaches with their rohe. (EOA)	Q1-Q4

Improving sustainability

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving sustainability	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Improved out year planning processes**	
			Waikato DHB is committed to improving our financial and workforce out year planning processes and will:	
			Implement position management including holding a position budget, role profiles and role size to enable accurate workforce reporting as a foundation for workforce planning.	Q2
			Implement workforce role profiles and record these against positions in the HRIS as a baseline to support reporting and forecasting of workforce composition to enable improved out year planning.	Q2
			Complete workforce modelling and agree a workforce plan that shows anticipated composition (employee, alternative workforce types and automation), size and cost of the Waikato DHB across 2019-2024. This includes the identification of new workforce roles required to implement the Te Korowai Waiora, Waikato HSP strategic direction.	Q4
			Savings plans – in year gains	
			Waikato DHB is committed to developing a savings plan and will:	
			• Conduct costing review to enable benchmarking to identify saving opportunities	Q3
			• Review stock management and external contract opportunities	Q1
			• Delay recruitment	Q1
			• Optimise ACC revenue	Q1
			Savings plans – out year gains	
			Waikato DHB is committed to improving system sustainability through savings plans and workforce planning that supports innovative models of care. To achieve this we will:	
			Five significant initiatives from savings plan The 2020/21 savings outlined above as 'in-year' gains are all recurring and will continue to provide out year gains. Refer to Annual Plan: Financial Performance.	
			Workforce planning Embed the Waikato DHB Resource Review organisation structure changes to improve efficiency across the organisation. Metrics will be identified to measure the success of the change to ensure improvements have been achieved and are being sustained.	Q4
			As per the workforce plan we will continue to grow partnerships with education providers and training institutions to prioritise the development of the Māori workforce. The current focus is to grow the options available for nurse training in the Waikato district. (EOA)	Q2 and ongoing
			As per the workforce plan we will support the Puna Waiora programme, a kaupapa Māori support system to empower and support rangatahi interested in pursuing a career in health. The current focus will be establishing hui with Māori partners to provide input into growing Māori participation in the health workforce. (EOA)	Q4

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving sustainability	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Working with sector partners to support sustainable system improvements** Waikato DHB is committed to working collaboratively with sector partners to achieve equitable health outcomes for our population and will: Partner with Raukawa (South Waikato); and Maniapoto, Tūwharetoa and Whanganui (North Ruapehu) to agree on a partnership approach to support implementation of Te Korowai Waiora, Waikato HSP by locality. (EOA) Develop and implement a health transport plan to reduce single user motor vehicles and encourage sustainable alternatives for example, e-Bikes, walking and public transport, and improve rural health transport options for rural communities. Waikato Primary and Community Care Alliance will strengthen relationships and clarify accountability of work programmes.	 Q1-Q4 Q4 Q4

Improving child wellbeing – improving maternal, child and youth wellbeing

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving child wellbeing	Pae tāumata – A centre of excellence in learning, training, research, and innovation	Goal 4: Improve access to services	**Maternity and midwifery workforce** Waikato DHB is committed to developing and retaining the midwifery workforce that meets the needs of our population and will: Complete a workforce development and retention approach that will establish a workforce retention target and key actions including: • WINTEC and the DHB will work together to increase the number of midwives in training and working in the sector who identify as Māori or Pacific. • Implement the approved 18 month programme, developed in conjunction with WINTEC and the Midwifery Council that allows a registered nurse (RN) to transition to be a registered midwife (RM). (EOA) • Review the Ministry of Health 2018 and 2019 data to understand our baseline and set targets to reduce the equity gap.(EOA) • Implement the Midwifery First Year of Practice programme. This programme will have a minimum of three lead maternity carers (LMC) participating each year. This will be targeted towards Māori and Pacific LMCs from rural localities. (EOA) • Establish a Māori associate clinical midwife manager with a portfolio of cultural competency. (EOA) • RN Specialists will be employed in Women's Health to support RM's in their practice (within the scope of the RN). Complete seasonal variation predictions to ensure effective mechanisms (i.e. flexible FTE in both the secondary and community midwifery team, LMC contracts) are in place to cope with fluctuating demand. December to February traditionally see increased demand on tertiary services due to reduced LMC availability.	 Q4 Q2 and Q4 Q4 Q2 Q1 Q2 and Q4 Q2 and Q4 Q2 and Q4

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving child wellbeing	Manaaki – People centred services	Goal 4: Improve access to services	**Maternity and early years** Waikato DHB has prioritised the First 1000 Days as a key focus area in 2020. This will be demonstrated through the following activities:	
			Co-design and implement new strategies that will improve registration rates of Māori and Pacific women in their first 12 weeks of pregnancy. The focus will be on achieving 85 percent registration rates for Māori and Pacific women. (EOA)	Q2 and Q4
			Enhance pregnancy and parenting programmes for Māori and Pacific e.g Hapū Wānanga or tupuake.(EOA)	Q4
			Provide one third trimester extended GP consultation to re-engage high need[4] parents with primary care before the child is born. This will provide an opportunity to discuss SUDI prevention, immunisations (of child and parents), smoking cessation and contraception. (EOA)	Q4
			Have available debrief follow up appointments six weeks post birth for wāhine, tāne, and their whānau who have experienced unexpected interventions or traumatic birth.(EOA)	Q2 and Q4
			A number of targeted actions to achieve at least 83 percent of Māori and Pacific babies living in a smokefree home at six weeks will be undertaken through the System Level Measure Improvement Plan.[5] (EOA)	Q4
			Provide safe sleep devices and education on safe sleep practices to reduce the risk of SUDI. The number of safe sleep devices provided will be reported to the Ministry. (EOA)	Q4
			A breastfeeding coordinator will provide advice and support to pre and post-natal women. (breastfeeding, smoking cessation, safe sleep)	Q1 and ongoing
			Whare Ora will provide more heating and healthy home products (e.g. curtains and dry bedding) to Māori whānau and other priority populations. (EOA)	Q2 and Q4
			Co-design and commence implementation of models of care that meet the needs of mothers of high need populations.(EOA)	
			See further related actions in the Maternal Mental Health section on page 39	
	Oranga – Health equity for high need populations	Goal 3: Support community aspirations to address the determinants of health	**Immunisation** Waikato DHB is committed to establishing innovative solutions to improve delivery and uptake of immunisations:[6]	
			This year, we will design and implement strategies and solutions that:	
			• Determine influences of new Māori and Pacific parents e.g. kaumātua/kuia, tāne, and midwives. (EOA)	Q1
			• Determine the key drivers behind lower GP enrolment rates of Māori babies at six weeks.	Q1 and Q2
			• Implement solutions that provide opportunistic and alternative approaches to reach unimmunised/overdue Māori and Pacific tamariki. (EOA)	Q1 and Q2
			• Adopt and implement the "courageous conversations with whānau" training to equip staff with the tools to discuss immunisation and ensure parents make an informed choice. (EOA)	Q4
			• Increase vaccination health literacy by providing appropriate information.	Q4
			Transition to business as usual the mobile immunisation outreach service developed in partnership with local iwi during the COVID-19 response. The mobile service will be able to access the National Immunisation Register and provide immunisation catch up to all age groups.	Q1
			Identify other service areas that need to improve Māori access rates and expand the mobile outreach service to meet the need.	
			Increase the number of clinicians who are able to give vaccinations, targeting Pacific, Māori and those working with priority populations. (EOA)	Q4
			With support from the Ministry, implement policy changes that will result in the national elimination of measles mumps and rubella.	Q4

[4] Māori, Pacific, high deprivation, youth

[5] See System Level Measure Improvement Plan in Appendix B

[6] All actions in this section that are not PHU specific are overseen by the Childhood Immunisation Leadership Group, a group consisting of Māori/Pacific providers, PHOs, hospital immunisation services, Te Puna Oranga (Māori Health), Public Health, Strategy and Funding and other community stakeholders who are focussed on co-design strategies to address the inequity gap in relation to Māori and Pacific immunisation rates in the Waikato district.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving child wellbeing	Oranga – Health equity for high need populations	Goal 5: Enhance the capacity and capability of primary and community health care	**School-based health services** Waikato DHB is committed providing high performance youth and school-based health services and will:	
			Monitor progress and provide quantitative reports on the implementation of school-based health services (SBHS) in decile 1 to 4 secondary schools, and decile 5 as applicable, teen parent units and alternative education facilities.	Q2 and Q4
			Implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. We will: • work with our providers to assist in the establishment of robust frameworks in each school. • ensure that there are processes in place for regular consultation with youth, and particularly Māori youth, to inform service development. (EOA)	Ongoing
			Co-develop a Rangatahi Ora Plan and consult with all key stakeholders. The plan will provide a cross-sector mechanism to address the biopsychosocial and multifaceted needs of rangatahi in the Waikato district, contributing to their positive development and wellbeing. (EOA)	Q2 and Q4
			As part of the locality development approach we will establish mechanisms to ensure the youth voice is captured during the planning, design and implementation or review of services. The locality project managers will ensure youth participation and engagement is an ongoing process.	Q4
	Haumaru – Safe, quality health services for all	Goal 2: Empower whānau to achieve wellbeing	**Family violence and sexual violence** Waikato DHB is committed to reducing family and sexual violence. To achieve this we will work in partnership with other agencies and:	
			Continue the VIP advisory group that includes senior clinicians from all designated services, Māori and Pacific staff, Oranga Tamariki, Women's Refuge and PHO's. This group supports the implementation of the VIP Strategic Plan (2018/21). (EOA)	Q1-Q4
			Ensure that Māori and Pacific staff have a voice and contribute to the Violence Intervention Programme (VIP) Governance Group, staff training, implementation and audit processes. (EOA)	Q4
			Enhance relationships and referral pathways with iwi, Whānau Ora providers, Māori services and Women's Refuges (EOA)	Q4
			Include cultural responsiveness as part of VIP training programme. This will be evaluated as part of the evaluation activities domain of the VIP audit tool. (EOA)	Q4
			Provide staff training on how to respond to child abuse and neglect and intimate partner violence. This is supported by policy and monitored through the staff training plan 2018-21. Training will also be provided to non DHB staff as appropriate e.g. lead maternity carers, staff midwives working in private facilities. Monitoring will take place through six monthly Ministry contract reports.	Q2 and Q4

Improving mental wellbeing

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving mental wellbeing	Manaaki – People centred services	Goal 2: Empower whānau to achieve wellbeing	**Mental health and addictions system transformation** Waikato DHB is committed to building on existing foundations to improve mental health and addiction services for Māori, pacific, youth, rainbow communities, whānau and others. Placing people at the centre of all service planning, implementation and monitoring programmes:	
			The Waikato DHB Consumer Council will engage with consumer and whānau groups in the Mental Health and Addictions service sector to ensure a lived experience voice. (EOA)	Q1 and ongoing
			Real Time' Feedback tool gathers feedback from service users and their families. It has been implemented across the Provider Arm Mental Health and Addictions services and Youth INtact (addiction services). The findings will be used to drive on-going quality improvement across services.	Q1 and ongoing
			The DHB will utilise more responsive mechanisms to support Māori, Pacific, youth and other population groups to provide feedback and contribute to how we might eliminate inequities. Consideration of social media recruitment processes and mechanisms to support attendance will be explored. (EOA)	Quarterly
			The DHB Mental Health and Addictions Oversight Development Group will provide oversight and direction to significantly improve outcomes for people and whānau requiring mental health and addictions supports in the Waikato. Membership includes Māori, Pacific, youth, rainbow communities, whānau and other stakeholders. (EOA)	Q1 and ongoing
			The DHB will continue to invest in the current consumer/peer and whānau support services funded in the Waikato. (EOA)	Q1 and ongoing
			Promote and provide resources that explain the Health and Disability Code of Rights throughout all hospital and community services. This information will also remain a core component of staff orientation at the DHB.	Q1 and ongoing
			Provide information about the Health and Disability Advocacy Service at all hospital and community venues, a free independent service.	Q1 and ongoing
			The Waikato DHB Mental Health and Addictions Seclusion Elimination Steering Group's purpose is to identify and monitor a Mental Health and Addictions service-wide strategy for the reduction and eventual elimination of seclusion. This group will identify and oversee team action plans that are informed by an overarching strategy leading practice changes at an operational level. (EOA)	Q4
			The multidisciplinary team will engage in a service culture change process that aligns with the National HSQC approach to the reduction and elimination of seclusion.	Q4
			A suite of KPI data was reviewed during 2019/20 to ensure reporting is meaningful and measurable and able to illustrate improvements for service users and their whānau. The findings will be implemented in 2020. Data will be reported and monitored monthly internally and reported to the Directorate of Mental Health at Ministry of Health. (EOA)	Q1-Q4
			Embedding a wellbeing and equity focus Waikato DHB hospital and community Mental Health and Addiction services and partners will utilise the Healthy Active Learning resources developed by Government as part of service provision to address inequities for children and youth.	Q1
			Promote and provide metabolic monitoring for all people receiving care throughout all hospital and community Mental Health and Addiction services.	Q1-Q4
			Promote interventions to support the physical wellbeing of people with Mental Health and Addiction issues by referral/engagement with other stakeholders such as Sport Waikato - Green Prescriptions and other Community based health and wellbeing programmes.	Q1-Q4
			Build stronger collaborative relationships with MSD and Kainga Ora to address social determinants for mental health and addictions clients and whānau. (EOA)	Q3
			Determine the effectiveness of our Mental Health and Addictions child and youth clusters that support children and young people with mental health and addictions and their family/whānau. Identify whether this is an effective model to deliver services. If not - identify alternatives. If so, what are the gaps and areas that require improvement. Refine the effectiveness. (EOA)	Q4

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving mental wellbeing	Manaaki – People centred services	Goal 3: Support community aspirations to address the determinants of health	**Mental health and addictions system transformation** The Waikato DHB will improve access to employment, education and training options through collaboration with other stakeholders such as Workwise.	Q2
			The Waikato DHB Mental Health and Addictions service will establish a local point of access service in two rural communities in partnership with Māori service providers in that area to improve engagement approach with Māori, people with lived experience, Pacific peoples, youth and rainbow communities. (EOA)	Q2
			The Waikato DHB will continue to work with key partners to help drive transformation in line with He Ara Oranga. (EOA)	Q1 and ongoing
			Increasing access and choice of sustainable, quality, integrated services across the continuum	Q1
			Enhance the range of community based options for tangata whaiora - inclusive of step up and step down options closer to home, home based treatment and other alternatives to inpatient care. (EOA)	Q3
			Review our rural crisis respite services and identify strategies to improve responsive and timely local supports to whānau in distress. (EOA)	Q3
			Waikato DHB will work together with Ministry of Justice, Police, iwi and other stakeholders to help inform the establishment of an Alcohol and other Drug Treatment Court. (EOA)	Q1 and ongoing
			The DHB will begin implementation of the Te Pae Tawhiti five year programme of work. (EOA)	Q3
		Goal 6: Strengthen intermediate care	The DHB will support and monitor 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. (EOA)	Q1 and ongoing
			Pass on the nationally agreed contribution to cost pressure funding to NGOs in the district to support sustainability as part of pricing adjustments when agreements expire.	Q3
			Workforce The DHB will continue to contractually require Mental Health and Addictions providers to utilise the Let's Get Real framework as part of quality improvement/workforce planning. This will be assessed as part of routine audit processes.	Q1
			The DHB will continue to support the Consumer Council and other consumer, whānau and peer networks to provide valuable lived experience to our strategic planning mechanisms.	Q1-Q4
			Forensics The Midland Regional Clinical Governance, Waikato Forensic services (Mental Health and Addictions and Hauora Waikato) will work with Ministry of Health to improve and enhance Forensic capability.	Q3
			Waikato DHB will ensure membership and involvement in the Forensic Framework project.	Q2
		Goal 4: Improve access to services	**Suicide prevention** Review the Suicide Prevention and Postvention Advisory Group to ensure strong Māori participation. (EOA)	Q1
			Complete a gap analysis of Mental Health and Addictions suicide prevention actions in the 'Waikato Suicide Prevention and Postvention Plan' and 'Every Life Matters.' Review and resolve any gaps identified. (EOA)	Q2
			Strengthen engagement with whānau when a client is transitioning to another service (internal and external services). (EOA)	Q2
			Complete an internal evaluation of the one-day training offered to Mental Health and Addictions staff during Q3 2019/20.	Q4
			Determine a consistent measure of Mental Health and Addictions involvement with a person who has died by suicide.	Q3
			Commitment to demonstrating quality services and positive outcomes The Waikato DHB will ensure membership and involvement in the development of new measures and reporting workstreams with the Ministry of Health.	Q1-Q4
			Health Improvement will complete scoping resiliency programme for high schools in conjunction with wider DHB services.[7] (EOA)	Q2

[7] Action and reporting will be completed by Public Health

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving mental wellbeing	Manaaki – People centred services	Goal 4: Improve access to services	**Mental health and addictions improvement activities** Waikato DHB is committed to minimising restrictive care and improving transitions. To support this focus we will:	
			Build on the success of the pilot in Waharoa in 2019/20. The Local Point of Access service will be established in at least two other rural communities in association with Māori service providers. (EOA)	Q1 and ongoing
			Report to the Ministry quarterly on the quality of transition and discharge plans.	Q1-Q4
			In early 2020 the Government announced the establishment of an Alcohol and Other Drug Treatment Court (AODTC) in the Waikato. The Mental Health and Addictions service will work with the wider sector to look at the repatriation of residential alcohol and other drug beds back into Waikato.	Q1-Q4
		Goal 3: Support community aspirations to address the determinants of health	**Addiction** Waikato DHB is committed to supporting people with addiction issues to experience a high quality of life and independence. To support this we will:	
			Review KPI data to ensure reporting is meaningful, measurable and able to illustrate improvements for service users and their whānau. All KPI's will be reported on quarterly by ethnicity (Māori, Pacific, other, total) to monitor equity gaps and inform service improvements. (EOA)	Q1
		Goal 2: Empower whānau to achieve wellbeing	**Maternal mental health services** Waikato DHB is committed to increasing responsiveness to wāhine, tāne and their whānau during and post pregnancy and will:	
			Develop the Maternal Mental Health group (linked to the Maternity Quality and Safety Programme governance board) to provide oversight of the actions and activity listed below.	Q1
			Carry out a stocktake of existing services for wāhine, tāne, their pēpi and whānau needing to access mental health support. Update to reflect changes in service provision that has occurred since the previous stocktake, in a format that is useable for all practitioners and services. (EOA)	Q1
			Co-design whānau centric pathways and linkages for access to Perinatal Mental Health services (secondary/tertiary) and mild to moderate (primary/community) mental health services / community support for wāhine, tāne, their pēpi and whānau needing to access mental health support. Maternal Mental Health group to inform linkages across the continuum of care. (EOA)	Q2
			Carry out information presentations, plus develop resources for the maternity sector on pathways to access Perinatal Mental Health services and mild to moderate mental health services / community support in Waikato for wāhine, tāne, their pēpi and whānau needing to access mental health support. (EOA)	Q3
			Establish baselines for access to secondary maternal mental health services. Access to services will be monitored by ethnicity (Māori, Pacific and other) and geography to ensure equity will be through the MQSP governance board. (EOA)	Q1
			Monitor access to the above services, by ethnicity (Māori, Pacific and other) and locality to ensure equity. (EOA)	Q4
			Identify gaps and explore other maternal mental health and addictions service models to provide maternal mental health care in the Waikato district. (EOA)	Q4
			Have available debrief follow up appointments six weeks post birth for wāhine, tāne, and their whānau who have experienced unexpected interventions or traumatic birth. (EOA)	Q4
			Understand needs and types of mental health interventions for wāhine, tāne, and their whānau who have pēpi in Newborn Intensive Care Unit. (EOA)	Q4

Improving wellbeing through prevention

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving wellbeing through prevention	Haumaru – Safe, quality health services for all	Goal 3: Support community aspirations to address the determinants of health	**Environmental sustainability** Waikato DHB is committed to mitigating and adapting to the impacts of climate change and will:	
			Coordinate and develop a sustainability position statement to provide a high-level policy position for our organisation that guides local response across our DHB catchment and broader as required.[8] (EOA)	Q4
			Health Improvement will actively promote Pare Kore across Māori settings.[9] (EOA)	Q2 and Q4
			Increase the sustainability officer position to be full-time.	Q1
			Complete carbon inventory audit (Totiu previously CEMARS), in alignment with other DHBs.	Q4
			Development and implement a sustainability framework and action plan from carbon inventory.	Q2
			Collaborate with Waikato Regional Council to improve public transport to Waikato Hospital for staff, patients and visitors.	Q1 and ongoing
			Monitor and report on greenhouse gas emissions to establish baselines.	Q1 and ongoing
			Include weighting for sustainability in all tender evaluations for the purchase of materials, equipment and services.	Q4
			Expand recycling service to all office areas with a target to increase recycling rates to 15 percent.[10]	Q1 and ongoing
			New builds and refurbishment project designs to consider green building standards and include use of natural light, use of sustainable building materials, energy efficient technologies such as in the Design and Construction Policy.	Q1 and ongoing
			DHB travel and transport plan to be developed and implemented, to reduce single user motor vehicles and encourage sustainable alternatives for example, e-Bikes, walking and public transport.	Q1
			Develop, consult and implement a sustainability policy for Waikato DHB.	Q1
			Waste management policy to be updated to incorporate DHB recycling expectations.	Q1
		Goal 7: Enhance the connectedness and sustainability of specialist care	**Antimicrobial resistance (AMR)** Waikato DHB will manage the threat of antimicrobial resistance and ensure alignment with the NZ Antimicrobial Resistance Action Plan 201-2022 by:	
			Implement the Antimicrobial Steering Group action plan for 2020/21. Progress will be reported on six monthly.	Q2 and Q4
			All data and reporting will be completed by ethnicity (Māori, Pacific, other, total) to any equity gap and outcomes of implementing the action plan. (EOA)	Q4
			Improving and monitoring the uptake of the use of the Microguide to provide antimicrobial guidance to Waikato DHB. This guide will be included in RMO orientation, PGY1 and PGY2 education, and published on our staff intranet page.	Q1 and Q4
			Reviewing the antimicrobial guidance available to staff annually to ensure it remains current.	Q4
			Publish antibiogram reports annually (and uploaded to Microguide) with other reports of special interest as necessary.	Q1
			A mechanism for control of antibiotic dispensing and administration will be established and trialled for a set of agreed broad spectrum antimicrobials.	Q4
			Monitor and measure (by ethnicity) the use of broad spectrum antimicrobials to establish a target and reduce the number of adverse events (C. difficile rates) associated to broad spectrum antimicrobials with a narrow therapeutic index.	Q2 and Q4
			Continue implementation of the IV to oral campaign, applying the national interventions. The campaign aims to: • Reduce antimicrobial consumption • Reduce unnecessary intravenous antimicrobial use • Reduce nursing time (anticipating for staff sickness) • Infection prevention (IV pumps and room allocations) • IV luer related issues associated with unnecessary intravenous antimicrobial use	Q1 and ongoing
			Monitor (by ethnicity) and report on the campaign progress and outcomes.	Q4

[8] Action and reporting will be completed by Public Health
[9] Action and reporting will be completed by Public Health
[10] Increasing the recycling rate to 15 percent will occur over a five year period.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving wellbeing through prevention	Haumaru – Safe, quality health services for all	Goal 2: Empower whānau to achieve wellbeing	**Drinking water**[11] Waikato DHB is committed health protection and will work to ensure high quality drinking water: Waikato DHB will report to the Ministry on the drinking water activities and measures contained in the drinking water section of the environmental and border health exemplar.	 Q2 and Q4
			Environmental and border health Waikato DHB Public Health is committed to undertaking compliance and enforcement activities relating to the Environmental Health manual, Health Act 1956 and any other environmental and border health legislation. In addition, we will: Protect the border from potential disease carrying insects (mosquitos) minimising the risk of new diseases entering and spreading through New Zealand. Such an outbreak would likely have greater impact on our already high need Māori and Pacific communities. Report on the performance measures contained in the Environmental and Border Health exemplar six monthly.	 Q1 and ongoing Q2 and Q4 Q2 and Q4
	Whanaketanga – Productive partnerships	Goal 3: Support community aspirations to address the determinants of health	**Healthy food and drink**[12] Waikato DHB is committed to supporting environments for healthy eating and healthy weight and will: Report as part of the Healthy Active Learning Initiative, on the number of Early Learning Services, primary, intermediate and secondary schools that have current: • water-only (including plain milk) policies • healthy food policies, consistent with the Ministry of Health's Eating and Activity Guidelines. Implement Te Mate Huka, a model to improve diabetes outcomes for Māori in the Waikato by focussing on: • policies, programmes and services that support communities to be hauora enhancing environments with accessible and attractive options for fresh kai and exercise. (EOA) • recognition and early mediation of the impact of the social determinants of health in the development of diabetes. (EOA) Report on number of settings engaged in Healthy Active Learning (HAL) and their policies currently in place.[13] (EOA) Include in all new contracts held between the DHB and provider organisations a clause that requires the provider to have a healthy food and drink policy in place (this excludes nationally negotiated contracts such as the Pharmacy and PHO contracts). Compliance will be assessed as part of the annual audit.	 Q2 and Q4 Q1-Q4 Q1 and ongoing Q4
	Oranga – Health equity for high need populations	Goal 2: Empower whānau to achieve wellbeing	**Smokefree Aotearoa 2025** Waikato DHB will continue progress towards achieving Smokefree Aotearoa 2025 by: Working with the local provider of the Ministry funded "Stop Smoking Service" to align activities and operational efficiencies (once and for all). Conducting tobacco retailer visits for education and/or compliance purposes to ensure retailers are aware of their responsibilities under the Smoke-free Environments Act 1990. Conducting Control Purchase Operations (CPO) to ascertain the level of sale of tobacco to minors.[14] (EOA) Support 'settings' to make being smokefree a priority.[15] Recruit a community smokefree coordinator to expand the scope of the Ministry of Health priority.[16] Develop and agree with Māori providers, an enhanced whānau ora approach that will better enable Māori providers to support whānau in their rohe to live smokefree. (EOA)	 Q1 and ongoing Q1 and ongoing Q1 and ongoing Q2 and Q4 Q1 Q1 and ongoing

[11] All actions in the Drinking Water section will be completed and reported on by Public Health
[12] Excludes inpatient meals and meals on wheels.
[13] Action and reporting will be completed by Public Health.
[14] One CPO equals one total organised operation that targets a number of tobacco retailer premises. Action and reporting will be completed by the PHU.
[15] Action and reporting will be completed by Public Health.
[16] Action and reporting will be completed by Public Health.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving wellbeing through prevention	Oranga – Health equity for high need populations	Goal 2: Empower whānau to achieve wellbeing	**Smokefree Aotearoa 2025** – continued	
			Develop and implement a DHB wide smokefree strategy that has measurable equity targets and intensive smoking cessation support for the next five years to achieve smokefree 2025.	Q1 and ongoing
			The strategy will be co-designed during 2020 with whānau and inter-sector partners and include: (EOA)	Q4
			• engagement with tobacco smokers and their whānau on what support, advice, and information will enable successful cessation;	
			• supporting appropriate equity (Māori and Pacific) focussed providers to initiate co-developed cessation systems; and	Q2
			• set measurable targets to increase the numbers of Māori and Pacific peoples who are smokefree.	Q1 and ongoing
			Support and advocate for legislation that prevents the supply and sale of vaping tools and products that encourage smoking practices and increase nicotine addiction rates.[17]	
		Goal 4: Improve access to services	**Breast screening**	
			Waikato DHB is committed to eliminating equity gaps and achieving participation rates of at least 70 percent. We will work in partnership to:	
			Develop and implement a Kaitiaki support plan to expand the current support provided to wāhine Māori during the breast screening pathway. (EOA)	Q2
			'Support to Screening Services' and GP practices to increase enrolment and screening rates for Māori and Pacific. (EOA)	Q2
			Support Hauora iHub to increase opportunistic breast screening rates in the Waikato DHB Breast Care Centre to 100 per annum for wāhine Māori who are due or overdue breast screening. (EOA)	Q4
			Develop and implement 'Test for Change' initiatives[18] in the Waikato to improve wāhine Māori coverage. (EOA)	Q4
			Lead the implementation of BreastScreen Midlands' new transition plan that reflects national service model changes, focussing on achieving health equity. (EOA)	Q4
			Cervical screening	
			Waikato DHB is committed to eliminating equity gaps in participation and achieving participation rates of at least 80 percent. We will:	
			Develop and deliver a Māori centred awareness campaign to improve cervical screening coverage.[19] (EOA)	Q2
			Provide onsite screening at large scale national and regional Māori and Pacifica events within the Waikato district. (EOA)	Q3
			Deliver cervical screening awareness and education with Kaumatua and Plunket. (EOA)	Q2
			Offer cervical screening, health history checks, and arranging any further service required at the Whirihia wānanga, for non-pregnant wāhine/whānau. (EOA)	Q3
			Provide a free screening clinic for annual #SYM (SmearYour Mea) day and support practices to do the same.	Q1
			Develop and test a prototype programme for the provision of a rural, mobile, opportunistic screening service. (A mobile Hauora iHub model, supported by Māori workforce). (EOA)	Q3
			Increase targeted (Māori and Pacific) opportunist cervical screening by providing screening at Anglesea Clinic. (EOA)	Q1
			Work with PHOs to identify and screen the women who are significantly overdue smears. (EOA)	Q2
			Provide smear taking support in practices with smear taking shortages and high needs populations. (EOA)	Q4
			Provide education and support to practice nurses in our rural settings to improve their screening coverage. (EOA)	Q3

[17] Waikato DHB accepts vaping is a successful cessation tool for current smokers and supports its availability through cessation support providers.
[18] Developed collaboratively by BreastScreen Midland and Bay of Plenty DHB.
[19] In partnership with Māori and PHOs.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving wellbeing through prevention	Whanaketanga – Productive partnerships	Goal 2: Empower whānau to achieve wellbeing	**Reducing alcohol related harm** Waikato DHB will undertake the following actions to reduce alcohol related harm:	
			Inquire into all on, off, club and where appropriate, special licence applications, and provide Medical Officer of Health reports to the District Licensing Committee.	Q2 and Q4
			Collaborate in police-led Controlled Purchase Operations (CPOs), to reduce sale of alcohol to minors.[20]	Q2 and Q4
			Take opportunities to advocate for better local alcohol policies with our territorial authorities.	Q4
			Provide guidance and support as needed to any of our settings (e.g. a workplace through the WorkWell programme).	Q4
			Promote the use of Health Promotion Forum resources.	Q4
			Advocate for national reform as opportunities arise.	Q4
	Manaaki – People centred services	Goal 4: Improve access to services	**Sexual health** Waikato DHB is committed to advancing sexual health services and promotion work and will:	
			Provide screening opportunities for sexually transmitted infection (STI) at events and through the Hauora iHub.	Q4
			Develop and implement a targeted, public campaign to raise awareness of STI screening for Māori and Pacific peoples. (EOA)	Q2
			Public Health will review and implement the DHB's Syphilis Action Plan in collaboration with Sexual Health. (EOA)	Q2 and Q4
			Develop and implement a pilot programme for the use of SH:24 (online sexual health service) to improve equitable access to sexual health services.[21] (EOA)	Q4
			Promote awareness in primary care about the increasing rate of syphilis, the appropriate diagnosis and management.	Q2
			Provide education through face-to-face and virtual continuing professional development sessions to raise clinical awareness of notifiable STIs and the notification process.	Q2
			Seek to procure and implement a new patient management system to improve and advance delivery of sexual health services.	Q2
	Ratonga a iwi – Effective and efficient care and services	Goal 5: Enhance the capacity and capability of primary and community health care	**Communicable diseases**[22] Waikato DHB is committed to working with iwi and Māori health providers to design, deliver and monitor the services and functions included below:	
			Conduct monthly surveillance for the purpose of preventing, identifying and responding to emerging communicable disease issues.	Q1-Q4
			Identify, investigate, assess, monitor, manage and report to Public Health, significant outbreaks and emergent risks from communicable diseases. Reports to Primary Care and the wider sector on emerging communicable disease or diseases of concerns will be completed as needed.	Q2 and Q4
			Maintain a communicable diseases (CD) response capacity and support CD staff to attend ESR epidemiological skills courses and other relevant courses.	Q2 and Q4
			Maintain an appropriate and efficient system for receiving, considering and responding to notifications and enquiries.	Q2 and Q4
			Provide all information and manage the local operation of databases and information systems.	Q2 and Q4
			Enforce the Health Act 1956, Health (Infectious and Notifiable Diseases) Regulations 2016 and other relevant legislation.	Q2 and Q4

[20] One CPO equals one total organised operation that targets a number of premises.
[21] In collaboration with sexual health service providers and the Ministry of Health.
[22] The activities in this section will be completed and reported on by Public Health.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Improving wellbeing through prevention	Ratonga a iwi – Effective and efficient care and services	Goal 5: Enhance the capacity and capability of primary and community health care	**Communicable diseases** – continued **Rheumatic Fever** Work with partners to raise public awareness about the importance of getting sore throats and skin infections checked and treated among the Māori and Pacific populations. Undertake gap analysis of notified rheumatic fever cases. (EOA) Enter all diagnosed rheumatic fever cases into the local rheumatic fever register. Engage with the DHB Governance Group to provide public health perspectives in relation to Rheumatic Fever Prevention. Work with the Child Health Action Group (CHAG) to advocate for a national register, and assist with implementation of regional or national register if initiated. Reporting on sore throat management to ascertain if processes in place are being effective. **Tuberculosis (TB)** Manage confirmed and probable TB disease cases. Manage and follow up TB contacts.	Q2 and Q4 Q1-Q4 Q1-Q4 Q1-Q4 Q4 Q2 and Q4 Q2 and Q4
	Whanaketanga – Productive partnerships	Goal 3: Support community aspirations to address the determinants of health	**Cross sectoral collaboration**[23] The determinants of health play a major role in the health and wellbeing of our population. Because of this Waikato DHB will be actively involved in the following: Facilitate a cross sectoral approach to influence public policy approaches across all levels of local government and government agencies. The key focus will be the social determinants of health such as housing, mental wellbeing, tobacco control, alcohol, gambling, land transport, and urban planning. Impacts of changes made to final local and central government policies as a result of this work will be monitored. Examples include: • advocate for better Local Alcohol Policies with our territorial authorities • provide support to agencies that identify smokefree as a priority wellbeing area Contribute to and support key agreed Waikato Plan priorities (mental health and wellbeing (lead role), housing (support role), and Waikato Wellbeing targets and goals (support role). Collaborate with stakeholders to develop a rural housing improvement and homelessness initiative in at least one locality. Expand Whare Ora healthy housing programme across all localities (Subject to securing resource from Te Waka (Waikato regional economic development agency). Scope and develop a Health in All Policies (HiAP) action plan or organisational policy to collaborate with others in on HiAP work. Participate in the Vibrant Safe Waitomo joint leadership group. Work with Waikato Tainui and Counties Manukau DHB on responding to health need in the Northern Corridor (link to population growth management).	Q4 Q4 Q4 Q4 Q4 Q1 Q2 and Q4

[23] The activities in this section will be completed and reported on by the Public Health and/or DHB

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

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Oranga – Health equity for high need populations	Goal 2: Empower whānau to achieve wellbeing	**Delivery of Whānau Ora** Waikato DHB is committed to the strategic change for whānau-centred approaches and will continue to support and to collaborate, including through investment, with the Whānau Ora initiative by:	
			Continue to support shared understanding of what whānau-centred approaches and whānau ora approaches mean and how they contribute to health improvement. (EOA)	Q1 and ongoing
			Work with all providers to ensure they are clear of our expectations for whānau-centred approaches and ensure providers are able to demonstrate in practice. (EOA)	Q1 and ongoing
			Work with Māori and Pacific providers to enable them to provide more enhanced whānau ora services within their rohe. (EOA)	Q1 and ongoing
			Support delivery of the new Whānau Pai collaborative, a Māori led approach for the delivery of enhanced primary mental health services across the DHB rohe. It supports Māori to lead and drive the development and delivery of services for Māori while also ensuring clinically and culturally excellent services. (EOA)	Q4
			Work with Whānau Ora providers, commissioning agencies and partners to contribute to Māori and Pacific health advancement and to achieve equity, including: (EOA) • agreed working arrangements • clear understanding of the strengths, weaknesses, opportunities and challenges facing parties • exploration of opportunities for alignment • prioritising future investment and disinvestment to support whānau ora centred services and whānau ora approaches.	Q1 and ongoing
		Goal 3: Support community aspirations to address the determinants of health	**Pacific health action plan** Waikato DHB is committed to improving health outcomes for our Pacific population and will actively support the delivery of Ola Manuia, the national Pacific Health and Wellbeing Action Plan (2020-2025). (EOA)	Q1 and ongoing
			Support the executive director Māori Equity and Health Improvement with the evidence and expertise required to deliver on key actions of Ola Manuia, and Faiva Ora; the National Pacifica Disability Plan 2016-2021. (EOA)	Q4
			Facilitate a co-design process with Pacific providers and Pacific community members to produce an updated Waikato DHB Pacific Health Equity Profile. (EOA)	Q4
			Facilitate and support health improvement partnerships with and for Pacific families and communities incorporating Pacific methodologies and models of health in engagements and activities. (EOA)	Q4
			Provide guidance and oversight to a DHB wide services approach that will improve access, deliver culturally safe services, improve quality and achieve equitable health outcomes for the Pacific population in the Waikato DHB district. This will include working with and in alignment with identified focus areas including: (EOA) • improving maternal, child and youth wellbeing • improving mental wellbeing • public health prevention focused activities (in particular communicable diseases, healthy food and drink, Smokefree 2025, screening, reducing alcohol related harm, sexual health, and health in all policies) • better population health outcomes (public health and disability system) areas (including delivery of Whānau Ora, Disability Action Plan, workforce priorities, data and digital, primary care integration).	Q4

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcomes supported by strong and equitable public health and disability system	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Care capacity demand management (CCDM)** Waikato DHB is committed to implementing CCDM to better match workforce capacity with patient demand. To further progress this work we will: **Governance** CCDM council will meet monthly to use core data to look at decision making with regards to CCDM processes.	Q3
			Local Data councils will meet monthly to run and examine completed core data sets including target FTE. This will ensure all components of the CCDM programme are met.	Q3
			Councils will be enure that Mana Tangata is considered and will present workforce data split by: Māori, Pacific, non-Māori, non-Pacific, and will ensure policy is in place to ensure Māori is correctly represented as a part of our workforce. (EOA)	Q4
			Patient acuity data Continue using Trendcare on all wards.	Q4
			Core data set To have all 23 core data sets available by October 2020. Data will be split by, Māori, Pacific and other.	Q2
			Incidents and complaints will be identified by ethnicity and action plans discussed to address identified inequity. (EOA)	Q2
			Variance Response Management (VRM) It is proposed that a director of operations will be established. This role will have the ability to ensure all VRM actions are embedded. Currently all standard operating procedures and escalation plans have been complete, and capacity 'At A Glance' screens are being built. The structure of the Integrated Operations Centre will meet the VRM CCDM expectations under the proposed establishment of the director of operations.	Q3
	Oranga – Health equity for high need populations	Goal 2: Empower whānau to achieve wellbeing	**Disability action plan** Waikato DHB is committed to improving health outcomes of our whānau hauā (disabled people) and developing a Waikato DHB disability action plan that will focus on data, access and workforce. (EOA)	Q4
			The action plan will be co-designed with whānau hauā, building on and being respectful of the significant work completed in 2020 that produced a Waikato Disability Responsiveness Plan and Waikato Disability Profile, both documents completed with significant leadership from whānau hauā and our broader disability community. (EOA)	Q4
			Disability Waikato DHB is committed to better understanding the needs of disabled people through improved data collection and will: Implement a training programme for employees on how to interact with disabled people. This will be part of our learning framework for employees and attendance will be reportable.	Q4
			Update our patient management system (iPM) and clinical work station (CWS) with patient information regarding disability. This information will be a 'patient alert' assisting services to provide enhanced care to patients and whānau.	Q1 and ongoing
	Manaaki – People centred services	Goal 5: Enhance the capacity and capability of primary and community health care	**Planned care** Waikato DHB is committed to meeting planned care service delivery and waiting time expectations. To support this we will: Develop and begin implementation of a three year plan for the planned care initiative, which will be focussed on achieving equitable health outcomes for Māori and Pacific. (EOA)	Q1 and ongoing
			Better understand the needs of communities through locality planning, identify demand for services and any health disparity that exists in each locality. Following the identification of locality needs, develop services to improve equity of access and outcomes. (EOA)	Q1 and ongoing
			The Mobile Surgical bus will be extended to South Waikato to create a consistent rural health service, delivering quality care closer to home. (EOA)	Q2
			Implement a gynaecological theatre list 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.	Q1
			Integrate general practice and district nurses, and remove co-payments for planned care initiatives that occur in primary and community care setting.	Q2

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcomes supported by strong and equitable public health and disability system	Manaaki – People centred services	Goal 5: Enhance the capacity and capability of primary and community health care	**Planned care** – continued Develop service models to support prevention and early intervention by extending services into the community with clinically appropriate personnel[24] for: • Skin Lesion service • Plastics • Minor operations • Gynaecology • Community referred radiology – GPs to have direct access to community radiology provider • Non-surgical – COPD, respiratory	Q4 and ongoing
	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Acute demand** Waikato DHB is committed to improving acute data capturing and developing plans to address the growth in acute inpatient admissions by: **Acute data capturing** Implementation will start with capturing information for each presentation at Waikato Hospital Emergency Department (ED).	Q3
			Required data relating to each ED presentation will be recorded by the nurse during triage, using existing systems.	Q1
			Procedures will be recorded as part of the ED discharge documentation, using existing systems.	Q1
			Implement the replacement process for recording a diagnosis.[25]	Q3
			Adapt current reporting to National Non-admitted Patient Collection to extract Systematised Nomenclature of Medicine – Clinical Terms (SNOMED-CT)[26] information from current transactional systems.	Q3
			Staff who use the new SNOMED-CT coding system will receive training to ensure the appropriate use of the SNOMED-CT codes.	Q1 and ongoing
			Acute demand Develop a work plan focused on priority areas to ensure the Waikato health System can meet the growth in acute demand including ED presentations and acute hospital admissions. The work plan will have a key focus on developing new equity focussed community models of care. The ADMAG group will monitor and report on progress.	Q1 and ongoing
			Primary Options for Acute Care (POAC) Clinical Monitoring and Improvement Group will further develop the POAC service for general practice. This will include increasing access to diagnostic services in community and other services that will help to reduce the number of unnecessary ED presentations and admissions. (EOA)	Q4
			Expand the acute frailty admission avoidance service with the addition of a new nurse practitioner in the community response team who will be dedicated to complex care management.	Q4
			Work closely with Saint John Ambulance service to develop a community based model of care for COPD patients to better meet their needs in the community as an alternative to hospital admissions. (EOA)	Q4
			The ED redirection model will be expanded to rural hospitals as part of the locality development process and supporting rural hospitals in their ability to respond to acute demand.	Q4

[24] Either DHB employees and or other third party provider.
[25] ICD-10 based diagnoses.
[26] SNOMED is required by the Health Information Standards Organisation (HISO) as a standard for the health and disability system.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Oranga – Health equity for high need populations	Goal 5: Enhance the capacity and capability of primary and community health care	**Rural health** Waikato DHB is committed to improving access to services for our rural communities and will:	
			Complete a review of the rural hospitals (Tokoroa, Te Kuiti and Taumarunui).	Q4
			Review the Māori whānau targeted diabetes support service and build internal capacity and capability. Where appropriate expand into a high need rural location.[27] (EOA)	Q2 and Q4
			Establish local leadership groups in each locality to inform ongoing locality planning and health service enhancement.	Q1-Q4
			Implement new digital enablement products to connect clinicians with colleagues and patients.	Q4
			Extend the mobile surgical bus into the South Waikato to assist with minor surgical interventions.	Q2
			Implement a rural healthcare partnership in the Thames/Coromandel/Hauraki catchment with primary care health providers: (EOA) • Model of care development e.g. chronic disease management, whānau ora pathways, etc. • Co-location options e.g. one site model	Q2
			The provision of appropriate clinical secondary services in the localities to meet the needs of our rural population: • Increased use of Thames theatres • Increased use of outpatient facilities • Increased use of day procedure facilities • Increase use of telehealth capability.	Q1 and ongoing
			Complete a full review of the DHB's permanent and visiting medical rural workforce needs and implement any required changes to provide a quality, reliable and sustainable service to our rural communities: • Thames, Te Kuiti, Taumarunui and Tokoroa hospitals/health care services.	Q1
			Increase the support in the rural health setting (in collaboration with Mental Health and Addictions services) of the prevention, acute and respite care of people needing mental health care and support: (EOA) • Detoxification beds • Mental health step-up and step-down bed patient care models • Community and hospital owned patient management plans.	Q1
	Haumaru – Safe, quality health services for all	Goal 6: Strengthen intermediate care	**Healthy ageing** Waikato DHB will complete the following actions to support implementation of the Healthy Ageing Strategy 2016:	
			Continue to support the on-going delivery of the Kaumātua Day Programmes. This is a Māori cultural response to the Healthy Ageing Strategy framework. They vary from Community Day programmes as they are based on Māori principles of Manaakitanga (looking after each other), Wairuatangata (spiritual growth), and whānautanga (importance of whānau). (EOA)	Q1 and ongoing
			Work with ACC, Health Quality and Safety Commission (HQSC) and the Ministry of Health to promote and increase enrolment in strength and balance programmes and improve osteoporosis management, especially with Primary Care as reflected in the "Live Stronger for Longer" Outcome Framework.	Q1 and ongoing
			Work with the cross-sector Waikato DHB Falls Working Group to identify and understand the reasons for low referral volumes from ACC case managers.	Q1
			Align local Waikato DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS.	Q2

[27] Action and reporting will be completed by Public Health.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Haumaru – Safe, quality health services for all	Goal 6: Strengthen intermediate care	**Healthy ageing** – continued	
			Transition to a casemix delivery model across the home based support services.	Q1-Q4
			Regular communication with GP Practice nurses through Best Practice Advocacy Centre NZ (BPAC) to improve the programme's visibility.	Q4
			Continue to support the multidisciplinary team to review and manage older, frail and complex patients presenting to ED without a clear medical need for admission. This will review the needs of the patient and look towards alternatives to admission including the use of acute home based support, supported transfer and accelerated rehabilitation team (START), rest, recuperation and convalescent care.	Q1-Q4
			Focus on developing the Māori needs assessment and service coordination (NASC) services across the Waikato district. This will also include a pacific island resource and enable a more culturally appropriate NASC service. (EOA)	Q3
			In 2019/20 a stocktake of dementia care was undertaken and identified respite care as a gap and priority for Waikato. As part of the locality approach being taken, dementia respite services will be co-designed and implemented.	Q4
		Goal 2: Empower whānau to achieve wellbeing	**Improving quality**	
			Waikato DHB is committed to improving the quality of our consumer engagement, hand hygiene and mental health. This year we will:	
			Implement the actions included in the 2020/21 System Level Measure Improvement Plan and report on progress quarterly.[28]	Q4
			Consumer engagement	
			Establish a governance group of staff and consumers to guide implementation of the quality safety markers.	Q1
			Complete a baseline stocktake of current consumer activity.	Q1
			Agree a process for obtaining information regarding consumer engagement from all DHB providers.	Q3
			Data will be uploaded onto the consumer engagement quality safety markers dashboard every quarter.	Q1 and ongoing
			Report against the quality safety markers framework yearly.	Q3
			Hand hygiene	
			Ensure gold hand hygiene auditors in each service (currently 60 active auditors; aim for 80).	Q4
			Incorporate hand hygiene compliance into the directorate performance meetings with executive leadership.	Q2
			Encourage front line ownership (FLO) approach.	Q2
			Instigate reward and recognition for sustained high compliance (>90%).	Q2
			Promote the hand hygiene national online learning package.	Q1 and ongoing
			Promote the hand hygiene resources on the Waikato intranet Infection Prevention and Control intranet page including moment's stickers, patient stories and quizzes.	Q1 and ongoing
			Ensure correct placement of hand gel in each clinical area.	Q2
			Encourage staff to report non-compliance (of hand hygiene and bare below elbows) through the 'Speak up for Safety' code.	Q2
			Mental Health and Addictions (zero seclusion)	
			Data will be collected and monitored monthly internally then reported to the Directorate of Mental Health at Ministry of Health.	Q1 and ongoing
			The multidisciplinary team will engage in a service culture change process that aligns with the national HQSC approach to the reduction and elimination of seclusion.	Q1 and ongoing

[28] See appendix B for the full 2020/21 System Level Measure Improvement Plan.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**New Zealand cancer action plan 2019-2029**	
			Inform and implement new initiatives through analysis of timeframe breaches and delays by ethnicity to achieve equity of access and outcome.	Q4
			Carry out database audits to ensure data capture accuracy.	Q1-Q4
			Manually check individual records to ensure the database captures appropriate clinical rationale for any delay or breach.	Q4
			Identify organisational or system generated opportunities and implement activities for quality improvement.	Q1-Q4
			Highlight any system delays to the relevant service and work with the service managers and clinicians to resolve.	Q2
			Develop the CNS equity and access role to improve equity by supporting champions within tumour streams and service specific areas. (EOA)	Q1-Q4
			Monitor high risk population groups and pre-emptively mitigate potential DNA events through making initial contact with patients and helping with any transport or timing issues. (EOA)	Q1-Q4
			Pro-actively facilitate patient and system management to mitigate delays where possible. Using the Faster Cancer Treatment (FCT) database to highlight patient pathways and prospective tracking of patient pathways to ensure first specialist assessment, diagnostics and treatment occur in timely manner and having sound rationale for any delays.	Q1-Q4
			Utilise FCT reporting database to identify Māori and Pacifica complex pathways to first treatment with a view to eliminating barriers to access for these target populations. (EOA)	Q1 and ongoing
			Work across organisational and service boundaries (community, public health, primary/secondary/tertiary) to support patient care pathways with good communication, resolve transport issues and make appointments which work for our patients.	Q1
			Continue to support the newly appointed hysteroscopy nurse practitioner in providing colposcopy services.	Q1-Q4
			Bowel screening and colonoscopy wait times	
			Waikato DHB is committed to reducing the rates of bowel cancer in its population and ensuring colonoscopy wait times are met by:	
			Ensure diagnostic waiting time indicators are consistently met regardless of implementation of bowel screening. This requires active management of supply, demand, capacity and capability.	Q1 and ongoing
			Monitor Waikato DHB internal waiting time compliance reports.	Q1 and ongoing
			Utilise theatre lists and schedules to capacity. Backfilling lists as the primary option to avoid list cancellations.	Q1 and ongoing
			Manage and monitor weekly demand through weekly audits of inflows and outflow.	Q1 and ongoing
			Daily focus on ensuring that Māori, Pacific and rural patients if required have access to talk with an endoscopy clinical nurse specialist prior to booking or rebooking of a theatre date. This can help with preventing 'Did Not Attend" (DNA) events and will ensure people are aware of what they need to do prior to attending their appointment. (EOA)	Q1 and ongoing
			Implement a same day booking system for clinic patients to receive their colonoscopy appointment and bowel prep prior to leaving the hospital and then review quarterly.	Q1 and ongoing
			Reduce 'Did Not Attends' for Māori and Pacific to less than six percent. Collate data quarterly and report findings to clinical leads. (EOA)	Q4
			Achieve compliance of the global rating scale requirements prior to bowel screening go live date.	Q2
			Work towards meeting all pre-assessment requirements of the National Bowel Screening programme prior to go live.	Q2 and Q4
			Through the implementation phase of bowel screening develop equity plans for community, primary care and secondary care in line with Ministry of Health timelines, then commence implementation. (EOA)	Q3 and Q4
			Through the implementation phase of bowel screening develop a high level equity plan across symptomatic endoscopy and bowel screening services then commence implementation. (EOA)	Q3 and Q4
			Manage and monitor compliance against bowel screening indicator 306.	Q4
			Work toward achievement of participation in the bowel screening programme of at least 60 percent (over a 24 month period). (EOA)	Q4
			Work towards eliminating equity gaps for Māori, Pacific and other priority groups through the development of equity plans and specific dedicated staffing resource. (EOA)	

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Workforce**	
			Workforce priorities Complete a Māori workforce development strategy and action plan that will include: • Implementation of a DHB-wide programme to address and eliminate racism • Through targeted development and placement, increase the number of Māori leadership and management roles throughout the organisation	Q4
			Continue work towards an employee value proposition that focusses on attracting and retaining talent. (EOA)	Q4
			Strategic sourcing is in place to identify current workforce supply issues internally and externally and address these in partnership with the Te Manawa Taki DHBs.	Q4
			Build on CCDM implementation and deliver actions informed by insights from the data and measures.	Q1
			Build on the learning governance implemented in 2019/20 to drive continuous improvement of organisational capability requirements and learning needs analysis outcomes.	Q4
			Complete the first phase of the Speaking Up for Safety programme to ensure 100 percent of the target workforce population has participated.	Q4
			Development of Human Resources (HR) metrics aligned to the workforce plan and compliance will be available to enable monitoring of progress towards targets. (EOA)	Q4 and ongoing
			Facilitate access to training opportunities to improve staff knowledge of cultural competency and safety when working with Pacific people and related data. (EOA)	Q4
			Undertake a training needs analysis on educational requirements for all staff.	Q2
			Develop an annual calendar of training opportunities, both face to face and online learning.	Q2
			Develop an organisational wide capability and development framework.	Q4
			Workforce diversity and cultural safety Increase Māori workforce by 1.5 percent across all areas to progress towards the longer term target of having a workforce that is 23 percent Māori. (EOA)	Q4
			Develop workforce diversity metrics to inform targeted actions to improve workforce diversity with a focus on outcomes for Māori, Pacific, people with disability and migrants. (EOA)	Q2
			Continue to integrate tikanga and Pacific (i.e. language, resources) into all Human Resources processes. For the 2020/21 year the focus will be on improving participation in the Te Hono Whakataki (Waikato DHB Orientation) and the introduction of a Te Reo learning programme. (EOA)	Q4 and ongoing
			Data and digital	
			Complete a trial of cardiology outpatient telehealth services to reduce wait times for diagnostics and treatment.	Q4
			Provide care closer to home and reduce wait times by offering general medicine outpatient consultations through telehealth. Validate and standardise the processes, systems and technology for future roll out to other services.	Q4
			Implement a community based information platform[29] to provide Māori and Pacific populations with increased visibility and understanding of the health and social services available in each locality and how to access these, to support equitable health outcomes. (EOA)	Q4
			The Consumer council and clinical equity leadership group will co-develop and implement the DHB's digital strategy.	Q2
			Database tools will be developed to capture ethnicity, allowing for transparency and easy recognition of inequities. (EOA)	Q1
			Qliksense will be enhanced to provide ready reporting and data access to clinicians, allowing for improved practice, disclose and address proven inequity. (EOA)	Q1
			Work with iwi to improve their access to health data, analytics and insight to inform collaboration, planning and joined up initiatives commenced. (EOA)	Q4
			Enhance and expand Clinical Workstation.	Q3

[29] Platform to be developed and updated regularly by Healthpoint who work with services providers to ensure information is up to date and accurate.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcome supported by a strong and equitable public health and disability system	Ratonga a iwi – Effective and efficient care and services	Goal 7: Enhance the connectedness and sustainability of specialist care	**Data and digital** – continued	
			Enhance the regional functionality for eOrders, eReferrals, Results Management and Medication Management (three year programme of work).	Q4
			Develop and implement a Public Health digital communication strategy to enhance the service's digital profile and facilitate digital dissemination of public health information e.g. community health profiles to the wider community.	Q4
			Develop and implement standard operating procedures for public health data analytics to improve efficiency of existing workflows to report on population level indicators and public health surveillance.	Q4
			Develop and provide metadata to organise public health information on the attributes of data elements.	Q4
			Develop social media data mining analytics workflow for public health related topics.	Q4
			Develop Qlik Sense modules for public health priority population level indicators.	Q4
			For further data and digital information see the stewardship section on pages 61-63.	
	Pae taumata – A centre of excellence in learning, training, research, and innovation	Goal 3: Support community aspirations to address the determinants of health	**Implementing the New Zealand health research strategy**	
			Research, innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes. This year we will:	
			Commit to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy.	Q1 and ongoing
			Evaluate research and analytic networks in the region. Nationally Waikato DHB is a member of the Research Office Managers Alliance.	Q3
			Waikato DHB has a research policy, clinical trials procedures and Māori Research Review Committee in place. We will review and evaluate the research policy and Māori Research Review Committee processes. (EOA)	Q4
			Provide a one page summary update to the Ministry and Waikato DHB commissioners, outlining progress towards the implementation of the New Zealand Health Research Strategy.	Q4
	Oranga – Health equity for high need populations	Goal 4: Improve access to services	**Delivery of regional service plan**	
			Waikato DHB is committed to supporting activities to reduce hepatitis C at a regional level, and will:	
			Continue to support implementation of the regional hepatitis C clinical pathway by supporting the local multi-disciplinary team (MDT) to develop and lead a local work plan for the next phase of the programme. The local work plan will incorporate objectives and actions from the regional work plan to ensure that roll out of the programme is regionally consistent and the MDT approach will ensure an integrated approach to increasing access to care and promoting primary care prescribing of the new pangenotypic hepatitis C treatment.	Q1 and ongoing Q1 and ongoing
			Provide information and support to primary healthcare organisations to enable general practice teams to provide optimal hepatitis C care and support for the delivery of accessible PHARMAC funded direct acting antivirals (DAA) hepatitis C treatment for eligible patients.	

Better population health outcomes supported by primary health care

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcomes supported by primary health care	Whanaketanga – Productive partnerships	Goal 5: Enhance the capacity and capability of primary and community health care	**Primary health care integration**	
			Further rollout of the primary and secondary electronic messaging service to improve access to specialist advice.	Q1
			Improved access to primary referred ultrasound using a 'smart referral' form. Direct access functionality will be enabled new contracting.	Q1
			The Waikato Primary and Community Health Care Alliance will develop a work programme to implement new integrated models of care to improve access and health outcomes for Māori. The Alliance will meet regularly and work streams will be established to progress work such as broadening the use of the health workforce. Alliance progress will be reported on quarterly. (EOA)	Q1 and ongoing
			The new Advanced Care Planning (ACP) facilitation service will provide a kaupapa Māori approach to ensure a culturally responsive service that meets the needs of Māori and other populations. This will help ensure we achieve the annual target of 600 ACP (total) with Māori being a targeted population group. (EOA)	Q1
			Locality development process will develop a community, primary, secondary care integrated service delivery model in South Waikato. (EOA)	Q4
			Implement primary care suspected skin cancer excision service supported by specialist tele-dermatology.	Q1
			Further implementation of the general practice and district nursing integrated model of care. Once complete, the model will be expanded to include the Allied Health workforce.[30]	Q4 and ongoing
			Strategy and Funding will work alongside The Whānau Pai Collaborative to support and monitor implementation. The Whānau Pai Collaborative, developed by Māori, Pacific, PHOs and other NGO services will provide a Māori for all approach that seeks to provide earlier and more responsive primary mental health and addiction supports and outcomes for whānau. (EOA)	Q4
			Air Ambulance centralised tasking	
			Waikato DHB will actively participate with National Ambulance Sector Office (NASO) in the design and planning phases to centralise the tasking of aeromedical assets in New Zealand.	Q1 and ongoing
	Oranga – Health equity for high need populations		**Pharmacy**	
			The Waikato Primary and Community Health Care Alliance will develop a work programme to implement new integrated models of care to improve access and health outcomes for Māori. The Alliance will meet regularly and work streams will be established to progress the work programme and broaden the use of the pharmacy workforce. (EOA)	Q1 and ongoing
			Commence a project to examine outlier referrers and claimers of pharmaceuticals in order to ensure best use of pharmacy resources and clinical outcomes for patients.	Q1
			Develop a Pharmacy procurement plan to signal the role of pharmacy within Te Korowai Waiora, Waikato HSP and locality planning.	Q2
			Integration of clinical pharmacist services into the frailty pathway to optimise medicines management for older people.	Q1
			Complete a stocktake of Medications Utilisation Review (MUR) coverage and identify service gaps.	Q3
			Data analysis of ED presentations with polypharmacy will identify high need localities and inform service development and equitable access.	Q2 and Q4
			MUR service will be aligned to equity needs, locality development and Te Korowai Waiora, Waikato HSP. (EOA)	Q4
			Community prescribing pharmacists will be able to order selected laboratory tests and be accountable for results.	Q1
			Increase coverage of MMR vaccine for 16-49 year olds through increased numbers of pharmacist vaccinators. This will be monitored and reported on quarterly by ethnicity (Māori, Pacific and other).	Q1
			Increase coverage of Influenza vaccinations to 75 percent, with a particular focus on Māori and Pacific. Vaccination rates will be reported on annually (Q1).[31] (EOA)	Q1
			Clinical pharmacists to 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.	Q2

[31] Full System Level Measure Improvement Plan included as Appendix B.

Government planning priority	Waikato DHB strategic imperative	Te Korowai Waiora, Waikato HSP	Activity	Milestone or completion date
Better population health outcomes supported by primary health care	Oranga – Health equity for high need populations	Goal 2: Empower whānau to achieve wellbeing	**Long-term conditions including diabetes**	
			In partnership with Māori and Pacific providers we will strengthen whānau ora services will be strengthened to enable Māori and Pacific whānau to better manage their conditions and live well through effective clinical and holistic supports. (EOA)	Q2
			Whānau ora providers will offer Kimi Ora to Māori with diabetes, living in high need communities. This is a nutrition and physical exercise programme by Māori for Māori. (EOA)	Q1-Q4
			Promote the community development approach to support wellbeing and resilience. (EOA)	Q1
			Develop a locality based system of care that facilitates a model of care approach for Diabetes, CVD, Renal, Cancer and First 1000 days. To progress the Model of Care approach for each area we will: (EOA)	Q1-Q4
			• establish partnerships with iwi by working in conjunction with the locality development.	Q1
			• complete a stocktake of services and service providers, status of current performance, investments, workforce, challenges, gaps and opportunities for the service to reduce equity gaps and improve health outcomes	Q1
			• co-design and co-develop a model of care by actively engaging with stakeholders including patients, whānau and iwi – the diabetes model of care will incorporate Te Mate Huka, a model co-designed with iwi to improve diabetes outcomes for Māori in the Waikato	Q2
			• from the outcomes of the co-design process explore new insights and perspectives to scope opportunities to test	Q3
			• test new ideas and new ways of service delivery, before scoping for broader implementation.	Q4
			Secondary services We will work with local iwi and Māori health providers to improve engagement with patients and whānau and to provide more secondary services in the rural sector including: (EOA)	
			• Podiatry services in Tokoroa, Te Kuiti, and Huntly will be expanded to provide hospital level podiatry services to active high risk feet patients.	Q2
			• When appropriate, patient's annual diabetes review will be coordinated to include their retinal screening. This will help to improve access and uptake rates of retinal screening in high need areas.[32]	Q4
			• Engagement and coordination with Māori health providers and local community support services to improve access to secondary diabetes services.	Q4
			• A diabetes specialist dietitian will be recruited to work in rural localities.	Q2
			• Complete a qualitative study[33] to better understand barriers to access and the Māori patient journey when engaging with health care providers.	Q1
			• Provide a formal diabetes liaison consult service and standardise the management of inpatient diabetes. An additional 0.5 FTE senior medical officer (SMO) will join the hospital team[34] to provide a formally supervised consult liaison service.	Q2-Q4
			• Finalise and implement a standard formal inpatient charting of point of care glucose, ketones, carbohydrate intake, and insulin in one document to facilitate transparency of diabetes management.	Q1-Q4
			Health Improvement team will grow the current Hamilton diabetes support group in Hamilton by promotion in Māori settings.[35] (EOA)	

[32] Enderley, Huntly, and Ngaruawahia.
[33] Subject to ethical approval.
[34] Currently consists of 2 Clinical Nurse Specialists and 0.5 FTE of a Registered Medical Officer.
[35] Action and reporting will be completed by Public Health.

Financial performance summary

Table: Statement of Prospective Comprehensive Income

Please note: Waikato DHB's efforts to address its financial situation mean that future forecasts will be under constant review.

Forecast Statement of Comprehensive Income	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2019/20 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE						
Patient care revenue	1,500,647	1,600,356	1,707,350	1,785,205	1,863,218	1,941,101
Other operating income	20,341	22,053	19,514	20,414	21,315	22,215
Finance income	1,093	521	328	333	337	342
TOTAL REVENUE	1,522,081	1,622,930	1,727,192	1,805,952	1,884,870	1,963,658
EXPENSES						
Personnel costs	688,995	709,774	757,735	770,661	807,142	844,259
Depreciation	46,545	50,808	51,303	55,843	58,489	60,348
Amortisation	8,371	5,550	9,059	5,153	4,509	4,652
Outsourced services	97,043	85,545	73,363	75,146	77,926	80,575
Clinical supplies	159,291	168,074	174,549	181,514	189,114	195,564
Infrastructure & non-clinical expenses	95,668	90,979	63,064	63,658	67,728	71,009
Other district health boards	63,538	65,303	69,288	72,448	75,614	78,774
Non-health board provider expenses	447,910	484,983	520,946	544,700	568,504	592,268
Finance costs	415	796	464	475	492	509
Capital charge	34,137	33,507	36,421	36,354	35,352	35,700
TOTAL EXPENSES	1,641,913	1,695,319	1,756,192	1,805,952	1,884,870	1,963,658
Share of profit of Associates and Joint venture	68	-	-	-	-	-
SURPLUS/(DEFICIT)	(119,764)	(72,389)	(29,000)	(0)	0	(0)
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	90,351	(51)	-	-	-	-
TOTAL COMPREHENSIVE INCOME (DEFICIT)	(29,413)	(72,439)	(29,000)	(0)	0	(0)

SECTION THREE: Service configuration

Service coverage

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

Responsibility for the DHB's service coverage is shared between DHB and the Ministry of Health. The DHB is responsible for taking appropriate action to ensure that service coverage is delivered for the population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups.

The DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

The DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule in 2020/21.

Service change

We are undertaking a locality development programme in 2020/21 that will be focused on improving responsiveness to local community needs. This programme will inevitably involve reconfiguring services and may result in service changes to improve access and wellbeing for local communities.

Furthermore we are reviewing our models of care for long term conditions (e.g. diabetes), rehabilitation (e.g. home based support) and aged care. It is possible that improvements in model of care, in line with best practice, national direction, our planned care initiatives, and COVID-19 recovery will result in some service changes, but these are unknown at the time of publication of this plan.

The table below describes all known service reviews and service changes that have been approved or proposed for implementation in 2020/21. There may be other service changes required throughout the year as part of the DHB's 2020/21 Savings Plan. These service changes will be communicated to the Ministry as and when required.

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Mental Health and Addictions services	Reconfiguring services across adult, child and youth, and older persons mental health services, as well as adult alcohol and other drugs	Improved outcomes, reduced number of acute admissions, people will be supported to live and remain well in their communities	National, Regional and Local (in line with all)
Selected primary care services	Following a review of all Primary Care contracts, some selected contracts will not be renewed and will instead be reprioritised in conjunction with our PHOs	To deliver tangible outcomes and equity	Local
NGO contribution to savings plan	Following a review of all NGO contracts, some contracts will not be renewed in order to meet the DHB's 2020/21 financial goal	Financial sustainability as per savings plan and financial section	Local
Palliative care review	Possible change in service configuration of our community based palliative care services	People will be better supported in their communities, improved equity	Local
Project Energize	Revise the current service to better align with school governance and policy structures	Increased health outcomes, achieve wider reach and impact by working with school boards and the curriculum	Local
Whānau ora	Enhance whānau ora service arrangements across the district	Equity and improved outcomes	Local
Whānau pai collaborative	Integrated approach	Improved access to primary mental health supports as close to home	Local
Urgent and emergency care	Review of urgent and emergency care arrangements will lead to enhanced subacute service run by urgent care	Help to avoid inappropriate hospital admissions	Local
Primary care delivery model	Explore options for primary care delivery in line with outputs from Te Korowai Waiora, Waikato HSP	System configured to meet the needs of consumers and their whānau as captured in Te Korowai Waiora, Waikato HSP consultation	Local
Alliance structure	Implement broad primary and community care local alliance	Consolidate existing alliancing structures into one broader alliance	Local

Managing our business

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

Organisational performance management

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

Table: External reporting framework

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

Funding and financial management

The DHBs key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHBs performance management process to stakeholders on a monthly basis. Further information about DHBs planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of this document on page 84, and in appendix A: Statement of Performance Expectations on page 69.

Investment and asset management

Property portfolio performance

Asset performance indicators	Indicator class	2015/16 Result	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2020/21 Target
The percentage of Waiora Waikato hospital campus IL3 & IL4 buildings that have a seismic rating of less than 34% of the NBS. Note 1	Condition	7%	7%	7%	6%	<1%	0%
Utilisation by DHB departments of Waiora Waikato hospital campus Building Core Services. Note 2	Utilisation	100%	99%	99%	99%	> 99%	> 99%
Waiora Waikato hospital campus disabled carparks as a percentage of total public car parking. Note 3	Functionality	5%	5%	5%	13%	> 13%	> 13%
Waiora Waikato hospital campus building energy efficiency savings as a percentage of targeted energy consumption. Note 4	Functionality	3%	7%	16%	14%	> 7%	> 7%
Percentage of Waiora Waikato hospital campus buildings with valid Building Warrant of Fitness.	Condition	N/A	N/A	N/A	N/A	N/A	100%
Percentage of Waikato DHB rural hospitals and community facilities with valid Building Warrant of Fitness.	Condition	N/A	N/A	N/A	N/A	N/A	100%

Clinical portfolio performance

Asset performance indicators	Indicator class	2015/16 Result	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2020/21 Target
Percentage of CT Scanners (Radiology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	100%
Percentage Linear Accelerators (Oncology) compliant with the requirements of the Radiation Safety Act 2016	Condition	100%	100%	100%	100%	100%	100%
For Waikato hospital Radiology department, actual CT scanned patients versus planned patient scans.	Utilisation	101%	101%	103%	100%	> 90%	> 90%
Percentage of the available time Linear Accelerators (Oncology) are used to carry out radiation treatment on patients	Utilisation	N/A	95%	92%	85%	>86%	>86%
For Waikato hospital, planned day theatre usage versus actual usage. Note 5	Utilisation	75%	74%	76%	73%	100%	>75%
For Waikato hospital, planned outpatient services to be delivered versus actual outpatient attendances.	Utilisation	104%	100%	100%	98%	<93%	>90%
For Waikato hospital actual beds occupied (days) as a percentage of planned bed occupancy over the last 12 months. Note 6	Utilisation	92%	92%	92%	88%	100%	>85% and <95%
For Waikato DHB, elective surgery completed as a percentage of MOH elective surgery targets for last 12 months. Note 7	Utilisation	103%	102%	105%	99%	>99%	100%
For Waikato DHB, weighted average age of clinical Fixed Assets versus Suppliers weighted average life expectancy.	Condition / Functionality	N/A	N/A	N/A	8.9 years	< 5 years	< 7 years
Percentage of diagnostic monitors meeting Quality Assurance (QA) requirements.	Functionality (Fitness for Purpose)	N/A	N/A	N/A	N/A	N/A	100%
Percentage of diagnostic Ultrasound machines meeting the International Accreditation New Zealand (IANZ) specified industry accepted standards	Functionality (Fitness for Purpose)	N/A	N/A	N/A	N/A	N/A	100%

Information Communication and Technology (ICT) portfolio performance

Asset performance indicators	Indicator class	2015/16 Result	2016/17 Result	2017/18 Result	2018/19 Result	2019/20 Target	2020/21 Target
Percentage of Computer hardware aged less than 5 years old, used by staff. Note 8	Condition	91%	97%	82%	62%	> 90%	100%
Availability of critical Clinical systems (iPM, CWS, iSL, PACS) to the Emergency Department. Note 9	Utilisation	100%	100%	100%	100%	100%	99.5%
Staff satisfaction rating for the management / performance of ICT systems, measured on a 1 -10 scale. Note 10	Functionality	88%	86%	92%	91%	> 75%	> 90%
User devices with the latest vendor-provided level of critical and security patching. Note 11	Condition	N/A	N/A	N/A	N/A	N/A	>= 85%
Percentage of server devices with critical and security patches, to latest vendor-provided level. Note 12	Condition	N/A	N/A	N/A	N/A	N/A	100%

Shared service arrangements and ownership interests

The DHB has a part ownership interest in HealthShare. In line with all DHBs nationally, the DHB has a shared service arrangement with TAS around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

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

Quality assurance and improvement

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

Building capability

The DHB has developed Te Korowai Waiora, Waikato HSP which takes a whole of health system and whole of DHB approach to building capability.

Capital and infrastructure development

The very recently revised four year capital plan and preliminary work on the Site Master Plan, has enabled a refresh of the annual plan 4 year capital outlook.

A refreshed site master plan will be completed in November 2020, where further updates to this outlook maybe provided.

Project name	2020/21 $M	2021/22 $M	2022/23 $M	2023/24 $M	Crown funding requirement
Acute Mental Health Facility	5	8	47	40	100
Regional Cancer Centre	0	2	23	25	50
Waiora Building Seismic Upgrade (HIIP)	5	-	-	-	5
Tokoroa Hospital (HIIP)	1	0	0	0	1
Linacs Machines	5	5	0	0	10
Total expected capital funding	16	15	70	65	166

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

Workforce (also see page 49 activity table)

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

Organisational culture
The DHB aspires to be an inclusive, supportive and safe place to work with a culture of innovation. Understanding the organisation's current Employee Value Proposition (EVP) will inform the strengths in its organisational culture. Embedding this culture will require organisational leaders to champion it. A new learning operating model should be used to build capability to reinforce the organisation's target culture.

Leadership
The DHB supports leadership development via a number of programmes which provide learning opportunities for new or experienced managers, or those with leadership potential in the Te Manawa Taki DHBs (formally known as Midlands DHBs).

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

Workforce development

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

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

The 2020/21 year will focus on implementing a solid foundation of workforce data through introduction of positon management processes which will enable improved out-year planning and metrics to monitor our progress towards workforce goals.

Māori workforce development

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

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

Co-operative developments

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

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

Information technology (IT) and communications systems (also see page [] activity table)

Improving equity through IT

Progress in health equity towards pae ora includes developing good-quality ethnicity data, developing knowledge and reconfiguring services to deliver high quality health care meeting the needs of Māori and other groups where inequity has been proven. A significant analysis report "Health Equity Report" will be released to the general public in Q1 2021.

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

IS has supported the development of the iHub which provides visitors and staff at Waikato Hospital with health screening and opportunistic vaccination, smoking cessation support and cervical screening. Over the next 12 months IS will also support the development of iHubs in our four rural hospitals.

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

Provision of health services via digital technology

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

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

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

COVID-19 has led to a review of the Telehealth Business Case and a rapid need to roll out and support remote ways of working. A newly formed IS Telehealth Program has partnered with the IS Microsoft Teams project members to co-design with our Clinical and consumer partners the use of MS Teams as a telehealth platform.

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

Access to regional patient notes is a pivotal part of healthcare provision, the shared regional (read-only) Portal provides for this, and further releases are scheduled to enhance the functionality. Currently, local primary care and community providers such as Lead Maternity Carers (LMC) have access to the Waikato DHBs Clinical Workstation (CWS) improving the accessibility of health information to health care providers and through them to patients. In collaboration with regional IS in HealthShare, access to NICU guidelines and procedures will be implemented as a pilot in August/September 2020 and as a pilot for other services.

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

The DHB is progressing access for a wide group of primary and community care partners to the patient data within CWS. Partners with access to CWS already include; GPs, nurses, St John, Hospice, LMC's, community pharmacies, mental health providers, radiology providers, DHBs/private hospitals, Corrections/prison services, and private clinics. During the 2019/20 year this solution is being enhanced by adding two factor authentication and expanding the solution to include regional radiology records. This is an interim tactical solution which will be replaced until a long-term regional solution is available.

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

Aligning with national and regional IT initiatives

The DHB is committed to leveraging, where it is appropriate to do so, national and regional investments. Accordingly the DHB has almost completed implementing the All of Government (AoG) IaaS solution, and has previously confirmed its commitment to implement the national maternity solution. The National Oracle Solution, ProVation and Dendrite are all implemented. The DHB is committed to, and the major funder of, future regional Midland solutions.

Monthly regional Information Services Leadership Team (ISLT) oversight and sharing of initiatives are progressed regionally and within each of the DHBs. Monthly Regional Information Services Clinical Lead (ISCL) Team have commenced at the end of 2019. Waikato's project portfolio reporting is provided monthly to the Midland Chief Information Officer group. In addition, we have established the Regional Capital Committee to ensure oversight at the Midland chief executive level of all significant DHB IS investments to ensure alignment.

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

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

Local plans and roadmaps reference national and regional plans, with national initiatives included in regional and local plans as appropriate.

Application portfolio management

The DHB plans to continue the work both locally and with the Ministry of Health on establishing a robust Application Portfolio Management Framework covering all classes of Information Communications Technology (ICT) asset, with a focus on appropriate lifecycle management of existing ICT assets. Historical funding for ICT has been constrained to annual depreciation, which has funded asset replacement, enhancements and innovation. As per previous reporting to the Ministry of Health the DHB has significant deferred maintenance (technical debt) which it has proposed to address through increased ICT capital funding over each of the next five years.

IT security maturity improvement

IS security maturity is overseen by the Finance and Risk Management Committee Audit and Risk Committee, with quarterly reporting in place. A rolling audit and assurance programme is in place, overseen by Internal Audit and reported to the Audit and Risk Committee.

The DHB has an Information Security and Privacy Governance Group (ISPG) in place which is a subcommittee of the executive leadership team (ELT) and is chaired by the executive director Digital Enablement. Membership includes the; executive director Digital Enablement, privacy officer, risk officer, and ELT. The primary role of the ISPG is to ensure that information security and privacy are an integrated and integral part of the mission of the DHB. The ISPG specifically includes a commitment to ensure the DHB meets its; HISO 10029 (Health Information Security Framework), HISO 10064 (Health Information Privacy Guideline), HIPC (Health Information Privacy Code), Privacy Act, and NZISM (New Zealand Information Security Manual) obligations.

The DHB has an IS Operations Security Team in place and consists of security manager, operational security personnel, vulnerability, threat management and application security personnel.

Key IT Initiatives for 2020/21

Initiative	Key milestones 2020/21
Disaster recovery Disaster Recovery 1st Stage Business Case Approval Business impact analysis Full Business Case Approval Detailed Design and Planning Infrastructure Implementation Network Implementation Application DR Plan Update and Test Project Closure	 Completed Q4 2019/2020 Q2 2020/2021 Q3 2020/21 Q3 2020/21 Q4 20202/21 Q4 2020/21 Q1 2021/22
Nutrition and Food management (MyKai) This project aims to implement the CBORD integrated Nutrition and Food management system, so as to transform the DHBs ability to effectively manage, produce and deliver 1.4 million safe, suitable, nutritious and cost effective meals per annum. This includes meals for patients, Meals on Wheels, visitors and the Waikato Hospital workforce. Business Case Approval Implement FSS Implement NSS Implement CBORD Mobile Patient App	 Complete Complete Q2 2020/21
Trend AV SMX project The DHB is enhancing its Trend AV solution to deliver better levels of information security management for the Waikato DHB. Business Case Approval Design and Planning Go Live MAC RFC	 Complete Complete Complete Q2 2020/21
Anaesthesia Information System This project aims to implement the CBORD integrated Nutrition and Food management system, so as to The DHB is in the process of developing the Single Stage BBC for implementation of an electronic Anaesthesia Information System enabling workflow through pre-operative assessment and planning, operating room processes and post-operative care. The solution is seeking to improve patient outcomes, clinical and administrative efficiencies. Executive Summary submitted to ELT (for approval to progress to BBC) Point of Entry Document Business Case Approval	 Complete Q2 2020/21

SECTION FIVE: Performance measures

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

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

Code	Dimension
CW	Child wellbeing
MH	Mental wellbeing
PV	Prevention
SS	Strong and equitable health and disability system
PH	Primary care and prevention

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1		61%
		Year 2		61%
CW02	Oral health: Mean DMFT score at school year 8	Year 1		<0.55
		Year 2		<0.55
CW03	Improving the number of children enrolled and accessing the Community Oral Health service	Children (0-4) enrolled (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the Community Oral Health service)	Year 1	>=95%
			Year 2	>=95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the Community Oral Health service)	Year 1	>=10%
			Year 2	>=10%
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	Year 1		>=85%
		Year 2		>=85%
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child health (breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with general practice	The DHB has reached the "total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Better help for smokers to quit (maternity)	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,		
CW09	Raising healthy kids	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		

Performance measure		Expectation	
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	
CW11	Supporting child wellbeing	Provide report as per measure definition	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, other and total	Māori 5.17%
			Pacific 3.36%
			Other 4.72%
			Total 4.82%
		Age (20-64) Māori, other and total	Māori 10.05%
			Pacific 5.17%
			Other 4.05%
			Total 5.31%
		Age (65+) Māori, other and total	Māori 2.65%
			Pacific 3.43%
			Other 2.39%
			Total 2.43%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within three weeks.
			95% of people seen within eight weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within three weeks.
			95% of people seen within eight weeks.
MH04	Rising to the Challenge: The Mental Health and Addictions Service Development Plan	Provide reports as specified	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
MH07 TBC	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	(expectation to be confirmed)	
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.	
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.	
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified	
SS03	Ensuring delivery of Service Coverage	Provide reports as specified	
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified	

Performance measure		Expectation		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Māori 9,384 per 100,000 Pacific 9,999 per 100,000 Total 3,858 per 100,000		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs	
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	25,459	
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times* (Only the five cardiac units are required to report for this measure)	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	

Performance measure		Expectation		
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	Base level: 12.9% (Year to Dec 2019) Acute readmission rate of 12.8% for 2020/21
SS08	Planned care three year plan	Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>2% and <=4%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified.		
SS13	Improved management for long term conditions (CVD, acute heart health, diabetes, and stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to support people with LTC to self-manage and build health literacy.	

Performance measure		Expectation	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath –** Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.
			Indicator 2a: Registry completion – >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within three months.
			Indicator 3: ACS LVEF assessment – ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator – in the absence of a documented contraindication/ intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - – Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and – LVEF<40% should also be on a beta-blocker (5-classes). **An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device registry completion – ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion – ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services Provide confirmation report according to the template provided	**Indicator 1** ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital

Performance measure		Expectation	
			Indicator 2 Reperfusion Thrombolysis / Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
SS18	Financial outyear planning and savings plan	Provide reports as specified	
SS19	Workforce outyear planning	Provide reports as specified	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above	
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

APPENDIX A: Statement of Performance Expectations including Financial Performance

Waikato District Health Board

2020-21 STATEMENT OF PERFORMANCE EXPECTATIONS

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

Contents

Published by Waikato District Health Board
Private Bag 3200, HAMILTON 3240

This document is available on the Waikato District Health Board website **www.waikatodhb.health.nz**

Signatories

Agreement for the Waikato DHB 2020/21 Statement of Performance Expectations

between

Dame Karen Poutasi
Commissioner
Waikato DHB

Date: 28 July 2020

Dr Kevin Snee
Chief Executive
Waikato DHB

Date: 28 July 2020

Waikato DHB (the DHB) has worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which it provides measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2020/21. The performance measures chosen are not an exhaustive list of all of the organisation's activity, but they do reflect a good representation of the range of outputs that the DHB fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, included with each measure is the past performance as baseline data.

The DHB reports quarterly to the Ministry of Health and/or internally to governance on performance related to this activity.

National performance story

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

Regional performance story

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

Waikato DHB performance story

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

Service performance

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

Stewardship

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

Impacts

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

This document demonstrates how the DHB will evaluate the effectiveness of the decisions made on behalf of the population. Measuring our performance against the desired impacts outlined within demonstrates our commitment to an outcome-based approach to measuring our performance.

Impact measures – measure of performance

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

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

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

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

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

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

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

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

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

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

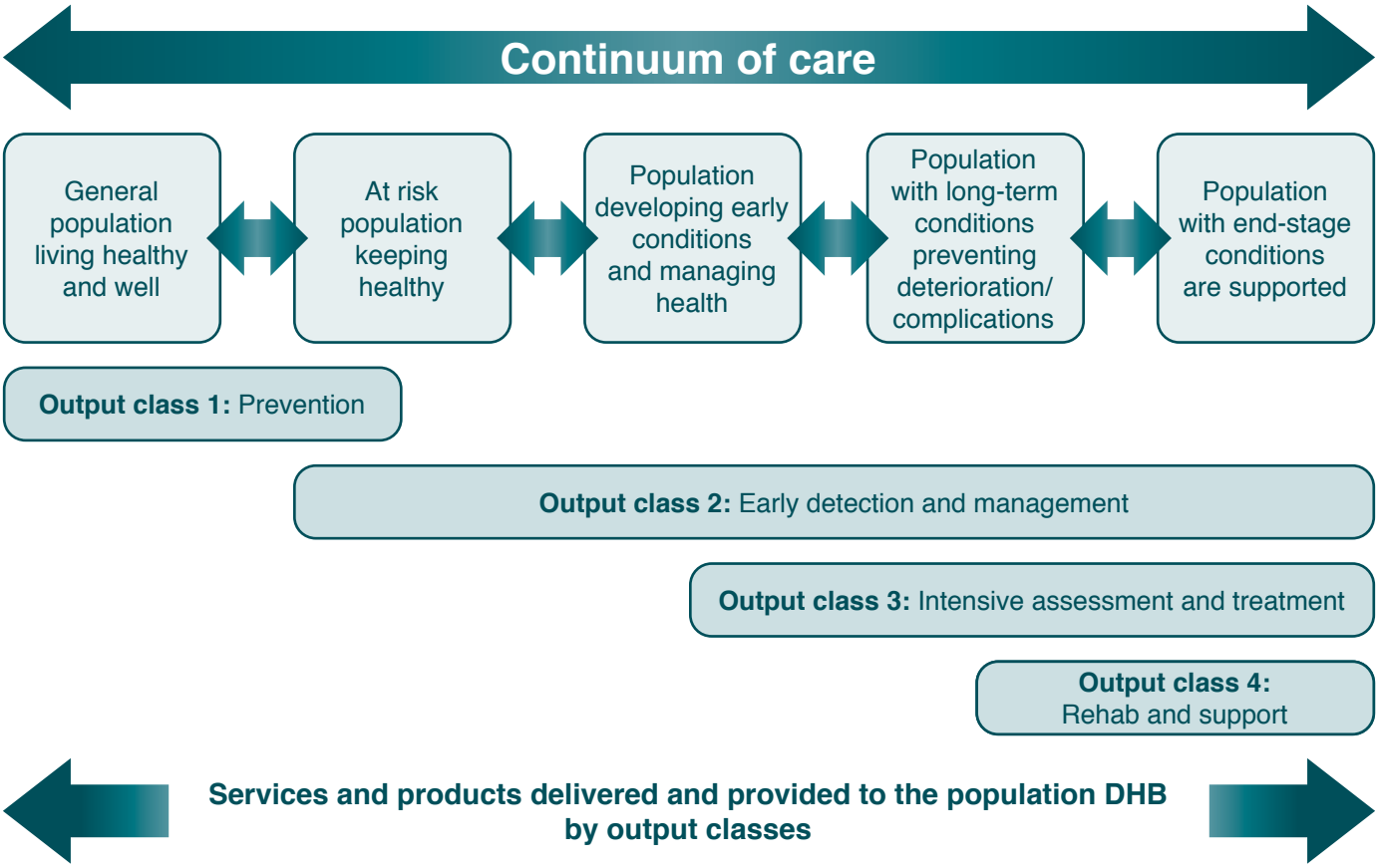
Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience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

Where people have end stage conditions it is important that they and their families are supported 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.

Output measures

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



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

Output class

Prevention

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

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

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

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

Early detection and management

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

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

Intensive assessment and treatment services

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

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

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

Rehabilitation and support

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

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

Setting targets

Wherever possible, we have included baseline data to support evaluation of our performance at the end of the year. All baseline data is taken from 2014/15 unless stipulated. In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Our targets reflect our commitment to reducing inequalities between population groups, and hence most measures are reported by ethnicity. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Measures that relate to new services have no baseline data.

Where does the money go?

Table 1: Revenue and expenditure by Output class

Forecast Statement of Cost and Revenue	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE				
Prevention	33,896	35,442	36,990	38,536
Early Detection and Management	347,409	363,251	379,125	394,972
Intensive Assessment and Treatment	1,205,835	1,260,821	1,315,918	1,370,924
Support and Rehabilitation	142,009	148,484	154,973	161,451
TOTAL REVENUE	**1,729,149**	**1,807,998**	**1,887,006**	**1,965,883**
EXPENDITURE				
Prevention	33,649	34,603	36,115	37,625
Early Detection and Management	342,385	352,093	367,479	382,839
Intensive Assessment and Treatment	1,224,731	1,259,456	1,314,493	1,369,439
Support and Rehabilitation	157,384	161,846	168,919	175,980
TOTAL EXPENSES	**1,758,149**	**1,807,998**	**1,887,006**	**1,965,883**
SURPLUS/DEFICIT	**(29,000)**	**-**	**-**	**-**

People are supported to take greater responsibility for their health

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

Fewer people smoke

Impact measure	Output class	Measure type	Baseline 2014/15	Target 2019/20	Target 2020/21
Percentage of babies living in smokefree homes at six weeks	1	Qn	Baseline (2018) Māori 26% Pacific 42% Other 51% Total 43%	Māori 60% Pacific 60% Other 60% Total 60%	Māori 60% Pacific 60% Other 60% Total 60%

Output measure	Output class	Measure type	Baseline 2014/15	Target 2018/19	Target 2020/21
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn	Māori 94% Pacific 100% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn	Māori 92% Pacific 91% Other 89% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	1	Qn	Māori 64% Pacific N/A Other 70% Total 66%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%

Reduction in vaccine preventable diseases

Impact measure	Output class	Measure type	Baseline 2014/15	Target 2019/20	Target 2020/21
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	<8.8	Māori <8.8 Pacific <8.8 Other <8.8 Total <8.8

Output measure	Output class	Measure type	Baseline 2014/15	Target 2019/20	Target 2020/21
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn	Māori 90% Pacific 95% Other 83% Total 91%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	Māori 91% Pacific 95% Other 91% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible children fully immunised at 5 years of age	1	Qn	Māori 73% Pacific 78% Other 76% Total 73%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible 12 year olds have received HPV dose three	1	Qn	Māori 70% Pacific 106% Other 62% Total 66%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%
Seasonal influenza immunisation rates in the eligible population (65 years and over)	1	Qn/T	Māori 46% Pacific 49% Other 53% Total 52%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%

Improving health behaviours

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
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)			Māori 7% Pacific 19% Other 8% Total 9%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
The number of people participating in Green Prescription programmes	1	Qn	5802	6700	*On hold for re-scoping*

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

People stay well in their homes and communities

Long term impact	Intermediate impacts	Impact and outputs
People stay well in their homes and communities	An improvement in childhood oral health	Mean decayed missing and filled teeth score of Year 8 children Percentage of children (0-4) enrolled in DHB funded dental services Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination Percentage of adolescent utilisation of DHB funded dental services
	Long-term conditions are detected early and managed well	Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years Percentage of 'eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past 5 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 the following age group: 45-64 year olds Percentage of eligible population who have had their B4 School checks completed Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to aged related residential care Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days Percentage of people enrolled with a PHO Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

An improvement in childhood oral health

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Mean decayed missing and filled teeth score of Year 8 children			Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.65 Pacific 0.65 Other 0.65 Total 0.65	Māori <0.55 Pacific <0.55 Other <0.55 Total <0.55

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	Māori 72% Pacific 72% Other 72% Total 72%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%	Māori ≥95% Pacific ≥95% Other ≥95% Total ≥95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	Māori 18% Pacific 20% Other 25% Total 18%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	Māori 45% Pacific 53% Other 80% Total 70%	Māori 85% Pacific 85% Other 85% Total 85%	Māori 85% Pacific 85% Other 85% Total 85%

Long-term conditions are detected early and managed well

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	Māori 87% Pacific 88% Other 91% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of 'eligible Māori men in the PHO aged 30-44 years' who have had their cardiovascular risk assessed in the past five years	2	Qn	74%	90%	90%
Percentage of women aged 25-69 years who have had a cervical screening event in the past 36 months	2	Qn/T	Māori 60% Pacific 65% Other 80% Total 74%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 80% Pacific 80% Other 80% Total 80%
Percentage of eligible women aged 50-69 who have a BreastScreen Aotearoa mammogram every two years			Māori 58% Pacific 60% Other 70% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 70% Pacific 70% Other 70% Total 70%

Fewer people are admitted to hospital for avoidable conditions

Impact measure	Output class	Measure type	Baseline (2018)	Target 2019/20 (45-64 year olds, total rather than per 100,000)	Target 2020/21
Ambulatory sensitive hospitalisation rate per 100,000 for the following age groups: • 0-4 year olds • 45-64 year olds	2		**0-4 year olds** Māori 10,531 per 100,000 Pacific 10,942 per 100,000 Total 9290 per 100,000 **45-64 year olds** Māori 9081 per 100,000 Pacific 7446 per 100,000 Total 4451 per 100,000	**0-4 year olds** Māori <10,886 per 100,000 Pacific <10,670 per 100,000 Total <9572 per 100,000 **45-64 year olds** Māori <9158 per 100,000 Pacific <8459 per 100,000 Total <4355 per 100,000	**0-4 year olds** Māori 9927 per 100,000 Pacific 10,924 per 100,000 Total 6423 per 100,000 **45-64 year olds** Māori 9384 per 100,000 Pacific 9999 per 100,000 Total 3858 per 100,000

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of eligible population who have had their B4 School checks completed	1	Qn/T	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)	2		3.9/100,000	1.2/100,000	1.2/100,000

More people maintain their functional independence

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Average age of entry to aged related residential care: • Rest home • Dementia • Hospital	2		**Resthome** 85 years **Dementia** 83 years **Hospital** 86 years	**Resthome** >84 years **Dementia** >80 years **Hospital** >85 years	**Resthome** >84 years **Dementia** >80 years **Hospital** >85 years

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/T	100%	100%	100%
Percentage of people enrolled with a PHO	2	Qn/T	Māori 91% Pacific 88% Other 96% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of needs assessment and service coordination waiting times for new assessment within 20 working days			62%	100%	100%

People receive timely and appropriate specialist care

Long term impact	Intermediate impacts	Impact and outputs
People receive timely and appropriate specialist care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks
	People have appropriate access to elective services	Standardised intervention rates (per 10,000) Percentage of patients waiting longer than four months for their first specialist assessment Improved access to elective surgery, health target, agreed discharge volumes Did-not-attend percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Percentage of child and youth with a transition (discharge) plan Average length of acute inpatient stay Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	Percentage of aged residential care facilities utilising advance directives Number of new patients seen by the Waikato hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days) Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days) Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days) Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People have prompt and appropriate acute and arranged care

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours	3		Māori 92% Pacific 91% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	3	Qn/T	56%	90%	90%

People have appropriate access to elective services

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Standardised intervention rates (per 10,000):	3				
• Major joint replacement procedures			27	21	21
• Cataract procedures			25	27	27
• Cardiac surgery			7.3	6.5	6.5
• Percutaneous revascularisation			11.4	12.5	12.5
• Coronary angiography services			33.9	34.7	34.7

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	2.7%	0%	0%
Number of planned care interventions completed *Previously called: Improved access to elective surgery, health target, agreed discharge volumes*	3	Qn/T	15,693	23,772	25,459
Did-not-attend percentage for outpatient services	3	Qn/T	Māori 21% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%
Elective surgical inpatient average length of stay	3	Qn/T	1.71 days	1.5 days	1.5 days
Acute inpatient average length of stay	3	Qn/T	3.89 days	2.3 days	2.3 days

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

Impact measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
28 day acute readmission rates			Māori 14% Pacific 8% Other 12% Total 12%	Māori <13% Pacific <13% Other <13% Total <13%	Māori <13% Pacific <13% Other <13% Total <13%

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
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% **8 weeks** Māori 93% Pacific 95% Other 90% Total 91%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 Weeks** Māori 95% Pacific 95% Other 95% Total 95%
Mental health clients discharged have a transitional (discharge) plan	3	Qn/T	37%	95%	95%

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Average length of acute inpatient stay	3	Qn/T/QI	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days
Rates of post-discharge community care	3	Qn/T/QI	Māori 69% Pacific 73% Other 72% Total 87%	Māori 90-100% Pacific 90%-100% Other 90%-100% Total 90%-100%	Māori 90-100% Pacific 90%-100% Other 90%-100% Total 90%-100%
Improving the health status of people with severe mental illness through improved access: • 0-19 years • 20-64 years • 65 plus years	3	Qn	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97% **20-64 years** Māori 7.12% Pacific 4.34% Other 4.34% Total 4.33% **65+ years** Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**0-19 years** Māori 4.73% Pacific 3.13% Other 4.23% Total 4.36% **20-64 years** Māori 8.77% Pacific 4.07% Other 3.78% Total 4.81% **65+ years** Māori 2.39% Pacific 1.69% Other 2.09% Total 2.11%	**0-19 years** Maori 5.17% Pacific 3.36% Other 4.72% Total 4.82% **20-64 years** Maori 10.05% Pacific 5.17% Other 4.05% Total 5.31% **65+ years** Maori 2.65% Pacific 3.43% Other 2.39% Total 2.43%

More people with end stage conditions are supported appropriately

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%	100%
Number of new patients seen by the Waikato hospital palliative care service	3	Qn	652 original *1085 revised*	1000	727

Support services

Output measure	Output class	Measure type	Baseline	Target 2019/20	Target 2020/21
Percentage of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days)	3	Qn/T	94%	95%	95%
Percentage of accepted referrals for CT scans will receive their scan within six weeks (42 days)	2	T	Māori 92% Pacific 100% Other 90% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of accepted referral for MRI scans will receive their scan within six weeks (42 days)	2	T	Māori 55% Pacific 53% Other 52% Total 48%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	2	T	78%	90%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T	49%	70%	70%
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer than 84 days beyond the planned date	2	T	70%	70%	70%
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	T	100%	100%	100%

Financial performance

Table: Statement of Prospective Comprehensive Income

Please note: Waikato DHB's efforts to address its financial situation mean that future forecasts will be under constant review.

Forecast Statement of Comprehensive Income	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE						
Patient care revenue	1,500,647	1,600,356	1,707,350	1,785,205	1,863,218	1,941,101
Other operating income	20,341	22,053	21,471	22,460	23,451	24,440
Finance income	1,093	521	328	333	337	342
TOTAL REVENUE	1,522,081	1,622,930	1,729,149	1,807,998	1,887,006	1,965,883
EXPENSES						
Personnel costs	688,995	709,774	752,610	765,449	801,683	838,549
Depreciation	46,545	50,808	51,303	55,843	58,489	60,348
Amortisation	8,371	5,550	9,059	5,153	4,509	4,652
Outsourced services	97,043	85,545	69,692	71,385	74,026	76,543
Clinical supplies	159,291	168,074	170,367	177,229	184,671	190,969
Infrastructure and non-clinical expenses	95,668	90,979	78,000	76,450	80,289	84,679
Other district health boards	63,538	65,303	69,288	72,448	75,614	78,774
Non-health board provider expenses	447,910	484,983	520,945	544,701	568,504	592,268
Finance costs	415	796	464	475	492	509
Capital charge	34,137	33,507	36,421	38,865	38,729	38,592
TOTAL EXPENSES	1,641,913	1,695,319	1,758,149	1,807,998	1,887,006	1,965,883
Share of profit of Associates and Joint venture	68	-	-	-	-	-
SURPLUS/(DEFICIT)	(119,764)	(72,389)	(29,000)	(0)	(0)	(0)
OTHER COMPREHENSIVE INCOME						
Increase/(decrease) in revaluation reserve	90,351	(50)	-	-	-	-
TOTAL COMPREHENSIVE INCOME (DEFICIT)	(29,413)	(72,439)	(29,000)	(0)	(0)	(0)

The underlying trend in cost growth applying to the Waikato DHB heading into 2019/20, would have taken the organisation to a deficit of around $100m for the 2019/20 year. Through enhanced oversight and tighter management we have constrained this deficit to a result of an on budget deficit of $72.4m.

We have applied a great deal of effort to our 2020/21 budget based on the best information we have available and with consideration to the significant changes that we are in the process of undertaking. The result is a $29m budgeted deficit for the year. This budget has some material activities included that will increase efficiency and effectiveness, resulting in cost reduction – total value of $45m. Specific and tangible plans are being worked up and will be in place as soon as practical.

The significant restructure that is imminent in our Provider arm is a potential risk in this regard, as the new structure and the expected skills and attributes in this structure are a dependency on implementation of a range of the required changes. There are also the expected challenges in the efforts to increase value for money, and to prioritise our investments together with primary care and NGO sector.

The key budget assumptions and risks are set out in section 1.4.

The Waikato DHB has budgeted to be breakeven 2021/22. Achievement of this will be extremely challenging and as noted above, highly dependent on the outcome of the Provider restructure and the effectiveness of Strategy and Planning functions.

Our demand is not expected to reduce in the immediate future and thus both capital and operating expenditure will be constrained in 2020/21 and outer years. In response to these issues, Waikato DHB will focus action on:

- Clarifying our strategic direction and consequential tangible strategic plans.
- Defining, actioning and monitoring the required $45m of efficiencies for 2020/21 through specific and tangible plans – this will be a material programme of work.
- Materially enhancing the approach to accountability to ensure that all levels within the organisation are held to account effectively.
- Prioritising capital expenditure investment for 2020/21 and beyond in order to focus on investing in the right things to reduce risk and improve efficiency and effectiveness (and thus clinical outcomes). Based on the current material investment backlog and capital expenditure constraint, our overall risk profile will increase as assets age and deteriorate.
- Enhancing the portfolio-based capital investment process based on a robust evaluation process aligned to our agreed strategic priorities.
- Improving asset and contract management.

Table: Statement of Prospective Position

Forecast Statement of Financial Position	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
CROWN EQUITY	579,404	624,492	651,395	664,201	732,007	794,813
CURRENT ASSETS:						
Bank balances, deposits and cash	8,756	27,057	9,416	9,416	9,416	9,416
Receivables	56,225	60,276	60,159	62,155	63,569	63,016
Inventory	12,218	12,649	12,261	12,559	12,864	13,177
	77,199	99,982	81,836	84,130	85,849	85,609
CURRENT LIABILITIES:						
Bank overdraft	35,938	-	22,954	21,605	21,575	20,759
Short term loans	181	135	50	-	-	-
Payables and accruals	78,340	74,329	75,268	78,902	80,565	81,029
Employee entitlements	166,150	187,830	134,494	135,542	136,616	137,715
Provisions	987	1,044	1,036	1,061	1,087	1,113
	281,596	263,338	233,802	237,110	239,843	240,616
Net Working Capital	(204,397)	(163,356)	(151,966)	(152,980)	(153,994)	(155,007)
NON CURRENT ASSETS:						
Fixed assets	801,566	792,996	808,635	823,635	893,636	958,636
Prepayments	4,608	12,872	11,989	10,798	9,607	8,416
Investments	443	429	429	429	429	429
	806,617	806,297	821,053	834,862	903,672	967,481
NON CURRENT LIABILITIES:						
Borrowings	185	50	-	-	-	-
Employee entitlements	14,117	9,786	8,587	8,565	8,545	8,525
Provisions	491	313	414	425	435	445
Restricted trust funds	8,023	8,300	8,691	8,691	8,691	8,691
	22,816	18,449	17,692	17,681	17,671	17,661
NET ASSETS	579,404	624,492	651,395	664,201	732,007	794,813

Table: Statement of Prospective Movements in Equity

Forecast Statement of Movements in Equity	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
Crown equity at start of period	582,389	579,404	624,492	651,395	664,201	732,007
Surplus/(deficit) for the period	(119,764)	(72,389)	(29,000)	0	(0)	(0)
Increase in revaluation reserve	90,351	(50)	-	-	-	-
Equity injection from Crown	29,100	120,000	58,000	15,000	70,000	65,000
Repayment of capital to the Crown	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)	(2,194)
Other movements in equity	(478)	(279)	97	-	-	-
Crown equity at end of period	579,404	624,492	651,395	664,201	732,007	794,813

Table: Statement of Prospective Cashflow

Forecast Statement of Cashflows	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
OPERATING CASHFLOWS						
Cash was provided from Crown agencies and other income sources	1,522,179	1,619,818	1,726,152	1,805,829	1,885,419	1,966,258
Cash was disbursed to employees, suppliers and finance charges	(1,529,664)	(1,634,068)	(1,748,127)	(1,741,569)	(1,820,532)	(1,898,590)
	(7,485)	(14,250)	(21,975)	64,260	64,887	67,668
INVESTING CASHFLOWS						
Cash was provided from interest and sale of fixed assets	1,440	540	1,709	333	337	342
Cash was disbursed to purchase of assets	(44,756)	(49,676)	(76,000)	(76,000)	(133,000)	(130,000)
	(43,316)	(49,136)	(74,291)	(75,667)	(132,663)	(129,658)
FINANCING CASHFLOWS						
Cash was provided from proceeds of borrowings and equity	29,100	120,000	58,000	15,000	70,000	65,000
Cash was disbursed to repayment of borrowings and equity	(2,507)	(2,375)	(2,329)	(2,244)	(2,194)	(2,194)
	26,593	117,625	55,671	12,756	67,806	62,806
Net increase/(decrease) in cash held	(24,208)	54,239	(40,595)	1,349	30	816
Add Opening cash balance	(2,974)	(27,182)	27,057	(13,538)	(12,189)	(12,159)
CLOSING CASH BALANCE	(27,182)	27,057	(13,538)	(12,189)	(12,159)	(11,343)
Made up from:						
Bank balances, deposits and cash	(27,182)	27,057	(13,538)	(12,189)	(12,159)	(11,343)

1.1 Fixed assets

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

1.1.1 Disposal of land

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

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

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

1.2 Capital expenditure / investment

The Capital Plan cash flow is set out below:

New Capital Expenditure	2020/21 $M	2021/22 $M	2022/23 $M	2023/24 $M
Under $50,000	6	6	6	6
Over $50,000	53	54	56	58
Contingency	1	1	1	1
Strategic Assets	16	15	70	65
Total Capital Expenditure	76	76	133	130

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

Potential strategic capital spend includes:

Project Name	2020/21 $M	2021/22 $M	2022/23 $M	2023/24 $M	Crown funding requirement
Acute Mental Health Facility	5	8	47	40	100
Regional Cancer Centre	0	2	23	25	50
Waiora Building Siesmic Upgrade (HIIP)	5	-	-	-	5
Tokoroa Hospital (HIIP)	1	0	0	0	1
Linacs Machines	5	5	0	0	10
Total expected capital funding	16	15	70	65	166

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

1.3 Planned financial performance by division

Please note: Waikato DHB's efforts to address its financial situation mean that future forecasts will be under constant review.

Table: Prospective Financial Targets and Measures DHB Provider

DHB Provider Forecast Statement of Financial Performance	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE						
Patient care revenue	936,700	1,009,439	1,036,268	1,083,522	1,130,872	1,178,142
Other operating income	20,395	22,046	21,471	22,460	23,451	24,440
Finance income	1,092	521	328	333	337	342
TOTAL REVENUE	958,187	1,032,006	1,058,067	1,106,315	1,154,660	1,202,924
EXPENSES						
Personnel costs	685,432	706,029	749,272	762,053	798,124	834,830
Outsourced services	95,564	84,933	68,965	70,641	73,255	75,745
Clinical supplies and patient costs	172,279	181,237	183,783	188,249	195,214	201,851
Infrastructure & non-clinical supplies	171,553	168,205	161,580	165,511	171,700	177,624
Internal recharges	(2,309)	(2,421)	(2,421)	(2,480)	(2,572)	(2,659)
TOTAL EXPENSES	1,122,519	1,137,983	1,161,179	1,183,974	1,235,721	1,287,391
SURPLUS/(DEFICIT)	(164,332)	(105,977)	(103,112)	(77,659)	(81,061)	(84,467)

Table: Prospective Financial Targets and Measures DHB Governance

DHB Governance Forecast Statement of Financial Performance	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE						
Patient care revenue	5,583	7,906	8,127	8,498	8,869	9,240
Other operating income	12	7	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	5,595	7,913	8,127	8,498	8,869	9,240
EXPENSES						
Personnel costs	3,568	3,745	3,339	3,396	3,559	3,719
Outsourced services	1,480	613	727	744	772	798
Clinical supplies and patient costs	2	1	3	4	4	4
Infrastructure & non-clinical supplies	590	271	246	252	262	271
Internal recharges	2,309	2,421	2,421	2,480	2,571	2,659
TOTAL EXPENSES	7,949	7,051	6,736	6,876	7,168	7,451
SURPLUS/(DEFICIT)	(2,354)	862	1,391	1,622	1,701	1,789

Table: Prospective Financial Targets and Measures DHB Funding

DHB Funding Forecast Statement of Financial Performance	2018/19 $000 ACTUAL	2019/20 $000 ACTUAL	2020/21 $000 PLANNED	2021/22 $000 PLANNED	2022/23 $000 PLANNED	2023/24 $000 PLANNED
REVENUE						
Patient care revenue	1,432,069	1,527,859	1,639,558	1,714,322	1,789,237	1,864,028
Other operating income	4	-	-	-	-	-
Finance income	-	-	-	-	-	-
TOTAL REVENUE	1,432,073	1,527,859	1,639,558	1,714,322	1,789,237	1,864,028
EXPENSES						
Governance administration	5,583	7,906	8,127	8,498	8,869	9,240
Personal health	1,063,413	1,140,930	1,197,323	1,251,922	1,306,630	1,361,247
Mental health	145,064	150,961	162,888	170,315	177,758	185,188
Disability support	162,141	175,183	186,348	194,846	203,360	211,861
Public health	3,155	14,027	5,870	6,137	6,406	6,673
Maori services	5,795	6,126	6,281	6,567	6,854	7,141
TOTAL EXPENSES	1,385,151	1,495,133	1,566,837	1,638,285	1,709,877	1,781,350
SURPLUS/(DEFICIT)	46,922	32,726	72,721	76,037	79,360	82,678

1.4 Significant assumptions

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

Key Assumptions	2020/21	2021/22	2022/23	2023/24
Employee agreement assumptions: MECA and Step increases	1% - 5%	1% - 5%	1% - 5%	1% - 5%
Payments to NGOs (cost pressure)	2% - 4.6%	2% - 4.6%	2% - 4.6%	2% - 4.6%
Payments to suppliers	2.43%	2.43%	2.43%	2.43%
Capital charge – fixed rate	6.00%	6.00%	6.00%	6.00%

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

The key budget assumptions are

Key budget assumptions	
Revenue	The latest information has been applied to all aspects of revenue. In our capital plan we have assumed direct Ministry of Health funding of $16m in 2020/21 related to the Health Infrastructure Package, our mental health build and a Linac machine.
Impact of COVID-19	We are following Ministry of Health guidance that "DHBs should exclude any allowance for COVID-19 impacts" in our annual plans. There is a high level assumption that costs will be matched by direct Ministry of Health COVID-19 recovery funding including: • costs of catching up on planned care volumes • costs of catching up on clinics • costs of catching up on treatments that were deferred • costs of Community Based Assessment Centres • cost of COVID-19 tests • increased consumption of personal protection equipment • impacts of Managed Isolation Facilities • impact on costs of community dispensing • impact on sick leave as the threshold for staying away from work has changed due to COVID-19 • impact on any other MECA, of industrial relations type aspects resulting from COVID-19 • Impact on SSP arising from COVID-19

Key budget assumptions	
2019/20 business cases	Where relevant any business cases applied during 2019/20 have been extrapolated to reflect the full year effect.
Demographic growth	Demographic growth has been applied to external contracts where relevant, but not applied to Provider resources. Underlying assumption is thus that demographic growth impact on Provider resources will be absorbed.
Provider restructure	The Provider restructure is material and is very much a work in progress. One key assumption is that it will be at least cost neutral. However, the extent to which redundancy costs factor into this cannot yet to be determined.
Savings applied	A 5% saving target has been applied to non-clinical areas and locked into budgets – either as direct budget adjustments or as saving plan lines, with details related to how they will be achieved still to be defined.
Personnel costs	1% increase for all unresolved MECAs and IEAs.
Annual Leave Taken	Non–clinical – 100% of annual leave earned by staff is taken, i.e. leave accrued must equal leave taken. Clinical staff – Four weeks of leave taken in the year
Holidays Act Remediation	The provision from 2019/20 has been continued in the budget, recognising that we do not have a more accurate and reliable calculation of our liability for remediation yet.
NGO costs	Increase in funding to NGOs of 6.4%, including escalation and demographic growth funding.
Other provider costs – non personnel	Known cost increases have been included, plus general escalation where relevant.

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

Major risks	Mitigation strategy
The destabilising impact of the significant Provider arm restructure. In addition, there is a risk related to the restructure in the context of the outcome being cost neutral, with specific risk related to the redundancy costs.	• Manage the restructure process very carefully to ensure we balance the competing tensions.
The significant savings plan and the effort required to move to sustainability require considerable focus which may be challenging in the face of day to day pressures.	• Clarify the focus and specific plans to achieve the required savings as soon as is practical. • Ensure there is appropriate focus on execution of the plans. • Ensure that we manage to the bottom line financial outcome, which the saving plans are a component of.
The ability to essentially absorb demographic growth in the Provider arm.	• Do whatever is practical to manage demand. • Optimise the clinical service delivery.
The COVID-19 costs may not be fully covered by additional Ministry of Health funding.	• Engage effectively with the Ministry of Health at all stages.
Unbudgeted costs from central agencies.	• Do whatever we can to encourage effective consultation and decisions that provide optimal value propositions.
Resistance to increased Funder contract management may have an impact.	• Engage effectively with all stakeholders.
There is a risk of unfavourable variances due to the resynchronisation of the RMO rotations which may result in an excess of RMOs for a number of months.	• Manage the reality as best we can.
The assumed leave taken percentage may be too challenging.	• Ensure we have effective leave management practices in place in all areas, with clear visibility of level of achievement.

Major risks	Mitigation strategy
Our ability to re-prioritise information technology investments in order to increase functional delivery to the Provider arm.	• Ensure effective engagement between the Provider arm and Information Services, facilitated by the Enterprise Portfolio Office, in order to optimise delivery of functional gains to enhance clinical service delivery.
The employee relations environment presents uncertainty in terms of potential increases in employee remuneration packages, especially as a flow on from MECA settlements. A one percent increase or decrease in wage rates equates to approximately $7.2 million in additional payroll costs.	• Actively engage in national processes around relevant settlements. • Ensure stakeholders, including the Ministry of Health, are aware of the local "total cost of settlement".
Impact of the interpretation of the 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 2020/21 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, but could be significant for Waikato DHB. In the event that Holidays Act remediation is achieved in 2020/21, we will be dependent on funding from the Ministry of Health from a cashflow perspective.	• Actively engage in national processes around relevant settlements.
There is risk that cost increases for the goods and services will exceed the assumed percentage increases based on the inherent uncertainty of future inflationary pressures. A one per cent increase or decrease in the cost of provider arm goods and services equates to approximately $3.9 million in additional expenditure.	• Review contracting arrangements and negotiate more favourable terms. • Participate in national procurement initiatives to take advantage of bulk purchasing. • Take opportunities noted in the Resource Review.

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

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

1.6 Subsidiaries

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

APPENDIX B:
System Level Measure Improvement Plan

Waikato District Health Board

2020-21

SYSTEM LEVEL MEASURE IMPROVEMENT PLAN

Waikato District Health Board

Pinnacle Midlands Health Network

HAURAKI PHO Te Puna Hauora Matua o Hauraki

National Hauora Coalition

Contents

Introduction

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

Signatories

The 2020/2021 milestones, contributory measures and activities have been decided and agreed by the below parties:

Dr Kevin Snee

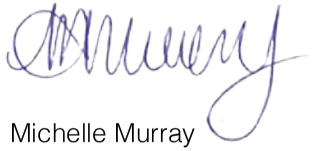
Chief Executive Officer

Waikato DHB

Helen Parker

Chief Executive Officer

Pinnacle Midlands Health Network



Michelle Murray

Chief Executive Officer

Hauraki PHO

Simon Royal

Chief Executive Officer

National Hauora Coalition

Executive summary

Waikato DHB, Pinnacle Midland Health Network, Hauraki PHO and National Hauora Coalition have jointly developed a 2020/21 System Level Measure (SLM) Improvement Plan. Quality improvement is at the heart of this plan with continuous improvement in the quality of care delivered and health outcomes experienced by our population being the main goal. We know we can improve health system performance through focusing on making the health care delivery effective, efficient and sustainable.

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

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

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

Purpose

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

Background

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

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

In the past, both the Waikato DHB and PHOs have had a challenging relationship. Recently, the relationship between the DHB and PHOs has improved significantly. There is also a strong evidence of PHOs also working collaboratively.

The current nationally set SLMs include:

0-4 Ambulatory Sensitive Hospitalisation (ASH)

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

Acute bed days

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

Patient experience of care

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

Amenable mortality

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

Babies living in smoke free homes

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

Youth access to health services

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

Development of the plan

This plan has been developed in partnership with Hauraki PHO, National Hauora Coalition, and Midland Health Network. In light of COVID-19 we are realistic about what we will be able to achieve in 2020-21 as resources must be re-prioritised to focus on COVID-19, limiting capacity within the PHOs and the DHB for the foreseeable. The plan also takes into consideration the experience(s) gained from the collaborative management of COVID-19 pandemic. During this time regular PHO lead catch-ups and weekly inter-PHO clinical and operational meetings took place resulting in strengthened relationships and a coordinated approach delivering services that best meet the needs of our population.

Our commitment to Māori and Pacific health gain remains and the key focus of this plan is eliminating health inequities. To ensure we make real progress a number of achievable activities that build on those from 2019-20 have been agreed.

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

Structure

The SLM plan has oversight from the Waikato Primary and Community Healthcare Alliance (membership still being finalised but currently PHOs, DHB, pharmacy, St John) who will receive quarterly updates on progress against the SLM activities. A smaller working group supported by the Alliance will be responsible for delivery and implementation of the 2020-21 plan.

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

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

DHB	Ethnicity	12 months to December 2017	12 months to December 2018	12 months to December 2019	Performance against target
Waikato	Māori	9263	12,472	10,238	18%
Waikato	Pacific	10,804	14,867	10,924	27%
Waikato	Other	7328	8132	7137	12%
Waikato	Total	8209	10,053	8474	16%
National	Total	6564	7009	6615	6%

Rationale

Respiratory

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

Enrolment

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

Improvement milestone: Annual 5% reduction in ASH rate for Māori and 7.5% for Pacific.

Waikato activity	Contributory measure	Lead responsibility
Respiratory		
Increase uptake of children's influenza vaccination to prevent respiratory admissions by:		
• PHOs providing practices with information on the children who are in the eligible population	Influenza vaccination rates for eligible Māori children. Target 25%.	PHOs
• prioritising vaccination of eligible Māori and Pacific children		PHOs
• using practice level data and quality improvement interventions to improve and monitor the improvement in Māori child immunisation rates		PHOs
• co-design and trial community based immunisation interventions targeting Tokoroa, Waharoa, Hauraki, Taumarunui and other hard to reach rohe		DHB and PHOs

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

System Level Measure 2: Acute bed days

Aim: **Improved management of demand for acute care.**

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

Ethnicity	Year to December 2019
Māori	7328
Pacific	9263
Other	10,804

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

Rationale

Care management

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

Māori are overrepresented in ASH conditions.

Smoking

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

Acute Demand Management Programme

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

Improvement milestone:
- 3% reduction for Māori populations by 30 June 2021
- 3% reduction for Pacific populations by 30 June 2021

Waikato activity	Contributory measure	Lead responsibility
Care management		
Māori patients with ASH conditions (e.g. CHF, CVD,COPD, AF/ Stroke and Cellulitis) receive appropriate clinical support:		DHB
• Māori patients who are eligible for a flu vaccine are targeted	Seasonal target of 75% of Eligible Māori patients adults who receive the flu vaccine.	DHB and PHOs
• To encourage the patients to have their influenza vaccinations the practices: – make phone calls – text – opportunistically vaccinate patients when they visit the practice, hospital, pharmacy, and accident and emergency centres.	Number of 75+ year olds 'Other' with two or more emergency admissions. Number of 65+ year old Māori and pacific with two or more emergency admissions.	PHOs DHB and PHOs
• PHOs to provide their general practices with prioritised lists to recall Māori, Pacific and other vulnerable patients for flu vaccinations, who have not already received their flu vaccination	ASH rate for Māori adults aged 45-64 years old. Target 2% reduction.	PHOs
• Practices to continue to operate their drive-through clinics as per COVID-19 management		PHOs
• promoting use of the a new BPAC referral form to Kainga Ora		PHOs
• General practices to provide targeted outreach for specific population groups such as Kainga Ora/Housing NZ tenants		PHOs
• PHOs to run ongoing communication campaigns to encourage patients to have their flu vaccinations		PHOs
• PHOs are also using their other home visiting services to administer the flu vaccinations		PHOs
• PHOs to use their long term conditions staff to provide a mobile flu vaccination service delivered to the homes of high risk patients		PHOs
• PHOs and general practices to work alongside Te Puna Oranga, local iwi and the wider Waikato network to reach high needs populations, especially Māori whānau and achieve the 90% CVDRA target		PHOs
• All outreach, community pharmacies and mobile services to ensure data is uploaded to the NIR in a timely manner, thus ensuring there is no unnecessary follow up for patients already vaccinated		PHOs

Waikato activity	Contributory measure	Lead responsibility
Smoking		
PHOs and Community Pharmacy will refresh their focus on smoking cessation with new resources to support practices.	15 to 74 year old PHO enrolled population who have had a smoking status of current smoker within the last 15 months.	DHB and PHOs
Patient outcomes related to harm from smoking will be improved by:		
• Incentivised personal and group smoking cessation support, by Māori for Māori	ASH rate for Māori adults aged 45- 64 years old. Target 2% reduction.	PHOs
• Regular reporting rates and referrals to cessation support and rates of medication therapy in primary care	Number of PHO enrolled patients who smoke offered help to quit smoking by a health care practitioner in the last 15 months.	PHOs
• Use of a surveillance reporting to monitor smoking prevalence by ethnicity and age		DHB and PHOs
The importance of smoking cessation as an intervention will be promoted by:		
• continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services to increase the number successful quit smoking attempts.	ASH rate for 45-64 year old Māori and Pacific.	DHB and PHOs
Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS.		PHOs
Acute Demand Management Programme		
As a result of the review of POAC, a cross sectoral Quality Improvement Group has been established to reduce the impact on Emergency Department and hospital services by providing care closer to home through the general practices.	PHOs to report ethnicity/age based utilisation of the POAC service.	DHB and PHOs
Systematically review Emergency Department presentation:		
• Identify specific groups of patients or conditions that could be managed safely in the community through general practices	Decrease in frequent Emergency Department attendees presentations by 60%.	PHOs
• Implement Frequent ED Attendees POAC service to better manage the patients in the community for all age groups including pediatrics		DHB and PHOs
• General practitioners will discuss and implement with the relevant senior medical officer (excluding Emergency Department) a plan for the patient to be managed in the community and avoid acute hospital admission.		

System Level Measure 3: Patient experience of care

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

Rationale

Primary care

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

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

Medicines knowledge

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

Improvement milestone:

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

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

System Level Measure 4: Amenable mortality

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

Rationale

Coronary/CVD

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

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

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

Diabetes

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

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

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

Waikato activity	Contributory measure	Lead responsibility
• Referral of Māori, Pacific and other high risk population groups to culturally appropriate providers for self- management and support i.e. Whanu Ora and mobile long term conditions teams	Rate of Diabetes Annual Reviews by ethnicity (Maori, Pacific and other).	DHB, PHOs and pharmacies
• Develop and implement a diabetes model of care that will include pharmacist, nursing, general practitioner and DHB specialist services to specifically work with high risk patients with diabetes (HbA1c >80). This model of care will be co-designed with iwi and Pacific partners using a locality approach.	Proportion of people with diabetes who have an HbA1c<64, by ethnicity (Maori, Pacific and other).	DHB and PHOs

System Level Measure 5: Babies living in smoke free homes

Aim: **Reduction in the number of maternal smoking as well as the home and whanau/family environments.**

Baseline as at December 2019

Ethnicity	Numerator	Denominator	Percentage of babies living in smoke free homes
Māori	271	960	28.2%
Non-Māori	1167	1927	60.6%

The equity gap between Māori and Non-Māori is 32.4%. This is a small improvement on the 34% start point indicated in the 2019/20 Plan.

Rationale

Pregnancy

Equity: Significant equity gap between Māori and NZ European.This measure targets Māori results to enhance equity focus for monitoring and activity.

Utilisation and access: Low numbers accepting referrals to smoking services.

Smoking during pregnancy leads to increased carbon monoxide concentration in the blood of both the mother and her baby, resulting in reduced oxygen and nourishment available to the baby. This increases the risk of babies being born with a low birth weight and increases the risk of neonatal mortality, sudden and unexpected death in infancy and long-term respiratory problems for the child.

Lifespan

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

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

Waikato activity	Contributory measure	Lead responsibility
Pregnancy		
Increase referrals to maternal incentives smoking cessation programmes by 10% for pregnant women and whānau.	Smoking cessation referral rates for Māori and Pacific. Target 10% increase.	DHB, PHOs and LMCs

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

System Level Measure 6: Youth access to health services

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

Baseline as per September 2019 , the latest national data available (at 3 June 2020)

Ethnicity	Waikato rate per 10,000	National rate per 10,000
Māori	61.6	63.5
Pacific	20.6	31.9
Other	64.8	47.3
Total	61.8	49.4

These rates are a small improvement on the rates reported in the 2019/20 Plan (Total Waikato Rate = 63.3 per 10,000 and Total National Rate = 52.2 per 10,000).

Rationale

Self-harm

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

Improvement milestone:
5% reduction in intentional self-harm hospitalisations including short-stay hospital admissions through Emergency Department for 10-24 year old.

Waikato activity	Contributory measure	Lead responsibility
Waikato DHB to provide workforce development for school based nurses and GPs to improve their capabilities to appropriately assessment, diagnose, support and refer at risk youth for self-harm.	10% increase in referrals to youth primary mental health services.	DHB
Trial and test extended GP consultations for youth (12-24) who are experiencing anxiety.	Number of extended GP consultations by ethnicity (Maori, Pacific, Total).	DHB and PHOs

Appendix

2020/21 SYSTEM LEVEL MEASURES (SLM) WORKING GROUP TERMS OF REFERENCE

Purpose

The purpose of the SLM working group is to bring together local experts across the sector to collaborate and recommend the following for the 2020/21 measure

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

Specific responsibilities

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

Outside of scope

- Funding related decisions

Linkages

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

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

Terms of membership

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

Accountability

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

Governance

Waikato DHB's executive leads for SLM are:

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

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

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

APPENDIX C: Accounting policies

Statement of accounting policies

Reporting entity

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

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

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

Basis of preparation

Financial statements are prepared on a going concern basis, and the accounting policies applied consistently.

Statement of going concern

The going concern principle has been adopted in the preparation of these budgeted financial statements. The Commissioner has received a letter of comfort from the Ministers of Health and Finance relating to the 2018/19 financial year on 21 October 2019 in which the Government acknowledges that equity support to maintain Waikato DHB financial viability may be required and the Crown will provide such support where necessary to maintain viability. The letter of comfort is considered critical to the going concern assumption underlying the preparation of the financial statements.

Statement of compliance

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

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

Presentation currency and rounding

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

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 as at 30 June 2018 that have not been early adopted, and which are relevant to the Waikato DHB and group are:

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34-38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6-8). The new standards are effective for annual periods beginning on or after 1 January 2019 with early application permitted.

These changes have no material implication on the Waikato DHB and group

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.

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

Service performance reporting

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

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant and equipment into the impairment accounting standards. Previously only property, plant and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the June 2020 financial statements.

Summary of significant accounting policies

Subsidiaries

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

Associates

The group's associate investment is accounted for using the equity method. Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

Financial statements include Waikato DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence begins until the date that significant influence ceases.

Joint ventures

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

Financial statements include Waikato DHB's interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases. When Waikato DHB's share of losses exceeds its interest in a joint venture, Waikato DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Waikato DHB has incurred legal or constructive obligations, or made payments on behalf of a joint venture.

Budget figures

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

Revenue

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

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

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

Ministry of Health (MoH) population-based revenue

Waikato DHB is primarily funded through revenue received from MoH, which is restricted in its use for the purpose of Waikato DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

Revenue from MoH is recognised as revenue when earned. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the funding arrangements.

Ministry of Health (MoH) contract revenue

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

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

ACC contract revenue

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

Revenue from other district health boards

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Grants received

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Derivative financial instruments

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

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

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

Inventories

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

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

Non-current assets held for sale

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

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

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

Property, plant and equipment

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

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

Land and buildings

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

Revaluations

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

Land and buildings

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.

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

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

Additions

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

Subsequent costs

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

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

Depreciation
Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives.

Class of asset	Estimated life	Depreciation rate
Buildings	3 - 77 years	1.3 - 36.0%
Plant, equipment and vehicles	3 - 36 years	2.8 - 33.3%

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

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

Impairment of property, plant, equipment and intangible assets
Waikato DHB does not hold any cash-generating assets. Assets are considered cash- generating where their primary objective is to generate commercial return.

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

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

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

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

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

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

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

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

Type of asset	Estimated life	Amortisation rate
Computer software	2 - 15 years	6.6 - 50%

Impairment of intangible assets

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

Trade and other payables

Short term payables are recorded at their face value.

Borrowings

Borrowings are initially recognised at their fair value. After initial recognition all borrowings are measured at amortised cost using the effective interest method.

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

Finance Leases

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

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

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

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

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 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.

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Provisions

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

ACC Partnership Programme

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

Repairs to motor vehicles provision

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

Restructuring

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

Demolition

A provision for demolition is recognised when an approved detailed formal plan for the demolition has either been announced publicly or for which demolition has already commenced.

Equity

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

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

Revaluation reserves

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

Trust funds

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

Income tax

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

Goods and services tax (GST)

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

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

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

Land and buildings revaluations

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

Land

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

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

Buildings

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

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

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

Restrictions

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

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

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

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

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

Retirement gratuities and long service leave

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

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

Critical judgements in applying accounting policies

Management has exercised a critical judgement in applying accounting policies for determining whether an agency relationship exists. In making our judgement we have considered 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.